U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

SMALL HEALTH CARE PROVIDER QUALITY IMPROVEMENT PROGRAM SOURCEBOOK

2019 – 2022

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Introduction

The Small Health Care Provider Quality Improvement Program is authorized by Title III, Public Health Service Act, Section 330A(g) (42 U.S.C. 254c(g)), as amended by Section 201, P.L. 107-251, and Section 4, P.L. 110-355.

The purpose of the Small Health Care Provider Quality Improvement Program is to support the 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.

Purpose

This sourcebook provides an overview of the 31 grantees of the 2019-2022 funding cycle by highlighting their grant projects and achievements during the life cycle of their grant. In this Sourcebook, the following information is included:

- Grantee Information
- Project Overview
  - o Goals and Objectives
  - o Focus Areas
  - o Counties Served
  - o Target Populations
  - o Needs Addressed
  - o Quality Improvement Stakeholders
  - o Evidence-Based Quality Improvement Models
  - o Services and Activities
- Project Results
  - o Outcomes
  - o Sustained Impacts
  - o Learning Opportunities

Program Impact

During the 2019 – 2022 funding period, the Federal Office of Rural Health Policy (FORHP) funded 31 grantees as part of the Small Health Care Provider Quality Improvement (Rural Quality) Program. These 31 grantees are in 19 states, and each received approximately $200,000 a year for program implementation. Included in the sections below are a map of the states with funded grantees and maps and tables that show information on how many grantees were in each state and the counties served by the program.

Funded grantees also represented a diverse set of organizational types. Slightly more than half of grantees were either Federally Qualified Health Centers (FQHCs) or Critical Access Hospitals (CAHs). The remaining grantees were either health departments, hospitals (non-CAHs), network/consortia, non-profit organizations, or rural health clinics (RHCs). Also included is greater descriptive information regarding the funded organization types.

The 31 grantees in the Rural Quality Program addressed a range of health issues in the areas of chronic disease management and clinical preventive screening measures, and focused on internal workflow efficiencies, standardization, and maximization of electronic health records (EHR) usage, and patient-centered medical home (PCMH) certification to name a few. Some common outcomes of the cohort include but are not limited to:

- Improved and enhanced infrastructure capacity for quality improvement work
- Enhanced education and care satisfaction among patients and providers
- Improved use of EHR's for patient tracking, documentation, and reporting
- Achievement of PCMH certification
- Training in motivational interviewing, use of health coaches and community health workers
- Improved clinical measures such as reductions in diabetic hemoglobin A1c scores (HgbA1c), blood pressure scores, and body mass index (BMI's) calculations
- Improvements in data usage, data sharing amongst partners, and development of data dashboards

Grantees by State

This section contains graphical images, represented by map and table, of grantee organizations across the country.

Map of Grantee Organization Locations by State

Table of Grantees by State

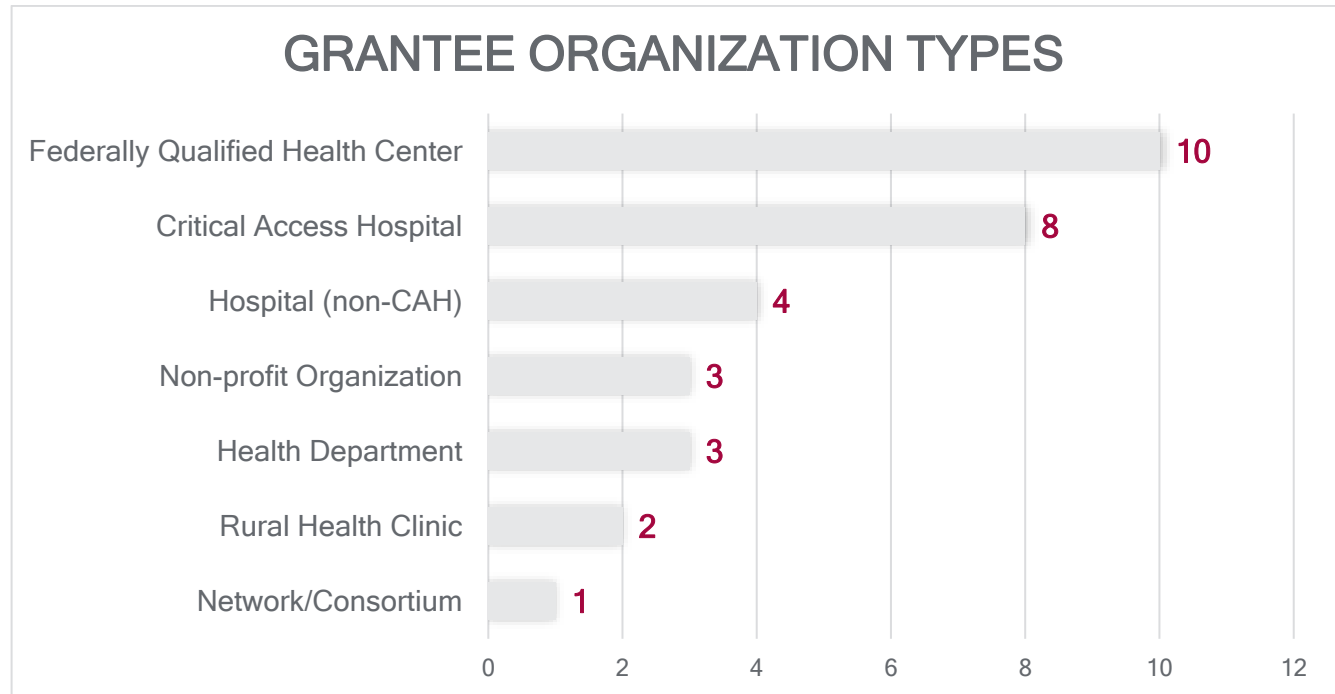| State	Grant Organization Name	Organization Type
Arkansas	Arkansas Rural Health Partnership	Non-profit Organization
Arkansas	DePaul Community Health Centers	Rural Health Clinic
Arkansas	Mainline Health Systems	Federally Qualified Health Center
California	El Dorado County Community Health Center	Federally Qualified Health Center
California	Mayers Memorial Hospital District	Critical Access Hospital
California	Tahoe Forest Health System Foundation	Critical Access Hospital
Colorado	Tri-County Health Network	Non-profit Organization
Illinois	Henderson County Rural Health Center	Federally Qualified Health Center
Illinois	Jersey Community Hospital District	Hospital (non-CAH)
Indiana	Marion General Hospital	Hospital (non-CAH)
Iowa	Greater Sioux Community Health Center	Federally Qualified Health Center
Kansas	Sheridan, County of	Federally Qualified Health Center
Kansas	United Methodist Health Ministry Fund	Critical Access Hospital
Kentucky	Mercy Health Partners of Southwest Ohio	Critical Access Hospital
Kentucky	Purchase District Health Department	Health Department
Louisiana	Innis Community Health Center	Federally Qualified Health Center
Louisiana	Teche Action Board	Federally Qualified Health Center
Maryland	Garrett County Memorial Hospital	Hospital (non-CAH)
Michigan	Upper Peninsula Health Care Solutions	Non-profit Organization
Missouri	Douglas County Public Health Services Group	Federally Qualified Health Center
Missouri	Health Care Coalition of Lafayette County	Federally Qualified Health Center
Missouri	Pike County Memorial Hospital	Critical Access Hospital
Montana	Northern Montana Hospital	Rural Health Clinic
Nebraska	Four Corners Health Department	Health Department
New York	Westchester-Ellenville Hospital	Critical Access Hospital
North Carolina	Granville-Vance District Health Department	Health Department
Pennsylvania	Keystone Rural Health Consortia	Federally Qualified Health Center
Washington	Kittitas County Public Hospital District No. 1	Network/Consortium
Washington	Pullman Regional Hospital Foundation	Critical Access Hospital
Wisconsin	Fort HealthCare	Hospital (non-CAH)
Wisconsin	Upland Hills Health	Critical Access Hospital

Counties Served by Grantee Organizations

This section contains graphical images, represented by map and table, of grantee organizations across the country.

Map of the Counties Grantees Serve(d)

List of Counties Served by State

State	Counties Served
Arkansas	Ashley, Arkansas, Bradley, Calhoun, Chicot, Cleburne, Cleveland, Columbia, Dallas, Desha, Drew, Garland, Grant, Hempstead, Jefferson, Lafayette, Lee, Lincoln, Little River, Monroe, Nevada, Ouachita, Phillips, St. Francis, Stone, Union
California	El Dorado, Placer, Plumas, Nevada, Shasta, Sierra
Colorado	Ouray, Montrose, San Miguel
Illinois	Des Moines, Greene, Henderson, Jersey, Mercer, McDonough, Warren
Indiana	Blackford, Grant, Huntington, Indiana, Miami, Wabash
Iowa	Sioux
Kansas	Cheyenne, Clark, Decatur, Ford, Gove, Graham, Greeley, Kearney, Logan, Meade, Norton, Phillips, Rawlins, Rooks, Sheridan, Sherman, Thomas, Trego, Wallace
Kentucky	Ballard, Breathitt Calloway, Carlisle, Clark, Estill, Fulton, Graves, Hickman, Lee, Madison, Marshall, McCracken, Montgomery, Owsley, Powell, Rockcastle, Wolfe
Louisiana	Assumption, Iberville Parish, Lafourche, Pointe Coupee Parish, St. James, St. John the Baptist, St. Mary
Maryland	Allegany, Garrett
Michigan	Alger, Luce, Mackinaw, Schoolcraft
Missouri	Audrain, Carroll, Douglas, Lafayette, Montgomery, Ozark, Pike, Ralls, Ray, Saline, Douglas, Texas, Wright
Montana	Big Sandy, Blaine, Chouteau, Hill, Liberty, Phillips
Nebraska	York
Nevada	Washoe
New York	Orange, Sullivan, Ulster
North Carolina	Franklin, Granville, Vance, Warren
Pennsylvania	Cameron, Centre, Elk, Fayette, McKean, Somerset
Washington	Grays Harbor, Lewis, Klickitat, Mason, Pacific, Pend Oreille, Whitman
West Virginia	Grant, Mineral, Tucker
Wisconsin	Dane, Grant, Iowa, Jefferson, Lafayette, Sauk, Walworth

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Grantees by Organization Type

This section contains graphical images, represented by graph and tables, of grantee organization types.

Graph of Grantees by Organization Types

GRANTEE ORGANIZATION TYPES

Organization Type	Total Grantees
Federally Qualified Health Center	10
Critical Access Hospital	8
Hospital (non-CAH)	4
Health Department	3
Non-profit Organization	3
Rural Health Clinic	2
Network/Consortium	1
Total	**31**

Table of Grantees by Organization Types

Organization Type	State	Grant Organization Name
Critical Access Hospital	California	Mayers Memorial Hospital District
Critical Access Hospital	California	Tahoe Forest Health System Foundation
Critical Access Hospital	Kansas	United Methodist Health Ministry Fund
Critical Access Hospital	Kentucky	Mercy Health Partners of Southwest Ohio
Critical Access Hospital	Missouri	Pike County Memorial Hospital
Critical Access Hospital	New York	Westchester-Ellenville Hospital
Critical Access Hospital	Washington	Pullman Regional Hospital Foundation
Critical Access Hospital	Wisconsin	Upland Hills Health
Federally Qualified Health Center	Arkansas	Mainline Health Systems
Federally Qualified Health Center	California	El Dorado County Community Health Center
Federally Qualified Health Center	Illinois	Henderson County Rural Health Center
Federally Qualified Health Center	Iowa	Greater Sioux Community Health Center
Federally Qualified Health Center	Kansas	Sheridan, County of
Federally Qualified Health Center	Louisiana	Teche Action Board
Federally Qualified Health Center	Louisiana	Innis Community Health Center
Federally Qualified Health Center	Missouri	Health Care Coalition of Lafayette County
Federally Qualified Health Center	Missouri	Douglas County Public Health Services Group
Federally Qualified Health Center	Pennsylvania	Keystone Rural Health Consortia
Health Department	Kentucky	Purchase District Health Department
Health Department	Nebraska	Four Corners Health Department
Health Department	North Carolina	Granville-Vance District Health Department
Hospital (non-CAH)	Illinois	Jersey Community Hospital District
Hospital (non-CAH)	Indiana	Marion General Hospital
Hospital (non-CAH)	Maryland	Garrett County Memorial Hospital
Hospital (non-CAH)	Wisconsin	Fort HealthCare
Network/Consortium	Washington	Kittitas County Public Hospital District No. 1
Non-profit Organization	Arkansas	Arkansas Rural Health Partnership
Non-profit Organization	Colorado	Tri-County Health Network
Non-profit Organization	Michigan	Upper Peninsula Health Care Solutions
Rural Health Clinic	Arkansas	DePaul Community Health Centers
Rural Health Clinic	Montana	Northern Montana Hospital

Grantee Focus Areas

This section contains a table, which displays the focus area(s) for each grantee organization.

Table of Focus Areas by Grantee Organization

Grantee Organization Name	Behavioral/Mental Health	Cancer Care Management	Cardiovascular Disease (CVD) Care Management	Case Management	Chronic Disease Management	Chronic Obstructive Pulmonary Disease (COPD)	Community-based Care Coordination	Diabetes Care Management	Health Education/Promotion and Disease Prevention	Health Improvement Special Project (HISP)	Health Screenings	HIV/AIDS	Maternal and Child Health	Oral Health	Pediatric Care	Pharmacy Assistance	Population Health	Prevention	Primary Care Services	School Based Care Coordination	Specialty Care Services	Substance Abuse Treatment and/or Education	Telehealth/Telemedicine	Transitions of Care	Treatment and Management	Women's Health
Arkansas Rural Health Partnership			X	X			X		X							X	X	X	X					X		
DePaul Community Health Centers	X			X																						
Douglas County Public Health Services Group				X													X		X							
El Dorado County Community Health Center				X		X	X	X		X							X	X	X						X	
Fort HealthCare								X																		
Four Corners Health Department	X		X				X	X																		
Garrett County Memorial Hospital				X																						
Granville-Vance District Health Department																X										
Greater Sioux Community Health Center				X			X										X									
Health Care Coalition of Lafayette County	X		X	X			X											X	X			X	X		X	

Organization	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Henderson County Rural Health Center			X						X				X							
Innis Community Health Center				X			X													
Jersey Community Hospital District	X			X			X													X
Keystone Rural Health Consortia													X							
Kittitas County Public Hospital District No. 1	X	X		X			X					X	X	X				X		
Mainline Health Systems			X	X			X	X			X									
Marion General Hospital		X		X			X											X		X
Mayers Memorial Hospital District	X														X			X		X
Mercy Health Partners of Southwest Ohio				X	X	X	X	X				X	X				X	X		X
Northern Montana Hospital				X			X													
Pike County Memorial Hospital	X		X	X			X	X				X	X	X				X		X
Pullman Regional Hospital Foundation			X	X			X						X							X
Purchase District Health Department		X		X		X		X	X			X						X		
Sheridan, County of	X	X		X		X	X	X	X	X	X	X	X	X		X	X	X	X	
Tahoe Forest Health System Foundation	X																			
Teche Action Board				X								X	X							
Tri-County Health Network		X		X			X	X				X		X						
United Methodist Health Ministry Fund				X			X	X												
Upland Hills Health		X	X	X	X		X	X					X					X		X
Upper Peninsula Health Care Solutions	X												X							
Westchester-Ellenville Hospital		X		X			X		X			X	X							X

Grantee Profiles

The following section contains brief descriptions of the 31 grantees of the Small Health Care Provider Quality Improvement Program during the 2019-2022 funding cycle. These descriptions include a project overview, which highlights the following: grant goals and objectives, program focus areas, counties served and target populations, quality improvement stakeholders engaged, and evidence-based quality improvement models or promising practices implemented. Highlights of program results are also shared and include a description of project outcomes, sustained impacts of the program, and learning opportunities for other communities.

Arkansas Rural Health Partnership

Arkansas Rural Health Partnership Regional Quality Improvement Program
G20RH33260 | Non-Profit Organization | www.arruralhealth.org
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Amber O'Fallon | Senior Programs Director | amberofallon@arruralhealth.org | (870) 461-0276

PROJECT OVERVIEW

Goals & Objectives

Goal: Strengthen the organizational and infrastructural capacity of hospital and primary care clinic partners to address critical quality improvement needs throughout rural South Arkansas by 2022.
Objectives:

1. Throughout the three-year grant, the Arkansas Rural Health Partnership (ARHP) Consortium will share the responsibility of the achievement, dissemination, and sustainability of the quality improvement (QI) program activities.
2. Beginning in year two, ARHP will focus of moving forward with the QI initiatives with four partner clinics (Family Clinic of Ashley County, Magnolia Regional Family Clinic, McGehee Family Clinic, and Ferguson RHC).
3. Throughout the duration of year two, ARHP will continue to develop infrastructure and tools to support existing and new QI activities throughout the region.
4. In year one, ARHP project staff will train local health workforce partners to utilize and implement an evidence-based QI model within their practice setting.
5. Throughout the duration of the grant, the Project Director (PD) will assist primary care clinic partners to improve the utilization of the Electronic Medical Record (EMR). Objective 6. Each year, assist four clinic partners to improve selected clinical measures by 3-5% through focused quality improvement efforts.
6. Beginning in year two, Implement a health coach program at one partner hospital to improve patient outcomes and compliance by providing a touch point after inpatient and/or emergency room discharge to ensure patients are adhering to treatment plans, medication schedules, and/or keeping follow-up appointments.
7. In year two, Provide Rural Health Clinic (RHC) Compliance Support to five staff members at 11 partner clinics.

Focus Areas

Case Management, Chronic Disease Management, Prevention, Community-based Care Coordination, Health Education/Promotion and Disease Prevention, Pharmacy Assistance, Primary Care Services, Population Health, Transitions of Care

Counties Served

The project serves 26 counties in primarily Southeast Arkansas:
- Fully rural: Arkansas, Ashley, Bradley, Calhoun, Chicot, Cleveland, Dallas, Desha, Drew, Grant, Lee, Monroe, Ouachita, Phillips, St. Francis, Union, Columbia, Lafayette, Little River, Nevada, Stone, Lincoln, Cleburne, and Hempstead
- Partially rural: Jefferson and Garland

Target Populations

The target populations served by the Quality Improvement Grant included:
1. Adult patients at participating rural health clinics (8) and/or rural hospitals (2) that meet criteria for ongoing Clinical Quality Measure Tracking
2. Adult patients recently discharged from a participating rural hospital (2) and enrolled in the Health Coaching Discharge Follow-Up Program.

Needs Addressed
The majority of patients served by the project were adults with chronic disease, primarily diabetes and/or heart disease. Primary needs of the patient population served included:
- Access to durable medical equipment assistance (i.e. patients discharged from the hospital needing oxygen and would not make trip to acquire needed supplies).
- Prescription assistance (i.e. patients without funds for needed medications were connected to population health specialists to get needed prescriptions).
- Transportation assistance (particularly to follow-up appointments).
- Education related to medication adherence, disease processes, and treatment options

Quality Improvement Stakeholders
- Key stakeholders initially involved in the project included ARHP senior leadership, staff, ARHP member hospitals (14), and rural clinics (10).
- For the duration of funding, QI stakeholders included 2 member hospitals (Jefferson Regional, Magnolia Regional Medical Center) and 12 rural clinics (Ferguson RHC, Family Clinic of Ashley County, Ashley Health Services, Hamburg Health Clinic, Bradley County Medical Center Rural Health Clinic, Marsh George Clinic, Lake Village Clinic, Delta Health Services, McGehee Family Clinic, BCMC Family Clinic, Monticello Medical Center, Burleson Medical Center).

Evidence-Based Quality Improvement Model(s) or Promising Practices
The project utilized the evidence-based Model for Improvement. The Model for Improvement is a proven model for maintaining focus areas and rapid Plan-Do-Study-Act (PDSA) cycles in the real work setting. The PDSA cycle guides the test of a change to determine if the change is an improvement.

Services & Activities
1. Developed and implemented required infrastructure to ensure success of project efforts (includes preliminary QI survey with clinic partners, collecting preliminary baseline data for required QI measures, conducting a site-specific needs assessment at each clinic, develop calendar/meeting schedule for Regional QI collaborative meetings, establish needed contracts).
2. Provided education to clinics about maintaining rural health clinic (RHC) accreditation.
3. Assisted partner hospitals and clinics to update policies and procedures related to transitional care management and chronic care management services.
4. Reviewed clinical measure data and utilized PDSA cycles (as needed) each month to ensure continuous quality improvement of defined measures.
5. Assisted clinics to leverage existing and potential incentive and reimbursement programs.
6. Provided health coaching services to target population to assist with follow-up and treatment adherence.
7. Trained clinic staff to improve tracking of measures within EMR.
8. Provided support to clinic partners related to QI model implementation.

PROJECT RESULTS

Outcomes

1. Improved and enhanced infrastructure and capacity within partner clinics and hospitals to support and provide healthcare, which targets and supports QI measures in the patient population, which improves health outcomes and quality of life of those engaging in care.
2. Enhanced support and education provided to clinic partners improves quality of care, continuity of care, and patient/provider satisfaction. Clinics maintain relevant accreditation, which improves visibility in community and local access to care.
3. Local clinics and hospitals maintain a high standard of care that is based on QI metrics and evidence-based practices.
4. Local clinics and hospitals leverage additional funding to support care delivery, which increases the sustainability and viability of rural health services throughout the region. This helps to prevent the outward migration of patients due to need to access quality healthcare, which in turn supports the rural ecosystem, including the local economy.
5. Patients are supported in their healthcare and benefit from access to needed assistance, treatment adherence support, and enhanced connection to local providers. This improves follow-through and engagement in care, which improves health outcomes.
6. Improved tracking in the EMR increases clinic revenue (and sustainability) and improved care delivery (benefiting the health outcomes of patients).

Sustained Impacts

Sustained impacts of the project include:

1. Improved Service Models and Increased Capacity: Clinic providers will continue to use InQdocs, a cloud-based policy and document subscription service to maintain up-to-date policy and procedure manuals that reflect QI measures and initiatives. Partner clinics will continue to improve QI performance measurement by continuing current, effective tracking methods. Partner clinics will continue to use PDSA cycles to improve decision-making and workflow. PHQ2 and PHQ9 screening tools for depression will continue to be used. Partner hospitals will continue to provide health coaching discharge follow-up call services to improve patient self-management/compliance (which in turn reduces the healthcare burden on patients, the hospital, the and Medicare system).
2. Changes in Knowledge, Attitudes & Behaviors: Clinic staff will continue to utilize training acquired to improve workflows, accurate billing and coding, and in turn, increased revenue & sustainability of the clinic. Patients engaged in health coaching will continue to improve self-management of care and related compliance to treatment recommendations.

Learning Opportunities

- A major lesson learned during the QI project was that not all EMR systems have equal capabilities for capturing quality reports for clinical quality measures. This discovery sadly eliminated several clinics from participating in the project due to the EMR's inability to properly track clinical measures.
- Health coaching was wildly successful in supporting patients that needed enhanced follow-up to chronic care management and transitional care management services upon hospital discharge. This service successfully supported patients to increase follow-up and continuity of care with primary care providers post hospital discharge.
- Patient-Centered Medical Home (PCMH) accreditation was simply too staff intensive, particularly during COVID-19 to pursue. This element of the proposed project was eliminated early into the project.

DePaul Community Health Centers

Whole Health Program
G20RH33266 | Rural Health Clinic | www.depaularkansas.org
161 South Main Street, Dumas, Arkansas 71639 | (870) 382-3080
Lisa Goodgame | Vice President of Operations Arkansas | LGoodgame@ascension.org | (870) 377-1132

PROJECT OVERVIEW

Goals & Objectives

The DePaul Community Health Center's (formerly known as Daughters of Charity Services of Arkansas) Whole Health Program centered on three main goals.

1. Increase access to behavioral health care.
2. Provide holistic care in the true spirit of patient centeredness.
3. Improve the continuum of care infrastructure through the efficient use of scarce behavioral health resources.

DePaul Community Health Centers (DCHC) has a fundamental goal to improve the quality of life for adult patients with multiple chronic diseases by providing this population with access to treatment for mental health and substance use disorders. This behavioral health integration program screened and identified mental health and substance use disorders among the targeted population which has allowed for timely and effective primary care-based intervention and therapy and linked patients with complex multiple morbidities to psychiatric/counseling consults.

The implementation of the "Whole Health Program" as a hybrid primary care behavioral health integration program drew on elements from evidence-based models. The Screening, Brief Intervention, and Referral to Treatment (SBIRT) framework was adopted to ensure all targeted patients were screened for Mental Disorders / Substance Use Disorders (MD/SUD) using multidimensional health assessment tools. Patients identified as needing counseling were triaged to Telehealth Behavioral Services provided by a Licensed Clinical Social Worker (LCSW). Those patients needing external psychiatry consultation could access care via the telepsychiatry resources of the University of Arkansas for Medical Sciences/e-Link telehealth network, a collaborating partner, to install the e-Link system at clinic locations in Dumas and Gould, AR. This allowed for telehealth services to be available at both locations.

Focus Areas

Behavioral/Mental Health, Chronic Disease Management

Counties Served

Desha and Lincoln County, Arkansas

Target Populations

Whole Health Program (WHP) targeted rural patients, aged 18 years and older, registered in the DCHC Chronic Disease Registry with chronic comorbid diseases of hypertension, Diabetes Mellitus (DM), high cholesterol and behavioral health needs.   Desha and Lincoln Counties encompass an estimated 26,170 persons and are the poorest and most disadvantaged counties in the United States.

Needs Addressed

DCHC focused on decreasing the burdens of poverty, unemployment, lack of access/transportation, isolation, provider shortages and overall poor health. Many persons with chronic disease also suffer MD/SUD and it is widely recognized that the combination of MD/SUD and chronic diseases are often inextricably linked. This impairs the patients to self-manage their overall health. The integration of MD/SUD screening and treatment and chronic disease medical care in the primary care setting is a huge benefit to the patient. Improving telehealth accessibility increases the access for behavioral health visits, thus improving the quality of care and services for those without transportation.

Quality Improvement Stakeholders

- DCHC established a relationship with University of Arkansas for Medical Sciences to establish a HIPAA-compliant telehealth platform, Arkansas e-Link. This system is in both clinics, Dumas and Gould, and established a behavioral health integration into our Primary Care settings.
- DCHC also received training from the University of Washington Advancing Integration of Mental Health Solutions (AIMS) Center for the integration of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) assessment into clinic workflows. The training was for the entire staff from front desk to providers on how to implement the SBIRT in a rural setting.
- Jennifer Frizzell, Vice-President of Population Health, provided extensive training on "AIM for Excellence". This program focuses on improving Huddle Boards and overall Quality improvement.

Evidence-Based Quality Improvement Model(s) or Promising Practices

DCHC has implemented many evidenced-based models.

1. SBIRT has been implemented and patients needing additional follow-up are scheduled with the LCSW.
2. The Patient Health Questionnaire (PHQ9) assessment is completed by all patients on a yearly basis and the shorter PHQ2 is given to patients at each visit.
3. The "AIM for Excellence" Program taught the clinical staff how to look at issues differently and operate as a team with the PDSA and Smart Goals.
4. PDSA Model was utilized for many activities but most specifically through our monthly nursing and provider meetings. Planning occurs in one meeting, the "do" is then completed for one month. After that, the "study" and "act" is then implemented at the next meeting. This process is ongoing until the clinic team can reach the identified goal.
5. Rapid Cycle was utilized daily. As tasks arise, items were discussed, usually via telephone, an adjustment was made, and an outcome was evaluated immediately. This may be repeated several times throughout the day until the team was able to achieve the desired outcome

Services & Activities

- WHP improved the quality of life for patients with multiple chronic diseases by providing the population with access to treatment for MH/SUD. The BH integration program identified MH/SUD among our population. Our approach was to enhance and implement new services/activities and integrate quality goals and scores.
- Enhanced services included: Chronic Care Management (CCM), disease management supported through the Electronic Medical Record (EMR), access to care, and restructuring our CCM. Transition to a new EMR fell short so the clinic system transitioned to eClinicalWorks. This transition was thought to be a better fit for disease management efforts.
- DCHC offered many new services during the funding period including AR e-Link and diabetes self-management education (DSME) classes. QI Teams were designed to specifically address hypertension and elevated Hemoglobin A1C and meet regularly. DCHC partnered with American Heart's Target Blood Pressure program to provide education and reward self-management of hypertension.

- DCHC established close working relationships with stakeholders to improve our quality outcomes and identified the significance of the team approach. Huddle boards provide crucial communication to staff each day. This preplanning for appointments focuses on closing care gaps and addressing all needs.

PROJECT RESULTS

Outcomes

1. Enhanced services: All patients were screened for depression. The PHQ9 is completed annually, with the PHQ2 completed at every visit. All patients are screened for Alcohol and Drug Use, using the SBIRT.
2. Expanded Services: Appointments with a LCSW is available through Telehealth. Chronic Care Management Program was re-established. Huddle Boards have improved with a focus on quality care for diabetic and hypertensive patients.
3. Quality Improvement Integration: Quality Improvement Meetings were held monthly. Process Improvement (PI) Teams were established and met weekly. Several PI Teams were established to improve specific Quality Measures. A1C quality measure (Percent of Diabetic patients with an A1C greater than 9) has decreased from 76% to 25%. Depression screening improved from 47% to 77%. The percent of patients with controlled blood pressure scores was at 44.3% and is now 54%. Quality Measures are presented and discussed with Clinical Staff monthly.
4. Established a workflow to contact No-Show patients and decrease the percentage of no-shows.
5. Care Gap reports were distributed, and phone calls/letters are made to those patients.

Sustained Impact

This project allowed DCHC to look beyond the traditional in-clinic patient visits and opened the door to allow for telehealth services. By working with the University of Arkansas Medical School (UAMS) and establishing their e-Link system, telehealth services are now available to the Southeast Arkansas community for not only Behavioral Health Services, but Primary Care was also available, especially during the COVID Pandemic. DCHC established the "AIM for Excellence" Program which contributed to improvement on the concept of Team Based Care. Morning huddles and huddle boards focus more on patient care allowing the team to reinforce quality measures and care gap needs with the team. A Quality Measure Scorecard is provided to the Clinical Team with measures for the entire organization and for each individual provider.

Learning Opportunities

- The biggest challenge was the ability to recruit a Behavioral Health Provider in rural southeast Arkansas. The team is now providing these services by telehealth with a LCSW, but feel patients still need face-to-face encounters. DCHC is exploring the option to recruit a Psychiatric Advanced Practice Registered Nurse (APRN) instead of an LCSW.
- DCHC has had numerous staffing challenges in key positions. A major challenge was finding a Director of Clinical Services who had experience in Quality Programs. This position is key to the success of Quality improvement. Leadership also recognized that the CCM nurse must be dedicated to CCM full time and not used as an option for clinical nurse shortages. A new clinical nurse was hired and the CCM nurse was relocated to eliminate distractions and work closely with billing and clinical leadership.
- Having a robust EMR is critical in establishing a Quality Program. The current EMR is severely lacking in reporting capabilities and is not capable of accurately reporting some of the National Quality Forum (NQF) measures, particularly those involving Depression Remission at Six and Twelve Months. Hopefully, the transition to a new EMR will alleviate this problem soon.

Douglas County Public Health Services Group

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Debby Jeckstadt| Program Coordinator | djeckstadt@mo-ozarks.org | 417-683-5739

PROJECT OVERVIEW

Goals & Objectives
Through the Missouri Ozarks Health Improvement Project (MOHIP), the goal was to realize better patient engagement in care, improved patient self-management, decreased use of hospital emergency departments for preventable visits, and ultimately, improve health status for the target population. MOHIP sought to improve coordination and integration of care using the Chronic Care Model, Community Health Worker model, and Institute for Health Improvement in a Patient-Centered Medical Home framework.

Focus Areas
Chronic Disease Management, Primary Care Services, Population Health

Counties Served
Douglas, Ozark, Texas, and Wright in Missouri

Target Populations
The target patient population was individuals identified with diabetes, cardiovascular disease, hypertension and depression, and individuals who had a history of smoking or tobacco use and/or weighed outside normal parameters. Specific emphasis was placed on individuals with no primary care provider or who frequented the hospital emergency department of ambulatory care with sensitive conditions.

Needs Addressed
The target population often required a frequency of primary care and specialty visits. This was usually a result of unmanaged patient needs and high utilization of emergency room care. Providing Care Coordinators and Community Health Workers to bridge those gaps provided a more targeted strategy to allow better patient outcomes overall. The team saw in practice how this comprehensive approach made it less likely for the high-risk patients to fall through the cracks in the healthcare system.

Quality Improvement Stakeholders
Continuous Quality Improvement Team (this included all department heads, CEO, COO, & CFO)
Community Health Workers
Missouri Primary Care Association
Azara/DRVS (data warehouse)
Medical Home Network (MHN) Direct Contracting Entity

Evidence-Based Quality Improvement Model(s) or Promising Practices
Patient-Centered Medical Home (PCMH)
Chronic Disease Management/Chronic Care Model
Institute for Health Improvement-Model for Improvement (Plan Do Study Act Cycles)
Community Health Worker

Services & Activities

Missouri Ozarks Health improvement Project (MOHIP) utilized the program to support a Project Coordinator, as well as a care team that included three Care Coordinators and two additional Community Health Workers. This staff was fully integrated into provider and nurse care teams, along with behavioral health and dental services, allowing patients a full spectrum of care and better patient outcomes.

The community health workers are an integral part of the care team, working as liaisons between the patient and many health and social service organizations. Other support included providing information and resources, coordinating transportation, making appointments, making appointment reminders, and helping those without insurance, apply for coverage through the Health Insurance Marketplace and/or Missouri Medicaid.

PROJECT RESULTS

Outcomes

1. Improved patient satisfaction – The project received a larger number of responses to a patient survey (324 responses). Results showed an improvement in ease of getting an appointment (4.58/5.00) wait time (4.32/5.00), enough time with the provider (4.69/5.00), and satisfaction with the payment amount (4.38/5.00).
2. Increased assessments of Social Determinants of Health (SDOH) - Increased to 26% completion rate as of April 30, 2022. (baseline = 0% in 2019)
3. Improved patient outreach and communication – Staff was added to make calls one-on-one, as well as utilizing a Care Message system that allowed for reporting of the number of messages sent to remind patients of upcoming appointments, as well as when appointments for cancer screenings were due and when children were due for immunizations.
4. Improvement in some clinical quality measures - The COVID-19 pandemic caused some issues with workflows and collecting some patient data over the last two years; however, the project began seeing an improvement in 2022. Body mass index (BMI) screening and follow-up improved to 82.4%. Tobacco use screening and cessation increased to 98.2%.

Sustained Impacts

Missouri Ozarks saw a great improvement between medical, behavioral health, and dental teams in utilizing the Community Health Workers and Care Coordinators to better serve patients. The team is seeing a greater need as it works to expand that support staff for the rural community served by the project. Medical providers are a great example of how those staff can be used to serve patients' SDOH requests, including help with medications, transportation to appointments, and help in obtaining durable medical equipment (DME) for those patients that do not have access. Care Coordinators are also creating care plans for patients that set obtainable goals and build a bridge between the patient and the provider, ultimately giving more one-on-one time to the population served. Overall, providers are becoming more receptive to the help offered by the integrated team of professionals which results in better health for all patients.

Learning Opportunities

The most important thing learned is the importance of staffing, especially in the nursing department. During this time of the COVID-19 pandemic, Douglas County Public Health was horribly understaffed with nursing supervisors down at times as many as 17 nurses. This downturn in consistent staffing proved just how large a role the nursing staff has in quality outcomes. Douglas County Public Health

is now close to being fully staffed and seeing more and more improvement in measures, and patients are reaping the greater benefit.

Douglas County Public Health also learned that the team approach is vital to our success. The team began presenting monthly reports to providers unblinded, which allowed them to learn from each other and have conversations on how to achieve greater success. Integrating the team-based approach has been very beneficial and continues to be of great importance to staff.

El Dorado County Community Health Center

Diabetes Prevention and Management Program
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PROJECT OVERVIEW

Goals & Objectives

El Dorado County Community Health Centers (EDCCHC) set out 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 were provided to pre-diabetic and diabetic patients through community-based classes and partnerships with Community Hubs and clinics.

Focus Areas

Chronic Disease Management, Prevention, Treatment and Management, Community-Based Care Coordination, Diabetes Care Management, Health Education/Promotion and Disease Prevention, Health Screenings, Primary Care Services, Population Health, Social Determinants of Health (SDOH)

Counties Served

El Dorado County, California

Target Populations

1,500 pre-diabetic and 900 diabetic patients living in rural El Dorado County, California

Needs Addressed

Diabetes prevention and management with a focus on lifestyle education, enhanced care coordination, and coordinated efforts to assess and meet social determinants of health.

Quality Improvement Stakeholders

Internal stakeholders included EDCCHC leadership, quality improvement and health information technology teams, care teams, integrated behavioral health clinicians and patient advocates. External stakeholders included Marshall Medical Center, Community Hubs, Senior Center, and El Dorado County Health and Human Services.

Evidence-Based Quality Improvement Model(s) or Promising Practices

The project utilized the Model for Improvement and Plan-Do-Study-Act (PDSA) cycles as its primary quality improvement models. In addition, the project implemented the Centers for Disease Control and Prevention (CDC) PreventT2 curriculum in sessions with patients living with pre-diabetes. The Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) Toolkit was implemented to assess Social Determinants of Health (SDOH) and the project ensured Patient-Centered Medical Home (PCMH) renewal occurred annually.

Services & Activities

The project offered evidence-based lifestyle education sessions to all project participants near where they lived and worked. This was adapted to tele-video and tele-audio sessions due to COVID-19. The PRAPARE Implementation and Action Toolkit was implemented among project participants to begin to understand and address Social Determinants of Health (SDOH). Provider dashboards were developed and implemented to support patient engagement and population management for pre-diabetics and diabetics. Finally, key standards and elements of Patient-Centered Medical Home (PCMH) were incorporated in the care of the target population.

PROJECT RESULTS

Outcomes

Nearly 100% of pre-diabetic and diabetic patients were offered lifestyle change education through provider and care team referrals, patient outreach, mailers and telephone calls. More than 900 patients with pre-diabetes and diabetes participated in lifestyle change education. The PRAPARE screening survey was successfully incorporated into eClinical Works (eCW), EDCCHC's electronic health record, and a workflow established to ensure positive surveys were reviewed by Patient Services. Seventy-five percent of project participants received the survey, with about half completing at least a portion of the survey. Approximately 100 patients received assistance with Social Determinants of Health (SDOH) through Patient Services and external partners. PCMH renewal was completed, and recognition achieved for all four clinic locations during year one and two of the grant. Once submission is complete, it is anticipated that the PCMH recognition will also be achieved for year three.

Sustained Impacts

Sustained impacts of the Diabetes Prevention and Management Project include:
1. The organizational commitment to continue pre-diabetes and diabetes lifestyle education for patients.
2. Continuation and expansion of data-driven decision-making through provider dashboards.
3. Continuation and expansion of patient screening for (and assistance with) Social Determinants of Health (SDOH) after the grant is complete; and
4. Increase in care team awareness and understanding of Patient-Centered Medical Home (PCMH) and a deeper commitment to patient pre-visit planning.

Learning Opportunities

COVID-19 required staff to creatively develop ways to continue project activities, most notably, lifestyle change education. Project staff learned they could adapt quickly and use tele-video and tele-audio sessions to provide lifestyle education to patients. As provider dashboards were developed and implemented during the pandemic, staffing became limited, making it difficult to pilot dashboards as planned. However, project staff were able to adjust plans and work with a few key providers to complete the pilot and make needed modifications to dashboards, resulting in effective tools used for population management and proactive outreach. Implementing the PRAPARE survey with EDCCHC's patient population presented challenges, due to sensitive questions in the survey and patient hesitancy to answer what they viewed as private information. Many patients also found the survey too long. During monthly TA calls, project staff were able to talk through ideas to address this challenge and designed an effective method to ask PRAPARE survey questions using a conversational approach and gathering survey information over multiple sessions when patients expressed discomfort with the survey.

Fort HealthCare

Improving Diabetes Care for Healthier Communities
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Traci Wilson | Grant Compliance Specialist | traci.wilson@forthc.com | (920) 568-5244

PROJECT OVERVIEW

Goals & Objectives

The Fort HealthCare Improving Diabetes Care for Healthier Communities project sought improvement in clinical outcome and process measures, increased community access to health care and services, and increased collection and analysis of social determinants of health (SDOH) data points for a target population consisting of patients who qualified for but did not meet the Hemoglobin (HbA1c) < 8% measure in the Cerner HealtheRegistries (approximately 541 patients as of Aug 1, 2019).

1. Improved diabetes care and patient health outcomes as represented by the following measures:
    a. Diabetes Registry (Blood Pressure < 140/90 mm Hg, Eye Exam, Foot Exam, HbA1c < 7%, HbA1c < 8%, HbA1c ≤9%, Lipid Panel, Nephropathy Monitoring, Statin Therapy);
    b. Adult and Senior Wellness Registries (Depression Screening and BMI Follow-Up Plan); and,
    c. Increased referrals and engagement to quality improvement project activities or programs (e.g., Comprehensive Care Management (CCM), Diabetes Self-Management Education and Support (DSMES)).
2. Increased community member access to care as measured by an increased number of attributed persons (denominator) in Fort HealthCare Cerner Diabetes Registry or at Rock River Community Clinic.
3. Increased collection and analysis of select Social Determinants of Health (SDoH) measures to identify and address health disparities.

Focus Areas

Diabetes Care Management

Counties Served

Fort HealthCare primarily serves Jefferson County, WI but does have clinics serving the border communities of Whitewater (Jefferson and Walworth Counties) and Cambridge (Jefferson and Dane Counties).

Target Populations

Fort HealthCare (FHC) selected a full patient population and target population that were not the same population. The full patient panel were FHC patients 18 years and older with a diabetes diagnosis meeting Cerner HealtheRegistry attribution (denominator) logic. The target patient population were all FHC patients 18 years or older with a diabetes diagnosis and not meeting the HbA1c < 8% measure within Cerner HealtheRegistries.

Needs Addressed

IIn Fort HealthCare's (FHC) primary service area at time of application, 14,025 persons were estimated to have diabetes, and improving health outcomes for patients with diabetes as a target population, especially those with poorly controlled diabetes, stood out as an area of improvement. Poorly controlled diabetes can lead to costly complications that can have a negative impact on the quality of life and potentially life expectancy. The

FHC target patient population was all FHC patients 18 years and older with a diabetes diagnosis and HbA1c ⬚ 8% (approximately 541 patients as of August 1, 2019).

Quality Improvement Stakeholders

At Fort HealthCare, the key stakeholders were as follows: Executive Director of Population Health & Clinical Services; Medical Director of Quality; Comprehensive Care Coordinator; Director of Quality and Integrated Care; Diabetes Support and Education Specialists; Pharmacy; Information Technology; and clinic-based Health Outcomes Specialists (closure of care gaps). Externally, the primary stakeholders were Rock River Community Clinic (medically underserved population); Dr. Yao Liu, University of Wisconsin School of Medicine and Public Health (teleophthalmology program); Fort Atkinson Lions Club and other community organizations/events (funding support, diabetes awareness).

Evidence-Based Quality Improvement Model(s) or Promising Practices

- Fort HealthCare (FHC) followed the Chronic Care Model as the selected QI model for improving high-quality chronic disease management at both individual and systems levels. Specific domains of this QI model have been effective with diabetes-related interventions. FHC also incorporated the Associates in Process Improvement's (API) Model for Improvement by using Plan-Do-Study-Act (PDSA) cycles to test select ideas and changes.
- Fort HealthCare participated in a University of Wisconsin rural teleophthalmology program (promising practice) which sought to increase rates of diabetic eye screenings in rural communities. This program has grown to three retinal-imaging cameras across Fort HealthCare and into a National Eye Institute study to further improve diabetic eye screenings in rural communities.

Services & Activities

Fort HealthCare's (FHC) Improving Diabetes Care for Healthier Communities key activities included:

- Launch of a Comprehensive Care Management (CCM) program, which has grown from 0.7 to 1.7 FTE, and is now exploring application to other priority chronic diseases for improved management outcomes.
- Implementation of project-related staff training and patient education.
- Integration of depression screening in primary care and through CCM program.
- Implementation of a teleophthalmology program to provide diabetic retinal eye screenings.
- Improved Diabetes Self-Management Education and Support (DSMES) referral and engagement coordination.
- Exploration of ambulatory pharmacy program for patients with diabetes.
- Establishment of strategic community outreach and partnerships to increase access to care and data.
- Built Information Technology and population health select measures into FHC's Cerner Electronic Health Record (EHR) or data systems.
- Testing of Social Determinant of Health (SDoH) tool(s) and data points.

PROJECT RESULTS

Outcomes

As of April 1, 2022, FHC can list the following outcomes. [Note: outcomes will be described in terms of peak performance. Due to the impact of the global pandemic, most measures hit low points in 2020 and have been rebounding since then.]

1. Diabetes: BP<140/90 mm Hg improved from 76.9% to peak at 82.7%
2. Diabetes: Eye Exam improved from 44.6% to peak at 47.8%
3. Diabetes: Foot Exam did NOT improve and decreased from 69.2% to 59%

4. Diabetes: HbA1c<7% improved from 38.4% to peak 45.2%
5. Diabetes: HbA1c<8% improved from 69.6% to peak at 72%
6. Diabetes: HbA1c≤9% improved from 82.1% to peak at 84.5%
7. Diabetes: Lipid Panel improved from 81.9% to peak at 85.7%
8. Diabetes: Nephropathy Monitoring improved from 84.2% to peak at 92.6%
9. Diabetes: Statin Therapy-Generic Diabetic Group improved from 65.15% to peak at 67%
10. Adult & Senior Wellness: BMI Follow-Up Plan improved from 32.5% to peak at 34.6%
11. Adult & Senior Wellness: Depression Screening improved from 16.7% to peak at 80.4%
12. Comprehensive Care Management (CCM) has grown from a single 0.7 FTE CCM nurse servicing the project's target population to two CCM nurses (1.7 FTE) servicing 178 patients with a variety of chronic condition needs (as of March 2022).
13. Diabetes Self-Management Education and Support data collection evolved from a focus on referral numbers to percent patient engagement. Average referral numbers and percent patient engagement per month: 60, 45% (2020) and 56, 64% (2021).
14. FHC Denominators for the Diabetes: HbA1c < 8% increased from 1,782 to a peak of 1,816
15. RRCC denominators for the Diabetes: HbA1c < 8% has grown from 6 in August of 2020 to 79 in April of 2022. This shows RRCC is actively managing diabetes care for more patients.

Sustained Impacts
1. New service models.
   a. Established CCM, growing from 0.7 FTE to 1.7 FTE and expanding care to patients with other chronic disease(s).
   b. Established and expanded teleophthalmology services through a partnership with University of Wisconsin.
2. Improved interdisciplinary collaboration. Established a diabetes team-based care model that will continue after the funding period.
3. Improved workflows, data collection, utilization, and analysis.
   a. Built experience and competence with social determinant of health screening, data collection, and analysis both internally & externally.
   b. Improvements in DSMES, CCM and other referral processes.
4. Improved behavioral health screenings.
   a. Compilation of mental health resources to be able to refer patients to appropriate resources.
   b. FHC updated its depression and suicide screening policy, which now requires primary care clinics to screen every patient at every visit for depression and suicide risk using the appropriate screening tool for both pediatrics and adults.

Learning Opportunities
Eager to start the project, the importance of ensuring all team members had adequate baseline knowledge to achieve project goals (i.e., formal quality improvement training, disease state education, project orientation) was overlooked. Key personnel need to commit time and energy to the project. This cannot be a side project or one owned by project leaders. Additionally, there was a heavy administrative burden, and FHC has since established a Grant Compliance Specialist to ensure administrative compliance and serve as a conduit between FHC and HRSA. On the positive learnings, the project team was thoughtful about the naming and initial marketing which generated a groundswell of community interest. It is important to be intentional about marketing and communicating the program both at FHC and within the community. Lastly, data competence and discipline are important and require project leadership to guide teams to ensure the right data is being collected, consistently. The project could have been more disciplined with SMART goals, particularly as there was a noticed lack of movement in objectives.

Four Corners Health Department

York Care Coordination Network Project
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Laura McDougall | Executive Director | lauram@fourcorners.ne.gov | (402) 362-2621

PROJECT OVERVIEW

Goals & Objectives
The overarching goal of the project was to improve the cost-effective coordination of health care services between primary care, hospital, and public health. Selected evidence-based population interventions and expanded implementation of the patient-centered medical home (PCMH) model will help to improve chronic disease management, increase engagement of patients and their caregivers, and integrate mental/behavioral health into the primary care setting. Implementation of the project sought to increase efficiency and effectiveness, improve access to care, better reach the underserved, and produce better patient, population, and rural health system outcomes, addressing all the overarching goals of the Small Health Care Provider Quality Improvement Program.

The specific goals of the project were:
1. Build a comprehensive integrated coordinated care network between primary care, public health, and critical access hospital.
2. Identify all patients at high-risk for heart failure, diabetes, and depression.
3. Implement high quality treatment practices and community/population-based interventions.
4. Determine ways to share data between all network partners.
5. Monitor progress and evaluate patient and population health outcomes.
6. Develop a sustainability model to ensure continuation of the project beyond the grant period.

Focus Areas
Behavioral/Mental Health, Cardiovascular Disease (CVD) Care Management, Community-Based Care Coordination, Diabetes Care Management

Counties Served
The grant project served the population of York County in Nebraska.

Target Populations
This project targeted patients at high-risk for heart failure, diabetes, and depression.

Needs Addressed
The primary needs addressed in serving the target populations included factors impacted by social determinants of health, such as access to health care services, access to behavioral health services, transportation, housing, food insecurity, poverty, and racial and ethnic health disparities.

Quality Improvement Stakeholders
The York Coordinated Care Network is primarily comprised of three members, who were the major stakeholders:

1. Four Corners Health Department, a local public health department serving four counties in rural Nebraska
2. York Medical Clinic, a private primary care clinic
3. York General Hospital, a Critical Access Hospital
4. Other important contributors and advisors to the project have been the evaluator, David Palm with the University of Nebraska College of Public Health, and Dr. Julie Fedderson with United Health Care Medicaid

Evidence-Based Quality Improvement Model(s) or Promising Practices

- The project expanded implementation of the PCMH model, using the evidence-based American Academy of Family Physicians (AAFP) Risk-Stratified Care Management (RSCM) and Patient Health Questionnaire (PHQ9) screening tools. The AAFP framework is used to identify patients with complex or high-risk medical conditions and the PHQ9 is used to identify patients with depression. Identified patients received an escalated level of health care and care coordination services.
- The York Medical Clinic maintains its accreditation through the Patient-Centered Medical Home (PCMH) program. PCMH has been shown to improve quality and the patient experience, increase staff satisfaction, and reduce health care costs.

Services & Activities

The primary activities implemented included steps taken to form an integrated care coordination team, develop workflows, share information, collect data, and create ways to sustain the work of the partners. A York Care Team was formed by integrating a Public Health Nurse (PHN) from the Four Corners Health Department into the York Medical Clinic's Care Coordination Team. The social worker from York General Hospital was also included in weekly meetings of the York Care Team to coordinate with the York Care Team. The role for the PHN was developed and centers around connecting high-risk patients to resources available in the local community. A screening form was developed for use in the clinic which incorporated a depression screening (PHQ-9) and brief questions to assess needs around social determinants of health. The care coordinators use information from the screening forms to make referrals, with the PHN leading the effort to make referrals to community resources. In Year 3, the Public Health Department hired and integrated a Licensed Independent Mental Health Practitioner into the system and is working toward sustainability through billing for services.

PROJECT RESULTS

Outcomes

1. A comprehensive, integrated and coordinated care network was built among the York Medical Clinic (YMC), Four Corners Health Dept (FCHD) and the York General Hospital (YGH).
2. Roles and responsibilities of each member (per discipline) were developed.
3. Patients were identified who were at high-risk for heart failure, diabetes, and depression.
4. A screening tool was developed which incorporated two elements, the PHQ-9 to assess depression together with additional questions to determine needs around Social Determinants of Health.
5. The screening tool became part of an annual screening offered to YMC patients. In the first 9 months of using the tool, data were collected from 669 positive screening tools completed by YMC patients.
6. A Licensed Independent Mental Health Practitioner (LIMHP) was hired by FCHD and integrated into the YMC and care coordination team workflow.
7. The YMC and FCHD used information from the positive screening tools to refer patients to community and public health programs, behavioral health services, and to other high-quality treatments and interventions.
8. Partners have agreed to share information about screenings and referrals using the YMC EMR.

9. FCHD is being credentialed with public and private payers to begin billing for the services of the LIMHP and sustain project activities. This will increase FCHD capacity to sustain other public health programs as well.
10. The coordinated efforts of these partners have increased the number of referrals to community-based and public health resources and programs.
11. Use of the screening tool pointed to transportation issues to medical care at the YMC for 243 people over the 9-month period. A community action group was formed to work on the issue and identify solutions.
12. United Health Care Medicaid plans to support the project moving forward to further develop it as a rural model of practice.

Sustained Impacts

- Sustained impacts include the much-improved coordination of medical providers and public health in York, NE, to bring clinical and community resources to bear in improving the health of the patient population. The improved coordination allows partners to better identify all the factors influencing the health of high-risk patients and to work as a team to improve health. The patient screening and subsequent process will continue at the YMC. Integration of the behavioral health professional has proved especially valuable for the partners to not only provide services but to also address the mental health needs alongside physical health, thereby effectively supporting the whole-health of the individual.
- Prior to this grant, FCHD had not billed for any services. FCHD is becoming credentialed with public and private payers in order to begin billing for mental health services. This process has created increased capacity for the health department to potentially bill for other future services, specifically dental and immunizations.
- When United Health Care Medicaid (UHC) learned about this project, they became interested in supporting it to further develop it as a rural model of practice.

Learning Opportunities

- The COVID-19 pandemic greatly impacted the project, especially as the public health department was the lead agency in this project and also in the local COVID response. The relationships and roles being developed to implement this project were a great asset to all the partners when, in the first year, the pandemic arrived. Working relationships, after responding to the pandemic, were improved because of this project.
- Many of the other challenges occurred because this is a new (and first-of-its-kind in Nebraska) model for integrating public health into primary care coordination in a rural area. There was also key staff turnover during the project. The keys to making progress have been to (1) continually communicate goals, progress and barriers; (2) honestly discuss and address the needs of each partner to achieve success; (3) seek out innovators and other community partners to overcome barriers; and (4) persevere when faced with obstacles.

Garrett County Memorial Hospital

Integrative Pain Center

G20RH33278 | Hospital (non-CAH) | www.grmc-wvumedicine.org

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PROJECT OVERVIEW

Goals & Objectives

Goal 1 was to establish an integrative pain clinic that provides non-addictive pain solutions and avoids the use of opioids.

Objectives included for Goal 1 included:

1. Limit the number of clinic patients prescribed opioids for pain relief.
2. Gradually reduce the dosage for patients previously prescribed opioids for pain relief; and 3) Ensure patients whose pain needs include opioid protocol feel supported and are carefully monitored.

Goal 2 was to provide a multi-disciplinary approach to pain management that incorporates various disciplines in addressing the components of pain using the biopsychosocial treatment model.

Objectives included:

1. Create a biopsychosocial care plan with input from the patient.
2. Reassess the created care plan on a bimonthly basis with patient input; and
3. Limit exposure to opioids for all patients, but especially those who screen as more likely to abuse opioids or other drugs.

Goal 3 was to address pain management practices in inpatient and outpatient hospital settings.

Objectives included:

1. Adopt perioperative guidelines that minimize opioid use and emphasize alternative pain relief measures.
2. Adopt acute pain management guidelines for common trauma management.

Focus Areas

Chronic Disease Management

Counties Served

Garrett County and Allegany County, Maryland; Mineral County, Grant County, and Tucker County, West Virginia; and Fayette County and Somerset County, Pennsylvania

Target Populations

The population of the areas encompassed by the eight counties was approximately 76,000. Patients struggling with chronic pain could be referred by a primary care or specialty physician throughout the service area.

Needs Addressed

The integrative pain management program provided holistic pain management services to people in a rural region where no other pain management clinic existed. The approach required patients to participate in the

creation of their own pain management plan. Patients were encouraged to incorporate services such as massage therapy, acupuncture, and reflexology to assist in pain management improve their quality of life.

Quality Improvement Stakeholders

Internal QI stakeholders included the Garrett Regional Medical Center's staff in the Integrative Pain Management Center in Oakland, MD, and Potomac Valley Hospital's staff at the Integrative Pain Management Center in Keyser, WV. These internal stakeholders included the physicians, Clinic Directors, Nurse Practitioner, receptionists, Certified Medical Assistants, Acupuncturist/reflexologist, massage therapist, radiology tech, LPN, and the respective hospital management teams. External stakeholders included the referring community physicians. By the end of the grant, there were 33 clinical facilities and 76 providers referring patients to the program.

Evidence-Based Quality Improvement Model(s) or Promising Practices

This project based its clinic design on the Office of the Assistant Secretary for Health's Draft Report on Pain Management Best Practices: Updates, Inconsistencies, and Recommendations (US Dept. of Health 2018). The focus was treating pain holistically using alternative pain treatments such as steroid injections, radio frequency ablations, spinal cord stimulation, Botox injections, occipital nerve blocks, and sphenopalatine ganglion (SPG) blocks. Ancillary services to improve quality of life were also used, including acupuncture, massage therapy, dietary consults, reflexology, and counseling. Patients are intimately involved in creating their own Patient Care Plans.

Services & Activities

The overall approach was to provide pain management services that involve patients in the creation of their individual care plans and that involve treating the whole patient to improve not only pain outcomes but overall quality of life. Clinics were established at two hospitals in isolated rural communities. A certified pain specialist physician traveled between the two each week to treat patients at each location. Staff included social workers who helped patients with non-clinical life issues, such as helping patients find housing, childcare, elder care, help with home management issues, etc. Ancillary services included massage therapy, acupuncture, and reflexology to help the patient find new approaches to treating their pain and/or living a healthier life.

PROJECT RESULTS

Outcomes

These are presented by each hospital, since each hospital runs its own clinic.

Garrett Regional Medical Center:

1. Patients served by the pain clinic: 86 in 2020; 507 in 2021; 190 in 2022 to date. TOTAL: 783
2. Patient Encounters: 166 in 2020; 1696 2021; 757 in 2022. TOTAL: 2619
3. Patients using massage therapy/acupuncture/reflexology: 87
4. Patients in medication management regarding opioid use: 81
5. 63 opioid patients have decreased or same dosage*

Potomac Valley Hospital:

1. Patients served by the pain clinic: 186 from 12/7/2020 to 6/30/2021; 158 from July 1, 2021 to April 27 TOTAL: 374
2. Patient Encounters: 382 from 12/7/20 to 6/30/2021; 484 from July 1, 2021 to April 27, 2022. TOTAL: 866
3. Patients using massage therapy/acupuncture/reflexology: 3
4. Patients in medication management regarding opioid use: 52
5. 12 opioid patients have decreased dosage*

*Hospitals have measured this differently

Sustained Impacts

Both hospitals provided care for a sizable group of patients during the grant period, demonstrating the need for pain management services in the region. Patients at both clinics commented on the importance of now not needing to travel for care in their ability to seek the services they needed. The clinics also decreased the number of patients seeing their Primary Care Provider for pain and for chronic pain medication management. Both hospitals found that screening patients and discussing opioid use/risk produced positive outcomes, with many pain patients reporting they actively tried to avoid the use of opioids in earlier treatments sought through their Primary Care Providers. The alternative pain treatments allowed those with chronic pain to lead more active, healthier lives compared to when local access to such treatments did not exist.

Learning Opportunities

- Both hospitals realized that the financial burden of paying for ancillary services, such as acupuncture, massage therapy, and even meeting co-pay requirements of physical therapy, were too much for most patients. Out-of-pocket payments meant few patients partook of those services, at both locations.
- Transportation remains a challenge for several patients.
- Screening for and discussing opioid use issues was very important in determining the correct direction for each patient.
- Other communities should look for transportation solutions up front (and share them with every rural community in the US, since no one has cracked that code). They should also consider the impact of out-of-pocket expenses and co-pays for ancillary services. Rural populations are used to doing without, and that cannot be forgotten in creating health care clinics.

Granville-Vance District Health Department

Rural Integrated Care and Oral Health Improvement Initiative
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PROJECT OVERVIEW

Goals & Objectives

1. Increasing by 20% the number of prenatal patients served by Carolina Fellows Family Dentistry (CFFD) who receive oral health care during the program period (2019-2022)
2. Over the project period (2019-2022), increasing annual preventive oral health services at CFFD by 30% for those with Medicaid who are children birth to 18 years of age
3. Increasing by 30% the number of pre-Kindergarten students in the district who have a dental home by July 2022
4. Increasing referrals to CFFD for patients from integrated care and health care partners by 40% over the program period (2019-2022)

Focus Areas

Oral Health

Counties Served

Franklin, Granville, Vance and Warren Counties, North Carolina

Target Populations

Pregnant women (all ages) and children (age 0-18) in the rural region

Needs Addressed

Primary needs for this grant project included: 1) Access to oral health care services due to shortage of dentist and dental hygienist across rural NC, especially dental offices accepting Medicaid or providing affordable services for uninsured; 2) affordable oral health care for uninsured through sliding fee scales; 3) poor oral health among pregnant women - NC Legislators reported in 2016, 40% of pregnant women have gum disease; and 4) children (0-18 years of age) not seeking or receiving oral care due to social determinants of health – North Carolina Institue of Medicine (NCIOM) reports 40% of children ages 2-8 years and 21% children ages 6-11 years have dental caries.

Quality Improvement Stakeholders

Granville Vance Public Health (GVPH) Maternal Health, Centering, WIC, Primary Care & Child Health Programs; Granville-Vance-Franklin-Warren HeadStart program; Henderson Collegiate School; Franklin-Vance-Warren Opportunity (SmartStart), Granville and Vance County Boys & Girls Club

Evidence-Based Quality Improvement Model(s) or Promising Practices

GVPH utilized the Model for Improvement as the Continuous Quality Improvement (CQI) framework, which focused on three simple steps: 1) setting measurable improvement goals, 2) testing and implementing changes in series of rapid cycle tests (Plan-Do-Study-Act cycles), and 3) measuring the impact of the changes on the processes and outcomes related to the improvement. The Model for Improvement allowed/assisted GVPH in

establishing the AIM (what we wanted to accomplish), MEASURES (helped us determine if the change(s) were an improvement), and CHANGES (what we could do to that may result in improvement. The changes were tested and implemented using Plan-Do-Study-Act cycles, Kaizen events, and Lean.

Services & Activities

There were many activities implemented over the grant cycle, but the primary activities include, but were not limited to:
1. Kaizen events to improve the workflow processes within the dental office with a new EDR (electronic dental record)
2. Multiple PDSAs on new and revised forms, referral processes within the agency and with outside agencies, improving communication methods with patients through patient engagement systems (completed PDSAs on three different systems before choosing the current system).
3. Lean principles through workflow analysis within all aspects of the dental clinic - front desk duties, clinical duties, and reporting.

PROJECT RESULTS

Outcomes
1. Implemented a new electronic dental record that provided GVPH better documentation and reporting functions;
2. Implemented oral health education into Maternal Health/Centering appointments;
3. Increased the number of GVPH prenatal patients receiving oral health care by 15% as of March 31, 2022;
4. As of March 31, 2022 Increased preventative oral health services for Medicaid children (0-18 years) by 26%;
5. Increased pre-K students who have a dental home by 10% as of March 31, 2022; and
6. Increased referrals from integrated care and health care partners by 28% of March 31, 2022.

Sustained Impacts

The long-term impacts the grant project has had and will continue to have on the dental clinic and within the community is substantial. The project was able to:
1. Increase referrals & patient census from GVPH Integrated Care services, daycares, schools, SmartStart, local community groups, as well as private Pediatricians and OB-GYN practices;
2. Increase patient satisfaction because some will receive assessments/care at school, daycare, community club, or other community outreach events, which addresses some of social determinants the population experiences;
3. Decrease number of Kindergarten students who have untreated tooth decay by completing assessments and providing needed oral health care prior to starting Kindergarten;
4. Increase number of children and prenatal patients in Granville and Vance County who have an established dental home; and
5. Improve workflow among clinic staff through implementation of new electronic dental record, patient engagement/notification system, and standard operating procedures that come from the workflow analysis conducted.

Learning Opportunities

Over the grant cycle the biggest challenge/learning opportunity experienced was COVID-19. COVID-19 required GVPH and stakeholders to be more creative in how to address the grant goals and needs of the targeted population. COVID-19 prevented the conduct of educational sessions for prenatal patients due to clinic changes in how services were altered, going into the schools, pre-K, and HeadStart facilities, and actually

seeing non-emergent patients in the dental clinic throughout most of the grant cycle. Because of COVID-19, GVPH was able to effectively and efficiently implement tele-dentistry for non-emergent dental patient needs and to train Maternal Health and Child Health staff virtually about oral health so they could conduct the educational component with patients directly.

Greater Sioux Community Health Center

Population Health Program to Improve Chronic Disease Management and Expand Preventive Services Access

G20RH33268 | Federally Qualified Health Center | promisechc.org

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Stephanie Van Ruler | Population Health Manager | svanruler@promisechc.org | (712) 722-1700

PROJECT OVERVIEW

Goals & Objectives

- Expanded Population Health Program with increased training and education on team-based, patient-centered, culturally competent care. This included the development of protocols for chronic disease management (specifically diabetes and hypertension), patient -centered care planning and preventive care services.
- Increased community outreach including increased awareness and access to preventive services.
- Development and implementation of screening for and documenting social determinates of health needs as well as responding to these needs.
- Utilization of electronic health records (HER) and data analytics tools to support care management, value-based care (VBC) and quality improvement (QI) strategies.

Focus Areas

Chronic Disease Management, Diabetes Care Management, Population Health

Counties Served

Sioux, Iowa

Target Populations

The full patient panel of Promise Community Health Center (PCHC) patients was included in the target patient population. Including persons/families at or below 200% of the Federal Poverty Level and patients with chronic conditions including diabetes and hypertension.

Needs Addressed

The development of a strong population health team, with two health coaches, one clinical pharmacist, a patient navigator, social worker, and transportation coordinator have significantly impacted our patient health outcomes and has improved chronic disease management. The project was able to see significant improvement in the Diabetes- A1C poor control Uniformed Data System (UDS) measure, finishing out 2021 at 22.5%, and with the hypertension-controlling high blood pressure measure, with 75.5% control. The implementation of PRAPARE, social determinants of health screenings on all patients at the health center has led to improved access, increased services and health equity.

Quality Improvement Stakeholders

- The Population Health team, the Quality Improvement committee, the Leadership team, and the Medical department at Promise are all internal stakeholders responsible for the Quality Improvement plan outlined in the grant.

- IowaHealth+, a consortium of Iowa health center and an Accountable Care Organization (ACO) that contracts with Iowa Medicaid CMO's is an important external consortia for the grant.
- Community agencies, such as Community Health Partners, the public health department in Sioux County and Hope Food pantry the local food bank have been valuable stakeholders during the grant period.

Evidence-Based Quality Improvement Model(s) or Promising Practices

The QI model for Improvement was a key model used in addressing patient needs. Use of the Plan, Do, Study, Act (PDSA) provided strong guidance for the project director, quality improvement committee and the medical teams. The Model for Improvement providing assurance that the right kinds of changes were being implemented. The standards outline in the Patient-Centered Medical Home served as a guide for the development of structured care delivery with the patient at the center of their care. The Chronic Care Model served as a guide for providing proper care to patients who receive chronic disease management services at the health center.

Services & Activities

- Development of Population Health Program (to include Population Health Manger, Patient Navigator, Nurse Health Coaches and Clinical Pharmacist)
- Development of defined care team roles, workflows, and standardized services.
- Training to all staff on Population health, chronic care, QI framework, cultural competency, literacy, and social determinants of health.
- Collaboration with Iowa Health+ in developing value-based care, population health strategies and working with insurers.
- Collaborative partnership with community organizations and members to increase awareness of the importance and availability of preventive health services.
- Integration of Model for Improvement framework with defined measures and monitoring.

PROJECT RESULTS

Outcomes

1. Improved chronic disease management, reflected in improved UDS measure outcomes
2. Improved rates of preventive screenings (including colorectal, breast and cervical cancer and screenings for adult body mass index (BMI), child weight, prediabetes, tobacco use and depression) reflected in improved UDS measure outcomes
3. Increased preventive care access
4. DSMES Program with American Diabetes Association accreditation
5. Expanded Population Health Program
6. Social Determinants of Health Screenings through the PRAPARE assessment tool
7. Development of a comprehensive, culturally competent, patient- centered care delivery model through the development of the Population Health program
8. Defined workflows and data/ performance tracking within the EHR

Sustained Impacts

The DSMES program served 25 patients in 2021 and has served eight patients so far in 2022. Sixty-three percent of these patients are self-pay patients who apply for our sliding fee discount to pay for these services. The Population health program has expanded and is now seamlessly integrated with our medical teams. Two full time health coaches have around 260 patients each in their caseload and a capacity of 300 patients. The UDS measures related to chronic disease management have seen significant improvements during the grant cycle and HTN and diabetes goals were met in 2021.

All patients at the health center are being screened on an annual basis for social determinants of health (SDOH) needs. Follow up by the clinical social worker and use of a national community resources referral platform, Unite Us have provided a strong foundation for continued and sustained changes. Procedures, screenings, and follow up that were put in place during the grant cycle have been implemented as ongoing. These policy and procedure changes will remain in place after the grant cycle and will continue to undergo re-evaluation and changes based on quality improvement reviews and PDSA cycles.

Learning Opportunities

- The greatest lesson learned is flexibility. The timing of global pandemics and health care shifts may not fit into your timing or grant activities. Be willing to adapt and change outcomes and activities, trusting the models for improvement and feedback you have set in place.
- Rural communities are unique, and not one template can be applied to every rural community. Learn about your community, through data collection and building of community relationships find out what and where the needs are.

Health Care Coalition of Lafayette County

Integrated Behavioral Health and Primary Care Initiative
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PROJECT OVERVIEW

Goals & Objectives
The first goal was a reduction, annually, of Emergency Department (ED) visits by 5% in Years 1, 2, and 3 for Health Care Coalition (HCC) patients diagnosed with chronic disease, including diabetes, cardiovascular disease, hypertension, or depression, with or without co-occurring mental health issues, substance, or opioid use disorder. This would target a total of 20% reduction post grant project. The second goal was a 5% improvement, annually on National Quality Forum Measures (NQFM). Overall, the goal is to promote the implementation of evidence-based quality improvement and to implement the delivery of cost-effective, coordinated health care services in primary care settings to chronic disease, substance use disorder (SUD), and opioid use disorder (OUD) outcomes.

Focus Areas
Behavioral/Mental Health, Case Management, Chronic Disease Management, Prevention, Treatment and Management, Diabetes Care Management, Primary Care Services, Substance Abuse Treatment and/or Education, Telehealth/Telemedicine

Counties Served
Carroll, Lafayette, Ray, Saline, Missouri

Target Populations
The target patient population is a subset of the full patient panel, and includes HCC patients with a chronic disease diagnosis, inclusive of diabetes, cardiovascular disease, hypertension, or depression, with or without co-occurring mental health issues, substance, or opioid use disorder, with an added focus on patients with high rates of emergency department use as well as individuals incarcerated in local jails.

Needs Addressed
In serving the target population identified, behavioral health is a necessary need in the rural community. In relation to behavioral health services, Medication Assisted Therapy (MAT) is also needed for the treatment of SUD and OUD. To provide MAT services, there is a need for waivered providers. HCC also recognizes that there is a need to annually increase NQFM measures through closing care gaps that we have identified.

Quality Improvement Stakeholders
Lafayette Regional Health Center – Hospital
Lafayette County Sheriff's Department – Law Enforcement
Lafayette County Jail – Law Enforcement
Lafayette County Mental Health Board – Behavioral Health

Evidence-Based Quality Improvement Model(s) or Promising Practices

- Model for Improvement – The project currently utilizes the Plan Do Study Act (PDSA) associated with the Model for Improvement.
- Health and Behavior Assessment Intervention (HBAI) – This model is used to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to assessment, treatment, or management of physical health problems.
- Medication Assisted Therapy (MAT) – This model is the use of medications in combination with counseling and other techniques to provide a "whole person" approach to treatment of SUD.

Services & Activities

Throughout the 3-year funding period, the project utilized telemedicine. During the pandemic, HCC was able to purchase iPads to distribute to the local jail to close care gaps. Peer recovery coaches were able to utilize virtual options to increase Narcotics Anonymous (NA) participants as well as provide client support services. Another activity was HCC's integration into the local jail as their medical provider. HCC was able to provide medical services to their jail on a weekly basis as well as provide medical equipment as needed. HCC was also able to provide healthcare interventions to patients with frequent ED visits in relation to our target population, by identifying specific programs to address healthcare gaps. The project implemented a transportation program to help support other social determinants of health as well as implement the Centers for Disease Control and Prevention's (CDC) National Diabetes Prevention Program which is offered at no cost. HCC has also started a peer recovery coach program during the 3-year funding period. This has been a huge benefit to the jail, hospital, and HCC's patient population. HCC has implemented MAT into its clinics, which has been supportive to the SUD and OUD population.

PROJECT RESULTS

Outcomes

Implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT); National Committee for Quality Assurance (NCQA) recognition for all of clinical locations; National Diabetes Prevention Program supplier; Implementation of a peer recovery coach program; Narcotics Anonymous and Celebrate Recovery started in Lafayette County to be supportive of the SUD and OUD populations; Medical provider in Lafayette County Jail; Begin Medication Assisted Therapy in HCC's locations; Improve NQFM measures

Sustained Impacts

Narcotics Anonymous and Celebrate Recovery will continue as support groups in Lafayette County. HCC Network will continue to be Lafayette County Jail's medical provider. Due to purchasing iPads for the jail, HCC was able to connect to incarcerated individuals for medical services as well as peer recovery coach support. In the jail and clinics, HCC will continue to bill for services. HCC will continue to offer Medication Assisted Therapy through our waivered provider. HCC implemented an evidence-based platform into our electronic health record.

Learning Opportunities

Throughout this grant-funded project, HCC recognized that housing is a huge need in the rural community. HCC provided hotel vouchers, however, there is no access to Department of Housing and Urban Development (HUD). In the rural community, access to treatment is also a hard space to navigate. Whether treatment is behavioral health, SUD or OUD related, or for referrals to specialty care (including for chronic disease), there is a shortage in the service area. During the pandemic, there was a staffing shortage and prevention took a back seat. However, throughout the pandemic, HCC was also able to utilize telehealth as an alternative option, having learned pre-pandemic this was a useful option that was heavily underutilized. In relation to recovery support services, HCC has learned that peer recovery coaches are a vital part in the prevention, recovery, and

treatment process. Tracking data is also a learning opportunity. During this funding period, it was difficult to retrieve timely and accurate data from the Emergency Departments, especially during the pandemic.

Henderson County Rural Health Center

Quality Improvement in Henderson County
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PROJECT OVERVIEW

Goals & Objectives

The overarching goals of this funding project were to help the health center become a more patient-centered medical home as well as improve our population with high blood pressure and those with diabetes. The project also hoped to establish Chronic Care Management for patients. Goals included obtaining patient-centered medical home certification through the National Committee for Quality Assurance (NCQA). The project also had goals to host programs and other educational events for those who have multiple chronic diseases as well as those who suffer from high blood pressure or uncontrolled diabetes. Finally, there were overarching goals to increase the number of individuals who received Annual Wellness Visits.

Focus Areas

Case Management, Health Screenings, Population Health

Counties Served

Henderson, Warren, McDonough, and Mercer County in Illinois, Des Moines County Iowa

Target Populations

The target population served by this grant is adult patients that are 18 and over who, as defined by Patient-Centered Medical Home (PCMH) and Chronic Care Management (CCM) standards, need care management (two or more chronic diseases). The grant project's target population also includes those who have uncontrolled diabetes as well as hypertension.

Needs Addressed

The idea of creating a Patient-Centered Medical Home is to better meet the needs of patients in a location that has been a medically underserved area. Achieving PCMH lets patients know that Henderson County Rural Health Center plans to be their home for healthcare and meet any and all needs they may have in one place, which in a rural area is especially difficult to do in a location where they cannot always receive patient care easily. Additionally, by being their medical home, the rural health center can focus on what other factors may be affecting their health and allow for intervention to help the patient overcome those barriers.

Quality Improvement Stakeholders

This project directly involved the development of an internal quality team composed of staff. This involved a stakeholder from each department to provide a whole view of the entire clinic.

Evidence-Based Quality Improvement Model(s) or Promising Practices

The evidence-based model used to implement the rural quality improvement grant was the Plan Do Study Act model. This was used with a number of implementation activities completed for PCMH as a way to ensure that they were achieving the desired results and to ensure that they would match the organization's internal workflow.

Services & Activities

The primary activities implemented during the funded grant period included all of the changes that were necessary to become PCMH certified. This included many workflow changes, implementing Chronic Care Management as well as more patient centered measures. Other activities have also included implementing strategies involving Community Health Workers to reach out to individuals who are due for their annual wellness visits. The project also used Community Health Workers as part of the care management team and are assisting with Blood Pressure programs as well as diabetic programs to help follow up with patients who are monitoring blood pressures as well as A1C Levels at home.

PROJECT RESULTS

Outcomes

Became Patient-Centered Medical Home certified as of March 18th, 2022.
Implemented Blood Pressure monitoring program April 22nd, 2022.

Sustained Impacts

The sustained impact of this project has really shown the community that Henderson County Rural Health Center is focused on their health from all angles and that the organization prides itself on quality care and being a medical home. Additionally, by creating this program, the rural health center was not only focused on patients but also their long-term health. It shows that the organization is focused on prevention and long-term care rather than just treating an issue as it arises.

Learning Opportunities

There are a number of major lessons learned during this grant project. The impact of COVID significantly impacted how staff was able to manage the changes that were a part of the PCMH modifications. Additionally, it made it difficult to create educational programs for staff. From this, the project team learned how to use the situations presented to implement changes. For example, the team knew that those with chronic diseases would be more impacted by COVID, so that was taken into account when creating programs. Additionally, the pandemic presented an opportunity to hire Community Health Workers who were then able to be implemented into this grant. Another major lesson learned is that without champions in each department it is hard to get a program moving, so by implementing more champions and getting the entire staff on board, the project was able to implement PCMH.

Innis Community Health Center

Healthy Patient, Healthy Life Program (HPHL)
G20RH33269 | Federally Qualified Health Center | www.Arborfamilyhealth.org
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Linda Matessino, RN, MPH | Director Grants Programs | Linda@arborfamilyhealth.org | (225) 718-8346

PROJECT OVERVIEW

Goals & Objectives

Innis Community Health Center (dba Arbor Family Health) is addressing the growing burden of chronic disease in the rural area of Pointe Coupee Parish as well as positioning healthcare providers for success within the pay-for-performance environment through its Chronic Care Model program. This is being achieved through the implementation of an evidenced-based health-coaching program which has been proven to engage patients in self-management of health conditions and encourage positive health behavior changes that are sustainable. The primary goal is to improve health outcomes for high-risk patients with a chronic disease dual diagnosis of diabetes and hypertension. The goal was 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". The overarching goal of the Health Coach Model was to improve compliance with the individualized treatment plan of care created by a care management team in conjunction with the patient's goals. The Health Coach Role is a relationship-based model and assists patients as their new normal is defined in their daily lives of living with chronic disease. The objective of this model is to be a Partner in Care with the patient in their health journey assisting them to discover their motivation to change and reduce this disease burden. In addition, objectives to complete a final assessment plan of the grant outcomes as well as develop a sustainability plan to ensure program services continue after grant funding ends are in place. This model of Chronic Care Management is becoming an embedded practice of care delivery based on a defined quality measurement monitoring process within the organization.

Focus Areas

Chronic Disease Management, Diabetes Care Management

Counties Served

Louisiana Parishes served: Pointe Coupee Parish, and northern Iberville Parish

Target Populations

The target population is health center patients with dual diagnosis of diabetes/hypertension seen in Arbor Family Health care clinics and who reside in Pointe Coupee and northern Iberville parishes. These parishes report a 10.3% age-adjusted diabetes prevalence rate and 42.2% adults reporting hypertension diagnosis. The target population is 485 patients, with a goal of 70% of the target population assisted through the Health Coaching Model-Chronic Care Management program.

Needs Addressed

Data for Louisiana in the rural area served by this project reports higher than average rates of age-adjusted mortality/heart disease, age-adjusted Diabetes prevalence, adult obesity prevalence and adults with Hypertension diagnosis. These are significant challenges for healthcare organizations/providers who manage chronic disease. Access to intensive chronic care management has been a challenge prior to Arbor Family Health's funded project. Diabetes and hypertension rates are increasing the need for identification and

support of lifestyle changes to support patients in living better without complications. The Chronic Care Model integrated with a Health Coach approach has shown positive effects on sustaining life style behavioral changes.

Quality Improvement Stakeholders

Quality improvement stakeholders included three Internal Teams: Healthy Patient Healthy Life Team (Grant Project Director, Grant Program Coordinator, Health Coaches, and IT Specialist); Clinical - HPHL Team (Medical Director, 6- Mid-level Providers delivering primary care to patients); and the Arbor Quality Committee (reps from all clinics, IT Specialist, Administration CEO, Board Member Quality representative). Arbor continues to use its experience with quality improvement actions and its solid foundation developed over the years in quality measurement as the underpinning supporting the project objectives.

Evidence-Based Quality Improvement Model(s) or Promising Practices

- Patient-Centered-Medical-Home (PCMH) - Workflow and processes model this evidenced based program and are integrated within Arbor Family Health's primary clinics.
- Health Coaching - Evidence-based model operationalized. The primary reference sources for this model is "Health Coaching for Patients with Chronic Illness", a model presented in the Journal for the American Academy of Family Practice (2010). Outcomes of this model include, improved health behaviors, patient accountability, higher levels of self-care proven to reduce progression of chronic disease condition, reduced ER visits and hospitalizations.
- Chronic Care Management Model - CMS recognized Chronic Care Management Program (CCM) as an evidenced-based critical component in providing care to Medicare patients with multiple chronic conditions. This includes comprehensive care management, person-centered care planning, improved communication and continuity of care with care providers, and enhancement of medical decision-making in complex disease management contributing to better health outcomes and increased patient satisfaction.

Services & Activities

This program implemented an accessible community-based chronic care model using a primary strategy of Health Coaching and Chronic Care Management principles for patients with a dual diagnosis of diabetes/hypertension. A formal health coach program was designed and delivered to improve patient outcomes and compliance. Health coaches served as a touch point between primary care provider (PCP) visits to ensure patients were educated on the disease process; adhering to treatment plans mutually designed to include medication, glucose, blood pressure management; obtain preventive screenings; and achieve behavioral lifestyle changes. The following services were provided:

- One-on-one initial health calls, introducing the HPHL program with discussion on the role of the health coach.
- Weekly Health Coach calls with patients discussing their issues with managing their chronic disease focusing on barriers and challenges in their life.
- Additional intermittent Health Coach calls for follow-up in between clinic appointments.
- One-on-one educational sessions on Living with Diabetes & high blood pressure, helping patients understand their clinical numbers and selection choices in daily meals.
- Other indirect services included data collection, data mining, monitoring changes, preparation of patient report cards, and readjusting patient goals.

PROJECT RESULTS

Outcomes

The outcome data presented below is not all-inclusive of the clinical indicators this project has been monitoring and evaluating since its inception. Presentation of the preventive measures and annual screenings such as dental visits, flu shots, depression & tobacco, filament foot exam and social determinants of health assessment are part of the overall dashboard of measurement and reported in a quarterly report card to the patient. In addition, the organization has monitored its progress for the management of chronic care using the ACIC tool (Assessment of Chronic Illness Care). This survey is designed to help provider practices move toward achieving excellence in managing chronic illness at the community, organization, practice and patient levels.

Primary Outcomes:
1. Total #of patients enrolled in program to date-276 Unique
2. Total # of providers oriented to HPHL + Outcomes evaluative measures (7)-100%
3. Total # of patients receiving initial Health Coach interview & welcoming packet-100%
4. Health Coach certification course completed by 3 of 3 =100%
5. Total # of patient calls to date: 3,188
6. Diabetes Care-Pts-HgbA1c-Equal to or > than 9 poor control
7. Diabetes Care- Pts- HgbA1c- < than 9 but > than 7
8. Diabetes Care- Pts- HgbA1c- less than < 7
9. B/P less than< 140/90 adequately controlled
10. Body Mass Index (BMI) > 25 screening + follow-up plan
11. Cardiovascular Disease Statin Compliance
12. Retinal Scan documented Initial upon entry into program
13. Retinal Exam completed at least 1 scan in pt. EMR
14. Pts. Screened for tobacco use & rec'd cessation counseling
15. ACIC Scoring- using scale 0-11(full developed) as of 4-1-22 score= 9.47

Sustained Impacts
Long-term effects of the grant project are demonstrated in changes in organization and clinical practice: integration of the health coach model into Arbor's chronic care management program influencing positive patient relationships; embedding developed clinical protocols for managing diabetes and hypertension; and establishing a role for reporting performance data to the Quality Committee and Board reports demonstrating care delivery impact on the health status of patients. Over the grant period, patients saw value in their behavioral lifestyle changes and their improving clinical numbers. The model has influenced sustainable changes on their lifetime journey with chronic disease. Patient satisfaction has increased, and new diabetic patients were enrolled in the program as a result of interest in this model of care. Both patient and providers have indicated increased satisfaction with this model and its ability to identify problems, including issues that can be corrected more timely. The organization's assessment of chronic care using the ACIC tool has indicated a significant improvement in the elements for improving chronic illness care at the community, organization, practice, and patient level.

Learning Opportunities
Chronic Care Management is a challenging dynamic process in primary care. A solid evidence-based foundation is vital to achieve sustained impacts on clinical practice. The Health Coach Model has proved to be the foundation upon which a patient-relationship is built, supporting the journey to be the "best you" living with chronic disease. Behavior change happens at home not in the clinic, and provider visits do not allow enough time to educate, support and assist the patient to make lifestyle changes. The Health Coach is an individualized bridge model confirming "one size does not fit all". Clinical outcome monitoring is vital to demonstrating effectiveness to the Care Team. Communication from the start is essential to get buy-in and change in clinical practice. Performance data talks! Patients learn in a variety of ways but creativity in presentation of facts is essential. Some examples are: diabetic friendly grocery lists, snack guides, and recommended food products

available in their community for sustained changes in selection to be achieved. Meeting the patient in their reality is achievable through motivational interviewing skills, which is an essential skill for Health Coaches.

Jersey Community Hospital District

Jersey Community Hospital - Helping At-Risk Patients Program
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PROJECT OVERVIEW

Goals & Objectives
- Jersey Community Hospital's (JCH) overall project goal was to increase the capacity of JCH to provide high quality health care at rural health clinics with a focus on chronic disease management. The three-year grant objectives included: secure Patient-Centered Medical Home (PCMH) designation for four JCH Rural Health Clinics, initiate a chronic disease management program, incorporate behavioral health services into the treatment plan for any patients with identified behavioral health needs, and continue to develop and refine the consortium processes to seamlessly coordinate care.
- The above project goal and objectives contributed towards achievement of following outcomes: increased access to coordinated care for patients chronic disease, increased access to high quality health care overall as a result of PCMH designation, increased access to behavioral health services, enhanced billing capabilities, increased health literacy for patients, reduced Emergency Department (ED) visits and hospitalizations for enrolled patients and reduced HgA1C for enrolled patients with diabetes.

Focus Areas
Behavioral/Mental Health, Chronic Disease Management, Treatment and Management, Diabetes Care Management

Counties Served
Greene County, IL and Census Tracts 1708301011 & 17083010401 in Jersey County, Illinois

Target Populations
The program targets rural residents of Greene and Jersey County in Illinois. Patients are insured by Medicare and have two or more chronic conditions.

Needs Addressed
The primary needs addressed by this program include: increasing access to coordinated care for patients with chronic disease, increased access to high quality health care overall, increased access to behavioral health services, increase health literacy for patients, and reduced ED visits and hospitalizations.

Quality Improvement Stakeholders
Quality Improvement Team and ACO Committee - Jersey Community Hospital
Chronic Care Management (CCM) Team - Jersey Community Hospital
Molly Peters - Greene County Health Department
Becky Shipley - Jersey County Health Department

Evidence-Based Quality Improvement Model(s) or Promising Practices
The evidence-based practice, The Chronic Care Model, is used within the Chronic Care Management program.

Services & Activities

Project leads consulted with the Compliance Team to prepare for and secure PCMH accreditation for four JCH Rural Health Clinics. The survey occurred in May 2022. The project initiated a Chronic Care Management program, in which internal providers from all four JCH Rural Health Clinics refer to. Jersey Community Hospital hired a registered nurse (RN) and medical assistant (MA) for this program and purchased ThoroughCare CCM software. The project also integrated behavioral health services into the primary care setting and hired a licensed clinical social worker (LCSW).

PROJECT RESULTS

Outcomes

1. Implemented a Chronic Care Management Program, based on the evidence-based practice, the Chronic Care Model. The project hired a full-time RN and MA for the program. Jersey Community Hospital had previously hired an LCSW who was employed until October 2021. Even with a vacant position, the program was grown to a sustainable patient panel of 60+ patients during the LCSW's time here. The project is actively recruiting for her replacement. As of April 27, 2022, there are 149 patients enrolled in the program.
2. Significant progress has been made in securing the PCMH accreditation for JCH Rural Health Clinics. The organization is scheduled to be surveyed between May 9-27, 2022. This will increase access to high quality health care overall in our community.
3. Increased billing capabilities because of the program.
4. Increased health literacy for patients.
5. Reduced ED visits and hospitalizations for enrolled patients.

Sustained Impacts

The project was able to bring much needed behavioral and mental health care services to the community. At the start of the grant period, there were no mental health services offered locally. In doing so, this project not only provided needed care, but also broke down some of the stigma and barriers that reduce access to care. The CCM program has grown significantly, currently serving 150 patients. Jersey Community Hospital has been able to reduce these patients' annual ED visits and improve their HgA1c. CCM staff connect patients to other resources as needed, such as home cleaning services through the department of aging and work to provide holistic care to these patients. The CCM staff also reduce burden on other departments, as most patient concerns that were previously addressed by visiting the ED or calling the provider, are now addressed by employees in the program.

Learning Opportunities

One of the initial challenges discovered was an overall lack of support from JCH physicians in regards to developing the Chronic Care Management Program (CCM). At first, physicians did not understand the benefit of the program and saw their weekly check-in with the CCM RN as burdensome. After provider education and discussing direct positive outcomes experienced by patients, physicians started to see the value in the program. As a result, they started referring more patients to CCM and the program was able to take off. If an organization is considering CCM implementation, it's important to get the physicians on board as soon as possible. They are a huge driving force of program growth and encouraging patients to become more engaged in their care plans and health overall.

Keystone Rural Health Consortia

Improving Connections of Patient Information to Care

G20RH33264 | Federally Qualified Health Center | https://keystoneruralhealth.com/

90 East Second Street PO Box 270, Emporium, Pennsylvania 15834 | (814) 486-1115

Danielle Reed | Staff Accountant/Operations Director | danree@keystoneruralhealth.com | (814) 486-1115

PROJECT OVERVIEW

Goals & Objectives

- Year 1 - Goal: Improve patients' visit experience; Objective: Reduce patient wait times; Goal: Enable clinic to connect patients to their care needs more effectively and efficiently; Objective: Staff access data in real time to determine patient needs and response during visit; Goal: Improve capacity to fulfill recommended screenings and patient health history; Goal: Significantly increase patient access to health services; Objective: Increase patient referrals; Goal: Improve staff engagement with patients; Objectives: Revise clinic workflow; Objective: Reallocate clinical staff time

- Year 2 - Objective: Staff access data in real time to determine patient needs and response during visit; Goal: Instill a deeper focus on QI at all sites through targeted initiatives led by a QI champion (the QAC); Objective: Improve the quality and accuracy of patient data; Goal: Improve staff engagement with patients; Objective: Personalize patient education; Goal: Significantly increase patient access to health services; Objectives: Increase referrals to community-based services, mental health, and substance use disorder (SUD) treatment; Goal: Facilitate transition to value-based patient care; Objective: Monitor accountable care organization (ACO) patients for progress towards outcomes; Objective: Complete enrollment as a Primary Care Medical Home (PCMH)

- Year 3 - Goal: Significantly increase patient access to health services; Objectives: Increase referrals to community-based services, mh, and SUD treatment; Goal: Increase practice revenue; Objective: Increase number of patient encounters by 25%; Objective: Reduce costs by 5% by eliminating paper forms; Objective: Reduce claim rejections; Objective: Utilize more consistently the billing codes for chronic conditions, substance use and social determinants of health.

Focus Areas

Primary Care Services

Counties Served

Cameron, Elk, Centre, McKean, Pennsylvania

Target Populations

The project's target population will Keystone Rural Health Consortia's (KRHC) full patient panel of all age ranges.

Needs Addressed

The overall goal of this project is to improve care delivery capacity and quality by reducing patient wait times and addressing patient needs through providing rapid staff access to patient data.

Specifically:

- Patient wait times will be reduced by .5 hour per patient.
- Patient satisfaction will increase by 20%.
- Patient referrals increase by 40%

- KRHC's continuous quality improvement (CQI) process has dedicated staff that develop initiatives
- 25% increase in primary care and dental encounters
- Patients with mental and/or behavioral health challenges will have an increased screening rate of 50%.
- Patients will receive referrals to services and treatment
- Care team will spend 50% more time on patient care

Quality Improvement Stakeholders
- Internal Team
- Victor Lahnovych
- Kristie Bennardi
- Danielle Reed
- Amanda Erickson
- Jack Jones
- Kelly Myers
- Sharon Price
- Gabrielle Padasak
- Networks
- EZAccess
- Get-Well Network
- CTI
- Virtual OfficeWare
- Health Federation of Philadelphia
- Health One Technologies

Evidence-Based Quality Improvement Model(s) or Promising Practices
KRHC utilizes the evidence-based Model for Improvement developed by the Institute for Healthcare Improvement in 1996. Improving Connections of Patient Information to Care will be implemented using the Model for Improvement approach.

Services & Activities
Keystone was able to implement Get Well Network fully in all medical offices. Get Well Network hosted the project for paperless patient data capture. While trying to also implement in all dental offices, KRHC found out that this company was no longer supporting the project. KRHC was then in turn able to partner with EZAccess. EZAccess is not yet operational but is in the testing phase.

PROJECT RESULTS

Outcomes
Due to the setbacks with Get Well Network Keystone has not been able to achieve any of their previously proposed expected outcomes to date. KRHC is still in the testing phase of EZAccess. Once this is completed and working correctly the next step would be to achieve proposed outcomes.

Sustained Impacts
Due to previous setbacks Keystone has not reached a level of sustained impacts. After the completion of the testing phase with EZAccess, the project hopes to have sustained impacts in the following:
- Patients avoid developing chronic conditions.
- Patients have a higher quality of life because their chronic conditions are under control
- Patients are receiving the care needed to address mental health and/or substance use disorders.

- Improved staff satisfaction.
- KRHC increases revenue that supports ongoing quality patient care.

Learning Opportunities
Keystone has had to overcome several obstacles while implementing its proposed project. Not only was COVID a very large factor but also the loss of the initial networking group, Get Well Network. The project not only had to put the entire project on hold until KRHC was able to partner with EZAccess, but also had to start over in some areas once Get Well was no longer active.

Kittitas County Public Hospital District No. 1

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PROJECT OVERVIEW

Goals & Objectives

GOAL
Improve chronic disease outcomes, costs of care and patient and provider satisfaction through the standardization of care coordination and identification and treatment of depression for patients with chronic conditions.

OBJECTIVES
1. Establish the necessary workflows and infrastructure to support the standardization of care coordination, depression screening and treatment, and behavioral health support for patients with select chronic diseases.
2. Integrate a system of care coordination designed to standardize work, share learning and best practices and improve follow-up and treatment compliance via patient engagement for patients with select chronic diseases and depression.
3. Develop a quality assurance/quality improvement program to ensure standardized integration of primary care and behavioral health and promoting the use of telehealth for the management of patients with select chronic diseases and depression.
4. Establish a data registry that allows for the collection and monitoring of data and outcomes and supports real-time adjustments to processes and workflows.
5. Create a sustainability and expansion plan that allows for project continuation and implementation across the Washington Rural Health Collaborative, as well as incorporation of additional chronic conditions.

Focus Areas

Behavioral/Mental Health, Cardiovascular Disease (CVD) Care Management, Chronic Disease Management, Prevention, Diabetes Care Management, Primary Care Services, Population Health, Transitions of Care

Counties Served

Grays Harbor County, Mason County, Pacific County, Lewis County, Klickitat County, Pend Oreille County, Washington

Target Populations

This project focuses on patients seeking care at any of the rural health systems in the Rural Collaborative network, with an emphasis on patients attributed into the Rural Collaborative Accountable Care Organization. Subpopulations include patients with chronic disease and/or behavioral health needs, especially those who would benefit from care coordination.

Needs Addressed

This grant project seeks to directly address the high rates of patients with chronic diseases and the shortage of behavioral health in several small rural communities throughout Washington state. 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.

Quality Improvement Stakeholders

Each rural health system within the Rural Collaborative network sends delegates to participate in several committees that collectively support the work of this grant. These include the Rural Health Clinic Committee, ACO Committee, Quality Improvement Committee, and others. At these committee meetings, delegates review data, discuss best practices, share tools and workflow ideas, and ask one another questions.

Evidence-Based Quality Improvement Model(s) or Promising Practices

- Chronic Care Management: care coordination services done outside of the regular office visit for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.
- Annual Wellness Visit: a Medicare covered yearly appointment to discuss plan of preventive care in the coming year.
- Population Health Management Software: participants in the ACO were offered free use of a population health tool to help providers aggregate and analyze data to create a comprehensive, actionable clinical picture of each patient. Using the information generated by these tools, providers can track and improve clinical outcomes — and lower health care costs.
- Accountable Care Organization: one of the Centers for Medicare and Medicaid Services' tools to reward health care providers with incentive payments for the quality of care they give to people with Medicare.

Services & Activities

- Contract with a consultant a specializing in rural accountable care organizations (ACO), to ensure standardization of training and best practices across the network. Emphasize behavioral health integration (BHI) for patients with chronic care management and behavioral health integration.
- The consultant works with each rural health system on specific needs to ensure success in the ACO. Focus on care coordination, chronic disease management, and annual wellness checks. Spread this training to rural health systems not in the ACO as well. Enable participating clinics to implement workflows for supporting care coordination and chronic disease management.
- Provide training opportunities for clinics on best coding and billing practices to maximize reimbursement.
- Create an online data registry that is used by all rural health systems in the network. Share performance data at quality improvement committees.
- Provide training opportunities for clinics on evidence-based care coordination interventions that are reimbursable under Medicare and/or value-based contracts.
- Support members in joining ACO with alternative payment models that will support transformation efforts.

PROJECT RESULTS

Outcomes

1. Roster of primary points of contact for QI initiatives within each rural health system.
2. Standing ACO Committee, Quality Committee, Rural Health Clinic Committee with monthly agendas and rotating chairs

3. Agreement to join an ACO together. Education of Boards of Commissioners on the value of ACO participation.
4. Development of a shared dashboard to enter data and track performance
5. Training on elements of an ACO, from Annual Wellness Visits to HCC coding to physician engagement.
6. Improvement in Annual Wellness Visit Rate over the three-year period
7. Increase in the number of rural hospital systems reporting quality measures into the dashboard.
8. On track for shared savings in the first year of participation in the ACO.

Sustained Impacts

1. Normalization of month data entry and sharing within the Committees, within the care teams, and with senior leadership.
2. Increased interest in participation in an ACO.
3. Increased awareness of the value of care coordination and utilization of data to manage the health of a patient population.
4. Interest in moving learning from the Medicare framework into the Medicaid framework, with similar payment strategies.

Learning Opportunities

- The pandemic stymied project momentum in 2020-2021. However, we came out of it with a renewed commitment to advancing payment for value. Workforce challenges have been immense, having significant impacts on the way of life for the past year and the foreseeable future. We have learned to be patient. The work will get done if it is the right work. It is important to identify the right people to take on this work.
- The data dashboard is up and running. Its success is rooted in the involvement of all rural health systems across all committees into its development. Shared ownership is key for the sustainability of any reporting tool.

Mainline Health Systems

Mainline Very Important Patient (VIP) Program
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PROJECT OVERVIEW

Goals & Objectives
The goal of the Pharmacy Management Program is to be a chronic care management and medication management program aimed at improving a patient's overall health status. This program is intensive and comprehensive and is meant to educate patients about their health conditions and medications. The pharmacist reviews each patient's medication regimen to ensure patients are taking the correct combination of medications for their health conditions. The health coach RNs and pharmacist also work to ensure patients are receiving recommended screenings and routine follow ups. The main two goals of this project were to have 70% or more of the enrolled patients with hypertension with a controlled blood pressure and less than 20% of patients with diabetes with an A1c less than 9. The other measurable goals that are tracked monthly: statin use in patients with cardiovascular disease, tobacco screening and cessation intervention, body mass index (BMI) screenings and follow-ups, flu vaccination rate, pneumonia vaccinate rate, depression screenings, emergency department visits, and hospitalizations.

Focus Areas
Case Management, Chronic Disease Management, Diabetes Care Management, Health Education/Promotion and Disease Prevention, Pharmacy Assistance

Counties Served
Ashley, Chicot, Drew, and Lincoln, Arkansas

Target Populations
The target population is non-Medicare patients who use Mainline Health Systems, Inc as their primary care provider and have a behavioral health diagnosis as well as a diagnosis of diabetes and/or hypertension. This subset population of Mainline Health Systems patients was found to have a large proportion of low-income people with socio-economic challenges affecting their health care.

Needs Addressed
The population targeted was found to have complicated treatment plans due to the dual diagnosis of chronic health conditions and behavioral health conditions. There is a high rate of low health literacy in the target population. Socio-economic challenges have presented barriers to access to medications and care for some of these patients. Utilizing the health coaches and pharmacist, the project has been able to recommend lower cost medication alternatives or find programs to help with medication coverage.

Quality Improvement Stakeholders
The Chief Quality Officer is the direct project director. The pharmacy team is part of the Mainline Health Systems quality team as well as the Chief Medical Officer and Chief Operating Officer.

Evidence-Based Quality Improvement Model(s) or Promising Practices

The pharmacy program utilizes Chronic Care Management as its main QI model.

Services & Activities
The Pharmacy Management Services program serves as a chronic care management program for the target population. Patients with qualifying diagnoses are enrolled and a monthly phone call or in-office visit is conducted with them. The main goals of the phone calls or visits are to improve medication compliance, encourage monitoring of blood pressure and/or blood glucose, encourage patients to follow a heart healthy or diabetic diet, and encourage exercise. The pharmacy team also will schedule appointments to ensure timely follow-ups. The pharmacist serves as resource for providers and aids in medication selection when needed. The health coaches and pharmacist work to ensure patients have their medications and any testing supplies needed.

PROJECT RESULTS

Outcomes
1. A1c >9: Goal was to have <20% of patients with diabetes have an A1c >9. Currently, there are 19% with an A1c >9.
2. Controlled hypertension: The goal was to have >70% of patients with hypertension with a controlled blood pressure. Currently, there are 78% with a controlled blood pressure.
3. BMI screening and follow up: The goal was to have >85% of our patients who have a BMI outside of normal parameters have a follow-up plan documented. Currently, there are 99% with a screening and follow-up plan documented.
4. Depression Screening and follow-up: The goal was to have >85% of our patients screened for depression and, if screening was positive, a follow-up plan is documented. Currently, 75% of patients are meeting this goal.
5. Tobacco use screening and cessation intervention: The goal was to have >90% of our patients screened for tobacco use and, if a tobacco user, have cessation intervention counseling documented. Currently, 96% of patients are meeting this goal.
6. Statin use in patients with cardiovascular disease: The goal was to have >75% of patients are at risk for cardiovascular events taking a statin. Currently, 96% of patients meeting are meeting this goal.
7. Pneumonia vaccination rate: The goal was to have >70% of our patients who meet criteria to receive a pneumonia vaccine, be in compliance with recommendations. Currently, there is a 34% vaccination rate.
8. Flu vaccination rate: The goal was to have >15% of patients receive the influenza vaccine. Currently, there are 31% who have received the flu vaccine.
9. Emergency department visits: The goal was to decrease the amount of patients enrolled in the program who use the emergency department. Currently, 48% of enrolled and controlled patients, were enrolled patients.
10. Hospital admission: The goal was to decrease the amount of patients enrolled in the program who are admitted to the hospital. Currently, 61% of enrolled and control patients, were enrolled.

Sustained Impacts
Due to the activities funded by this grant, the project team found a need to have a Mainline Health Systems chronic care management program in-house. The project has been able to educate staff on the benefits of using health coaches and a pharmacist in a primary care environment. The pharmacist now is utilized for maximizing the 340b savings for Mainline Health Systems. Providers have been able to see the benefit of the pharmacy team and will request their services for patients outside of the target population.

Learning Opportunities

When the pandemic began, there was a decrease in number of appointments. This halted enrollment since the project was only enrolling patients during visits. The project was able to mail consent forms and include a pre-stamped envelope for them to return the completed form. Around this time, Mainline began utilizing a text messaging function in the electronic medical record (EMR), eClinical Works. Mainline was able to send a text message with a link to an online version of the consent that is completed on their cell phone. The form automatically was emailed to the pharmacist after completion. The team also found that it was difficult to contact some patients since they worked the same hours as the services being provided. The existing phone software allowed for text messaging patients and increased the percentage of patients contacted monthly. With a high rate of low-income patients, some patients often run out of minutes or their phone and would be cut off portions of the month, often towards the end of the month. Project staff try to make calls towards the beginning of the month to accommodate this.

Marion General Hospital

Quality Processes for Health Improvement
G20RH33282 | Hospital (non-CAH) | marionhealth.com
441 N. Wabash, Marion, Indiana 46952 | (765) 660-7001
Kelley Hochstetler | Project Director | kelley.hochstetler@mgh.net | (765) 660-7204

PROJECT OVERVIEW

Goals & Objectives
The project aim is to improve care coordination to increase heart failure patient's quality of life through better healthcare engagement and access; decrease the incidents of heart failure; decrease conditions leading up to a heart failure diagnosis; and increase patients' use of appropriate healthcare resources. Another aim of the project is to build strong internal capacity for quality improvement though Lean First so it becomes hardwired into the Marion Health culture and organization.

Focus Areas
Cardiovascular Disease (CVD) Care Management, Chronic Disease Management, Treatment and Management, Health Education/Promotion and Disease Prevention, Telehealth/Telemedicine

Counties Served
Grant County, Indiana is the primary county served. Several bordering counties have minimal utilization of Marion Health Cardiac services Miami, Blackford, Huntington and Wabash.

Target Populations
The original target population of 405 includes 210 patients participating in the Marion General Hospital (MGH) Heart Failure Clinic and 55 individuals eligible for Medicare services and diagnosed with Congestive Heart Failure to determine a baseline for participation in the Bundled Payments for Care Improvement (BPCI) – Advanced Model.   The project shifted the target population in project year (PY) 2 and project year 3 to include all patients diagnosed with heart failure (HF) receiving inpatient and emergency department services at Marion General Hospital DBA Marion Health.

Needs Addressed
The targeted work in PY1 focused on the acute phase of illness for patients diagnosed with heart failure (HF) seen in the emergency department, then admitted to the hospital. In project year 2, patients at risk for development of HF with comorbidities of Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, and Chronic Kidney Disease. The final phase to re-engineer care for this target population will expand to incorporate preventative care and CMS/CDC Million Hearts® program. In PY3, the target patient population expands to include the management of patients with hypertension, high cholesterol, elevated body mass index (BMI), and tobacco abuse disorder, building a lean delivery system with telehealth/telemonitoring.

Quality Improvement Stakeholders
The success of the goals outlined for this project hinge on implementing a robust quality improvement methodology used to correct barriers to existing care as well as implement new approaches (i.e. data analytics and telehealth) through revisions to the hospital's value streams and standard work. Purdue Healthcare Advisors' (PHA) process improvement program Lean First offers principle-based training. Lean First focuses

entirely on lean methodologies to democratize lean across the MGH spectrum to assure more team members grasp valuable pieces of the puzzle and are engaged in the journey.

Evidence-Based Quality Improvement Model(s) or Promising Practices
CDC Million Hearts, Lean First QI, CMS, 1-800-Quit Now

Services & Activities
Project Year 1 – hiring a Community Health Worker, lean events including formation of a Value Stream Improvement team, Value Stream Analysis, Rapid Improvement events, and Lean Daily Improvement. Implementation of remote patient monitoring for HF patients. The team used advanced data analytics to express the current state of clinical, quality, safety, and financial measures for the patient population. Data from PY1 indicated the need for interdisciplinary rounding for in-patient and re-engineering of the care delivery processes. Project Year 2 & 3 continued limited Lean (due to COVID). New practices and protocols have been expanded to all inpatient units. Project Year 3 provided Lean events to evaluate and implement best practice communication and coordination with the primary care practices. All three years have focused on better utilization of healthcare resources. Data is showing cost reductions in several areas.

PROJECT RESULTS

Outcomes
1. Increase HF Clinic referrals data: 2018: 128 & 2021: 322
2. Active Clients in the HF clinic: 2018: 128 & 2021: 264
3. Pilot: Remote Patient Monitoring (RPM) for HF clients: 2019: 0 & 2021: 56
4. RPM – of the 52, 3 (0-30 days) and 4 (31-60 days) came to the ER
5. New Inter-professional rounding (Physician, nurse practitioner, nurse, social work, discharge planner, pharmacist, rehab therapist). Started in Medical Surgical Unit 2020, inhibited by COVID, initially met with resistance by providers, now widely accepted and valued by entire team. Patient and family satisfaction have increased. Increase discharge care coordination including medication reconciliation and primary care provider follow up support cost saving to the patient and the hospital (early data will be complete by end of grant period).
6. Changes from Lean Process Quality Improvement
   - RPM schedule and HF referrals built into electronic medical records (outpatient and inpatient)
   - Patients contacted within 24-48 hours after referral
   - Community Health Worker visit to inpatients for HF Clinic & RPM
   - Second RN in HF Clinic to build capacity for increased referrals
   - HF Clinic visits changed from 60 minutes to 45 minutes to increase HF Clinic capacity.
   - Updated home-based education packets – adjusted to meet patient needs with appropriate coding.
   - Inpatient & outpatient heart failure patient education updated at 6th grade reading level
   - Created a Social Determinates of Health Intervention to screen patients at high risk of failure due to hindering factors, i.e., no transportation, unable to read, can't afford meds, etc.
   - Created a Managed Conditions list to extract data on new hospital admissions with HF diagnosis
   - Obtained oxygen saturation monitors, scales, and automatic blood pressure cuffs for those unable to purchase on own
   - Obtained Hot Spots for those interested in RPM but had no internet connection
   - Provided packets of spices for patients to reduce cooking with salt

Sustained Impacts

- Primary prevention of cardiac issues in our population,
- Increased use and acceptance of telehealth and remote patient monitoring,
- Embedded Lean QI in the entire organization: inpatient, outpatient, and Primary Care Provider.
- Efficient use of healthcare dollars and resources,
- Increased workforce capacity and satisfaction
- Building the platform for the Post-Acute Care Team to expand services for chronic disease management through home visits with Telehealth/remote patient monitoring.
- Interdisciplinary rounding for in-patients utilizing the re-engineered care delivery processes has impacted the communication between staff, patients and families providing stronger coordination of the care plan, increased patient satisfaction and reduction in pharmaceutical costs. Initially, providers were resistant to the rounding, now it is a positive expectation for providers and care team. Later in May, units are celebrating the successes of rounding. Patients and families have expressed great confidence of meeting their healthcare needs upon discharge.

Learning Opportunities Learning Opportunities

Quality Improvement means change, and change is hard. It was a long process to gain interest and support from various levels of staff and providers. COVID and staff shortages, overworked staff and high patient acuity provided additional challenges. Implementation of the remote patient monitoring was also hindered by COVID. Education, certification, and training were difficult due to the switch to virtual learning platforms.   The lesson of perseverance by several of the Lean staff leaders eventually paid off. In a recent meeting, early doubters are now enthusiastic cheerleaders of the QI process. Primary care providers are now expressing interest in remote patient monitoring options. The project included a community health worker, which was new to the health care system, and consultation with other grantees provided by our HRSA Technical Assistant resulted in effective health education, scheduling, use of the electronic medical records, and patient home visit protocols and guidelines. The interdisciplinary rounding increased referrals and participation in the heart failure clinic support and interventions which has statically reduced re-admissions by 75%.

Mayers Memorial Hospital District

Take Four Counseling Program
G20RH33265 | Critical Access Hospital | https://www.mayersmemorial.com/
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Amanda Harris | Telemedicine Coordinator | aharris@mayersmemorial.com | (530) 336-5511

PROJECT OVERVIEW

Goals & Objectives
The Take Four Counseling Program was designed to make talk therapy services more accessible to the student population of a rural, remote school district that otherwise has one Psychologist assigned to service six different sites. By training a staff member at each school site to become a "Site Coordinator", the project developed small telemedicine clinics at each site, capable of organizing and carrying out blocks of counseling clinic right at the site with a provider via video. This service saves parents from taking time off work to take their children to appointments and fuel cost of getting there. For students over age 12, it also gave the opportunity for students to seek out assistance themselves. Per California law, students over age 12 can consent for themselves so this provided access to students that could be homeless or unable to get a consent form signed by a guardian to consent for themselves and receive the help they need. The Take Four Counseling Program also highlighted the need for services at all six sites by showing how full the blocks were and how many students used the service. This helped prioritize mental health in the eyes of school district administration so that future funding and resources can be considered to continue the service.

Focus Areas
Behavioral/Mental Health, Treatment and Management, School Based Care Coordination, Telehealth/Telemedicine

Counties Served
Fall River Joint Unified School District in Shasta County, California was served by the Take Four Counseling Program.

Target Populations
The Take Four Counseling Program's target population are the students that attend schools in the Fall River Joint Unified School District. The district has schools in both Fall River Mills, California and Burney, California and includes elementary, high,- and alternative schools.

Needs Addressed
The primary need addressed by the Take Four Counseling Program was access to talk therapy services for students in the school district. The school district has one Psychologist to provide mental health support at the six sites. While this provider is amazing, he is only one person and can only meet so many needs while traveling from site to site. The counselors provided via the Take Four Counseling Program allowed for much improved access to services including the ability for students to request services themselves if they are over 12 years of age. This type of access allows for problems to be addressed sooner, leaving the on-site district psychologist the bandwidth to address more pressing needs.

Quality Improvement Stakeholders

The Take Four Counseling Program has the privilege of having a wide variety of stakeholders that assisted the program along the three years it has been in place. Those stakeholders include Louis Ward, MHA, CEO, Mayers Memorial Hospital District; Merrill Grant, Ed.D., Superintendent, Fall River Joint Unified School District; Javeed Siddiqui, MD, MPH, CMO, Telemed2U; Susan Knoch, RN, BSN, PHN, COO Mountain Valleys Health Centers; and Candy Vculek, RN, MSN, CNO and Six Sigma Black Belt, Mayers Memorial Hospital District. These advisors met in the first year to review the logistics and provide feedback and guidance and were furnished reports thereafter (due to COVID) and opportunity to weigh in on the program.

Evidence-Based Quality Improvement Model(s) or Promising Practices

The project used a Lean Sigma A3 quality improvement model, 5 Why's and Plan Do Study Act (PDSA) to plan, continually improve and execute the grant program. Throughout the Take Four Counseling Program, the project had students complete post-appointment surveys after each encounter with the counselor and had principals, site coordinators, elementary school teachers and high school students complete period surveys. This served to help the project team repeatedly evaluate and improve the program to continue to provide high quality mental health services within the school district using telemedicine.

Services & Activities

The Take Four Counseling Program essentially established six small telemedicine clinics within a local school district to make mental health services more accessible to students within the district. To do this, the project established site coordinators at each site and trained them on HIPAA regulation and telemedicine clinic protocols. The project created flyers, consent forms, timecards for the site coordinators, surveys for students after their appointments and Survey Monkey surveys to regularly evaluate and improve. The project also established workflows for the sites to set up appointments for students with the counselor and ensure that these appointments were carried out with confidentiality in mind and in the most professional/high quality manner possible. During the summer breaks between school years, services were offered for students to connect to counselors directly from home or to come to the local hospital and connect with the counselor from there if they did not have the equipment/connection to attend from home.

PROJECT RESULTS

Outcomes

1. A teletherapy program was established at all six school sites with services provided to students grades kindergarten through 12th grade.
2. Site coordinators at the school sites grew more comfortable with the telehealth model of delivery of services.
3. Students that used the service completed post appointment surveys with positive results to demonstrate the benefit of having the service available to students.
4. The school district administration appreciated the need for greater accessibility of mental health services and wishes to continue the service after the grant period is over.

Sustained Impacts

Prior to the Take Four Counseling Program, the local school district only had one psychologist to serve all six sites. This was a huge task for one provider to cover, not to mention the amount of time spent traveling between sites. The provider was also tasked with helping students in the special education department, further limiting his time for counseling. With the addition of the Take Four Program, the school district became aware of the abundant need for regular talk therapy visits to maintain student well-being and mental health. As a result, the district is attempting to take over the administration of the program with the same workflow model so that it can continue to provide students with the talk therapy that they may not otherwise receive outside of the school system.

Learning Opportunities

One of the major learning points of the Take Four Program is the way that the public as a whole underestimate the power of telemedicine. When the program was in its early days, it was often met with skepticism regarding whether students would be interested in seeing a provider via video. When the program rolled out, students embraced the telehealth modality and had no qualms about opening up to the provider on the other side of the screen. Telehealth may seem impersonal or clunky to people that have the option to see someone in person, but to a student that otherwise has no options for services, telehealth is an opportunity for access to mental health services that they badly need. Providing talk therapy services via telehealth in the school district allowed for support to the district psychologist. It allowed him the peace of mind to know that the project's psychologist was "putting out the smaller fires" while he addressed the bigger ones. The project's psychologist established relationships with a large number of students and was able to bring to the forefront the students that needed in-person, on-site support more than others, thus ensuring the district psychologist's time was dedicated to those with greatest needs.

Mercy Health Partners of Southwest Ohio

Population Health Management Program
G20RH33256 | Critical Access Hospital | www.mercy.com
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PROJECT OVERVIEW

Goals & Objectives

The Population Health Management Program sought to achieve meaningful improvements in health care delivery for the service areas in order to reduce chronic disease and the resulting economic burden for patients by focusing on the following goals and objectives:

1. Goal 1: To provide specialty, multidisciplinary care for those patients with a high risk for hospital readmission or Emergency Department (ED) recidivism due to a chronic disease condition(s).
   a. Objectives:
      i. Develop and institute a population health management model of care.
      ii. Develop a Medication and Education Specialty Clinic aimed at addressing population health in the service area.
2. Goal 2: To provide a specialty care multidisciplinary clinic that is aimed at treatment of hepatitis and the prevention of its wider dissemination in the community.
   a. Objective:
      i. Develop a Hepatitis screening and treatment clinic within the Population Health Management Program.

Focus Areas

Chronic Disease Management, Chronic Obstructive Pulmonary Disease (COPD), Treatment and Management, Community-based Care Coordination, Diabetes Care Management, Health Education/Promotion and Disease Prevention, Pharmacy Assistance, Population Health, Substance Abuse Treatment and/or Education, Telehealth/Telemedicine, Hepatitis C treatment

Counties Served

Estill, Lee, and Powell Counties in Kentucky were the main counties of focus. The project also occasionally served patients from Montgomery, Clark, Wolfe, Madison, Rockcastle, Owsley, and Breathitt Counties.

Target Populations

The target population included patients in the aforementioned counties situated in Central Appalachia where there are regular higher health care costs and patients experience significant health care disparities. The project specifically sought to work with patients diagnosed with hepatitis C, substance use disorder, diabetes, chronic heart failure, atrial fibrillation and chronic obstructive pulmonary disease (COPD) because of the sizable burden of these diagnoses on communities.

Needs Addressed

Through the Population Health Management Clinic and the associated decentralized services, patients with Hepatitis C were able to receive care close to home. Patients with the previously mentioned chronic diseases received specialized education on care management as well as appropriate use of their medications.

Numerous patients received assistance obtaining medications that were prohibitively expensive or unapproved on their insurance plans and patients entering the hospital had their medications reconciled by a staff member to ensure appropriate transition of care and to identify potential needs for further education and management provided by the clinic.

Quality Improvement Stakeholders

Mercy Health Marcum & Wallace (MHMW) Hospital provided fiscal management and oversight for grant compliance as well as data collection and provision of a location for the physical clinic. The Mercy Health Clinics allowed the project to decentralize services and treat primary care patients closer to home. Members of the Project HOME Network (a consortium of local health care-related entities too numerous to list individually) served as referral sources for patients, allowed for the referral of patients with opioid use disorder as we don't have a waivered provider, assisted with prescription assistance applications, and helped streamline the specialty pharmacy medication dispensing process.

Evidence-Based Quality Improvement Model(s) or Promising Practices

Population health care management represents a move away from discrete, episodic approaches to health care toward one that emphasizes care management. The Chronic Care Model is a well-established conceptual model, which is intended to inform the design of the Population Health Management Program at MHMW. This program was informed by the Chronic Care model, addressing the antecedents and known determinants that often figure into a personal health crisis that results in an emergency admission and hospitalization, including disease severity, lack of recognition of the signs of exacerbation, under use of proven therapies, inadequate knowledge or skills in self-management, lack of adherence to medication and dietary regimens, inadequate social support and inadequate coordination and long-term follow-up among health care providers.

Services & Activities

The project was able to meet its goal of providing specialty, multidisciplinary care for patients at risk for hospital readmission or ED recidivism due to chronic disease conditions by providing education both in the hospital and primary care clinics. Hospitalists utilized staff to conduct medication reconciliations to ensure safe and accurate transition of care and to educate newly diagnosed patients with diabetes, congestive heart failure (CHF), COPD, and a defibrillator as well as patients with long-term chronic conditions identified as non-compliant for any reason. There was also a focus on assisting patients whose overall health was at risk because they were struggling to afford their medications by leveraging available manufacturers' assistance programs and other grant funding. In line with the project's second 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), the physical Population Health Management Clinic treated patients with Hepatitis C while providing behavioral health counseling to those patients as well. Without a waivered provider to prescribe MAT, the project was able to refer patients to a network partner organization while providing behavioral support and education.

PROJECT RESULTS

Outcomes

1. A Population Health Management model of care was implemented in MHMW's Medication and Education Specialty Clinic to reduce chronic disease and the economic burden in the service area. While a physical clinic was created in a hospital space for this purpose, many efforts were also decentralized (due in part to COVID-19) to our existing primary care clinics in order to better meet patients where they were. The project saw patients with targeted disease states in the hospital's clinic, at primary care clinics, and in the hospital as inpatients to ensure they were well educated on new (or existing) diagnoses prior to discharge.

2. Recognizing that many patients had suboptimal outcomes because of their inability to afford the necessary medications, the project focused on helping these patients leverage available resources to save more than $1 million on their prescriptions.
3. Medication reconciliation was performed for patients admitted to the hospital to ensure safe and accurate transition of care and to improve outcomes for chronic diseases bolstered by improved communication and less confusion for patients caused by unintended medication changes.
4. The specialty clinic also focused on Hepatitis C screening and treatment with a nurse practitioner trained and authorized to treat Hepatitis C under a mentorship program. In addition, one of the established primary care providers also received training to treat Hepatitis C which allowed the project to treat more patients in primary care as well with staff serving to educate patients and submit treatment plans to specialist mentors on their behalf. Patients were referred to the specialty clinic from local providers and health departments in the network.

Sustained Impacts

Beyond the improvement in the health of the population, the project has established a model within the ministry that allows for the use of an innovative practice structure to treat Hepatitis C (which normally requires travel for specialist intervention) locally. This model requires a provider care agreement between providers and the pharmacist, a first for this location. Forced by COVID-19, the project embraced the utilization of telehealth (mainly telephone) and decentralization (seeing patients in primary care clinics to keep them out of the hospital and to cut down on the total number of visits they had). Policies were put in place regarding prescription assistance and are already being revised and updated because of network utilization that will allow for an increase in the volume of assistance while freeing up the pharmacist to spend more time with patients on clinical work. This grant project overall has helped to entrench a pharmacist and pharmacy technician in the care of patients in both the hospital and primary care clinics. Their value has been embraced by providers and staff who now utilize them as a resource for numerous aspects of patient care.

Learning Opportunities

- One important goal of this grant originally was to provide treatment for substance and opioid use disorder. Despite having several capable providers on staff in our ministry, it has proven difficult to overcome the stigma associated with prescribing medication assisted treatment (MAT) in a small, rural community. The project has instead referred substance use disorder patients to partner organizations for treatment while still being able to provide education and other types of support in-house. Having a plan to combat the stigma in place before recruitment could prove helpful.
- Some efforts were, while tremendously helpful to patients, done by staff that should have been performing more specialized, clinical work. The project later identified network partners to utilize in order to maximize patient assistance while freeing up clinicians for more appropriate work from a perspective of fiscal responsibility.
- Data collection will be cumbersome. Elaborate as fully as possible on your spreadsheets early in the process. It will be easier to cull out information than to go back and collect with a looming deadline.
- Empower your patients. There will be aspects of care that will require a professional, but they also need to feel empowered to manage parts on their own. This is beneficial for the patients' confidence in their care as well as the program's ability to function efficiently.

Northern Montana Hospital

Northern Montana Quality and Chronic Care Initiative
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PROJECT OVERVIEW

Goals & Objectives

The focus of this project was to expand Chronic Care Management services to include proactive outreach to close patient care gaps and the use of technology to provide remote monitoring, and more importantly, to create and provide evidence-based education to the patient to encourage self-management of their chronic disease. To meet this goal, the project worked to affect functional and clinical outcomes associated with disease management with the use of standing orders and educational material.

Goals from the work plan included:
1. Goal 1: improve financial and operational efficiency with the northern Montana provider office practice using the chronic care model quality improvement strategies and optimizing the use of electronic medical record (EMR).
2. Goal 2: improve patient healthcare outcomes focusing on clinical indicators for management of diabetes and cardiovascular disease, as well as reduction of obesity and smoking.
3. Goal 3: improve patient engagement and satisfaction by offering health coaching and self-management support.

Focus Areas

Chronic Disease Management, Health Education/Promotion and Disease Prevention

Counties Served

Hill, Blaine, Liberty, Phillips; Chouteau County, Big Sandy District, Montana

Target Populations

Patients that reside in the service area with chronic health issues. Special emphasis was placed on patients who had diabetes or cardiovascular disease including stroke and hypertension.

Needs Addressed

During 2018, three of the top five diagnoses our clinics were chronic disease related. Hypertension visits alone were over 4500, with diabetes and hyperlipidemia both in the area of 3000 visits each. During this same time period, chest pain was the number one reason that patients were seen in the Emergency Department. Because of this high rate of utilization of healthcare by patients with these chronic diseases, Northern Montana Quality & Chronic Care Initiative (NMQCCI) will focus on this population of patients. Special emphasis will be made on managing the multiple chronic disease population.

Quality Improvement Stakeholders

Medical providers and staff of Northern Montana Health Care.

Evidence-Based Quality Improvement Model(s) or Promising Practices

Chronic Care Model of quality improvement was chosen as it closely characterizes the desired accomplishments for our patients. The strength of the Chronic Care Model is that it identifies the essential elements of a healthcare system that encourages high-quality chronic disease care.

Utilizing the six components of the Chronic Care Model, the project worked to:
1. Create a model of continual improvement within our health care systems,
2. Encouraged and coached patients in self-management
3. Redesign some of delivery system
4. Utilized clinical decision support
5. Use informatics to improve chronic disease tracking.
6. Identify community resources for support of chronically ill patients

Services & Activities
1. Chronic Care Management
2. Care Coordination
3. Behavioral Health Integration
4. Diabetes programs and continuing education
5. Hypertension coaching
6. Wellness programs
7. Walk with Ease
8. Stepping On Fall Prevention
9. Welcome to Medicare process created
10. Implementation of registry software for CCM program
11. Creation and utilization of reports to identify high resource usage patients

PROJECT RESULTS

Outcomes
1. Chronic Care Management program creation
2. Readmission reduction program - 0% readmission for 2021 and 2022
3. Identification and recruitment of patients with high ER usage
4. Medicare Wellness visits service established
5. Increased coaching services within clinic
6. Blood pressure loaner program
7. Self-measured blood pressure program implemented
8. Improved acceptance of Medicare Wellness visits
9. Community health through Walk with Ease program
10. Community health with Stepping On fall prevention
11. Increase offering of Diabetes Prevention Program by offering program online

Sustained Impacts
The grant funding from HRSA was used as confidence capital to encourage the acceptance of this program. The past three years have shown that Chronic Care Management (CCM) does provide reimbursement and a return on investment. CCM has helped to change the mindset of the organization to become more receptive to new programs as evidenced by the willingness to investigate Screening, Brief Intervention, and Referral to Treatment (SBIRT) education and becoming more receptive to behavioral health integration.

Learning Opportunities

One of the greatest learning opportunities is that resilience in the face of a pandemic is of highest importance. Other lessons learned are:
1. The importance of provider and nursing services buy-in
2. Prepare for turnover of staff with solid training program for new staff
3. Document everything
4. Recruit a champion for program that will speak up and provide support
5. Win buy-in from leadership
6. Recruit an advisory council that will be actively supporting of project
7. Provide ongoing education to providers and staff about the program
8. Identify data required to show project progress; collect and report to leadership quarterly
9. Importance of software program integration

Pike County Memorial Hospital

Effective Care Transitions Program
G20RH33264 | Critical Access Hospital | https://www.pcmh-mo.org
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Lisa Pitzer | Grants Administrator | lpitzer@pcmhmo.org | (573) 754-5531

PROJECT OVERVIEW

Goals & Objectives
The program goals included developing a hospitalist program using a Family Nurse Practitioner in that role. The hospitalist worked with case management and chronic care managers to improve care and transitions in care to prevent readmissions and make sure patients were provided care in the proper setting and receive targeted support post-discharge. Sustainability of the program relies on making sure Transitional Care Management (TCM) and Chronic Care Management (CCM) were completely embedded in the program's processes.

Focus Areas
Behavioral/Mental Health, Case Management, Chronic Disease Management, Prevention, Treatment and Management, Community-based Care Coordination, Health Education/Promotion and Disease Prevention, Pharmacy Assistance, Population Health, Transitions of Care (TOC)

Counties Served
Pike County, Ralls County, Audrain County, Montgomery County, Missouri

Target Populations
The target population included individuals in Pike County and surrounding counties that do not have a primary care provider and frequently seek care at the hospital Emergency Department for one of the following: diabetes, cardiovascular disease, high blood pressure, depression, and individuals who have a history of smoking, tobacco use and/or weight outside normal parameters.

Needs Addressed
Needs addressed included assuring patients receive coordinated CCM and TOC and have appropriate follow up post-discharge with access to transportation. Depression is common in patients with chronic conditions and establishing depression screening and Screening, Brief Intervention, and Referral to Treatment (SBIRT) follow-up is vital. Emphasis has also been put on patient education on disease process and medications with supportive medication reconciliation. The new hospitalist role allows primary care physicians to spend more time in the primary care setting. Patients have a support system through the TCM and CCM programs, which aides in reducing preventable readmissions to the inpatient setting.

Quality Improvement Stakeholders
Pike County Memorial Hospital stakeholders included the designated Nurse Practitioner in the hospitalist role, In-patient Case Manager, Chronic Care Managers, Clinic Manager, all Primary Care Physicians, QI Director and IT team. The project team worked with a network of existing support providers throughout the service area to make sure patients have what they need in place. Specifically, a relationship with the local Health Department and with Home Health and Hospice aided the project in meeting goals, and the project also worked with a local consortium of healthcare, schools, behavioral health entities and social service providers.

Evidence-Based Quality Improvement Model(s) or Promising Practices

Primary Care Health Home (PCMH), Chronic Care Model (CCM), and the Institute for Health Improvement Model, Plan Do Study Act (PDSA)

Services & Activities

More holistic and coordinated chronic care management was developed during the grant. A hospitalist Nurses Practitioner role was established as well as an expanded chronic care team, including a fulltime Chronic Care Manager and a Navigator. In addition, depression screening and SBIRT follow-up were implemented for chronic care patients. Discharge summaries were further developed and are used in warm handoffs at discharge for selected patients who are then followed post-discharge by the Navigator who facilitates follow-up appointments, conducts monthly patient check-in calls and helps assure access to medical transportation. Patient education was enhanced and medication reconciliation at admit and discharge were also implemented. Engaged business office in learning coding processes for CCM and TCM. Project progress was impacted by the COVID pandemic during much of the grant but is now back on track and progress is being seen.

PROJECT RESULTS

Outcomes

1. Improved HCAHPS scores, significantly in transitions in care areas and patient understanding of discharge instructions and medications.
2. Development of role of nurse practitioner in a hospitalist role and gaining physician confidence in this role.
3. Increased patient education and case management capacity and enhanced workflow with selected chronic care patients.
4. Integration of depression screening and follow-up into chronic care management.
5. Growing support for sustainability of grant successes by working with the business and clinic offices to learn the specific coding requirements to bill CCM and TCM.

Sustained Impacts

Many processes have been improved as a result of this grant program that go beyond just the goals of this project. Pike County Hospital has changed staffing patterns and provided increased educational opportunities for staff which include the Custom Learning Program for the entire hospital staff. The project institutionalized further coordinated chronic care management, transitions of care and depression screening into the hospital's care management services. The hospital has expanded into social determinant of health activities that include improved transportation alternatives so that there are fewer missed follow up appointments. This has greatly improved patient satisfaction levels and increased the effectiveness of processes. This grant has helped raise Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores which has gained the support of the Board of Trustees. All of these ensure sustainability of the program after the grant funding ends.

Learning Opportunities

We have learned that it is very critical to constant be working on improvement of our electronic health record to be able to adapt to our goals and capture the data we need for reporting purposes.   We have also learned that each hospital employee has a role to play in ensuring proper transitions in care and that a team approach and using the PSDA model are critical in learning what is working and what needs to be changed. We have also learned throughout most of the grant period that we will often be faced with challenges such as the COVID 19 pandemic and that we must remain resilient and flexible in our efforts.

Pullman Regional Hospital Foundation

Health Coaching/Motivational Interviewing in Acute & Primary Care Settings
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Becky Highfill | Grants Manager | becky.highfill@pullmanregional.org | (509) 332-2033

PROJECT OVERVIEW

Goals & Objectives
The goal was to build a sustainable health-coaching model, to include training, embedded in clinic and hospital processes whereby patients received health coaching from staff and providers who are proficient in motivational interviewing (MI).

Focus Areas
Case Management, Chronic Disease Management, Prevention, Treatment and Management, Diabetes Care Management

Counties Served
Whitman County, Washington

Target Populations
Patients who have two or more co-morbid chronic diseases, prioritizing those with depression (PHQ9 > 9 for clinic and > 10 for the hospital and/or anxiety Generalized Anxiety Disorder (GAD) score > 15 for clinic and > 10 for hospital).

Needs Addressed
As a result of implementing the Health Coaching/MI project, more patients were engaged in their own care with improved outcomes, including lower A1c, improved Patient Activation Measure (PAM) scores, lower blood pressure, and lower Patient Health Questionnaire (PHQ9) scores.

Quality Improvement Stakeholders
The collaboration was comprised of three health care providers: Pullman Regional Hospital, a 25- bed critical access hospital, Pullman Family Medicine (seven physicians), and Palouse Pediatrics (six physicians), members of the Pullman Regional Hospital Clinic Network.

Evidence-Based Quality Improvement Model(s) or Promising Practices
Health Coaching, specifically, Motivational Interviewing (MI), is an evidence-based intervention that addresses ambivalence to change.

Services & Activities
The project hired a registered nurse (RN) and social worker who were trained and certified as health coaches that led a "train-the-trainer" model for Pullman Regional Hospital, Pullman Family Medicine, and Palouse Pediatrics staff and providers. They also worked to embed motivational interviewing (MI) proficiency among vital primary care partners and began to track patients receiving the intervention and measure progress toward disease-specific self-management goals.

PROJECT RESULTS

Outcomes

1. Two people were trained and certified in motivational interviewing and health coaching. One was a RN and the other a social worker.
2. Using the train the trainer model, curriculum and instruction were created and trainings were planned. The team had to pivot due to COVID-19 and virtual trainings took place instead of in-person. Also, the project was unable to conduct as many trainings and had to rethink how clinicians would be trained due to the pandemic. The project had originally planned to train 200 hospital and primary care clinicians during the grant period.
3. Motivational Interviewing training was implemented into the new employee orientation and a competency evaluation and observation program was developed to ensure health coaching utilization and integrity on an annual basis.

Sustained Impacts

This project was a positive experience for people related to the medical field. Many of the people in the target population do not feel "heard" or understood by the medical field so it had a significant impact on them to have someone checking in and listening to them; taking extra time with them to help them where they are at and how they can have an effect on their own health.

Learning Opportunities

We have learned how flexible we can be. We were able to adapt to new rules/guidelines and come up with new ideas in order to still do what we needed to do. For anyone looking to replicate this: momentum is very important for things like this. We would recommend hitting it really hard and having a big roll out initially and trying to touch as many people as possible, even in little ways. As a result of significant communication about the program up front, you can build on the foundation.

Purchase District Health Department

G20RH33275 | Health Department | www.purchasehealth.org
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PROJECT OVERVIEW

Goals & Objectives

The purpose of the project was to improve patient outcomes and health for patients admitted to one of two hospitals in the rural health network (Baptist Health Paducah and Mercy Health Lourdes Hospital) by: 1) Decreasing unplanned avoidable readmissions (defined as readmitted within 90 days of original discharge) for patients admitted with a heart failure diagnosis; 2) Improving health outcomes for the target population; and 3) Improving the health literacy of the target population and their care givers. The goals were to provide greater support and contact with the patients and caregiver through the Purchase Area Health Connection (PAHC) Community Health Worker (CHW) program and provide weekly home visits and/or phone calls that support the patient and their care giver to both better understand and better manage their health as well as collect data to support improved quality of care and improved health outcomes. The initial goal was to follow patients who had been admitted only for heart failure however during COVID time it was apparent with low referrals to the program, it was necessary to pivot and expand the diagnoses. PAHC then expanded it to Heart Failure (HF) as well as Acute Myocardial Infarction (AMI), Coronary Artery Bypass Grafting, Stroke, Sepsis, Total Joint (hip and knee), Pneumonia, and Chronic Obstructive Pulmonary Disease (COPD) which were the top eight readmission diagnoses.

Focus Areas

Cardiovascular Disease (CVD) Care Management, Chronic Disease Management, Community-based Care Coordination, Health Education/Promotion and Disease Prevention, Health Screenings, Population Health, Transitions of Care

Counties Served

Purchase Area Health Connections CHW Program covers the eight Western Counties in KY: McCracken, Ballard, Fulton, Hickman, Carlisle, Graves, Calloway, and Marshall County.

Target Populations

The target population served by the project included patients who had been admitted as inpatient to one of two hospitals in the rural health network (Baptist Health Paducah and Mercy Health Lourdes Hospital) with one of the top eight readmission diagnoses: acute myocardial infarction (AMI), coronary artery bypass graft (CABG), Heart Failure (HF), Stroke, Sepsis, Total Joint, Pneumonia, and chronic obstructive pulmonary disease (COPD) and were at risk of risk of readmission. Patients would be identified as high risk for readmission based on history of admissions and social determinant risk factors.

Needs Addressed

The rural area served by this project has high rates of poverty, provider shortages, and barriers to accessing care as well as high rates of all chronic diseases. Poverty drives additional barriers to health which impacts healthy food choices, housing and transportation. According to the Centers for Disease Control and Prevention (CDC) 2022, top leading causes of death in Kentucky are heart disease, COPD, stroke, and sepsis. The primary purpose for the CHW program was to provide health literacy for clients to understand and better manage

their chronic disease, help them find a medical home, address social determinants of health, and connect clients to community resources which in turn impacts hospital readmissions.

Quality Improvement Stakeholders

Organization Name: **Organization Type:**
Purchase District Health Department   local health department
Purchase Area Health Connections   regional health coalition
Baptist Health Paducah Hospital   nonprofit hospital
Mercy Health Lourdes Hospital   nonprofit hospital
Pacific Institute for Research and Evaluation   external evaluators

Evidence-Based Quality Improvement Model(s) or Promising Practices

PDHD chose to use PDSA, or Plan-Do-Study-Act, an interactive, four-stage problem-solving model used for improving a process or carrying out change. PDHD has been utilizing it to develop process flow and surveys. This model helped to evaluate and improve the quality of CHW program and process in short periods of time. PDHD based the CHW program model on the following Evidence-Based/Promising Practices: "Community Health Coaches for Successful Care Transitions," "Motivational Interviewing-Connect Community Health Worker Program," "Abbeville County's Community Paramedicine Program," and the CHWs Evidence-Based Toolkit, provided by the Rural Health Information Hub.

Services & Activities

The hospital partner identifies and refers the client to the CHW program. CHWs follow the client for 91 days with at least seven home visits and five telephonic visits as needed. The CHWs and the client navigate not only healthcare needs but social determinant of health needs focusing on the attendance of follow-up care visits, compliance with medical orders, and improving health literacy so the client can understand and manage their chronic disease. This in turn impacts avoidable hospital readmissions as the client is more compliant, more informed, and a better advocate for themselves. PDHP uses clinically validated questionnaires and general surveys to understand the client needs and barriers such as: nutrition, weight and BP status, physical activity, social connection, insurance, self-efficacy, breathlessness, health care utilization, home safety checklist, and substance use. The CHW acts as a liaison for these needs. Additionally, the CHWs connect clients with a medical home if they don't have one or are unsatisfied with their current physician, specialist physicians, and facilitate health service access. Additionally PDHD encourages programs such as self-measured blood pressure (SMBP) and standardized messaging across agencies.

PROJECT RESULTS

Outcomes

1. Improved access to care through educating clients on how to use telehealth and addressing transportation needs
2. 88% of enrolled clients that had a follow up primary care provider (PCP) appointment post discharge, attended the appointment.
3. 98.1% of respondents to the graduation survey stated that they felt more confident being at home with their chronic illness.
4. 60.3% of those referred were enrolled
5. Of those enrolled, 57.3% graduated the program. Graduation is no avoidable readmission and completion of at least one health goal.
6. 3,158 social interventions by subcategory, within each subcategory there are multiple priorities and interventions.

7. Sustainability Modeling Consultant is presenting at our one-day seminar along with our evaluators to share how Value Based Care aligns with CHW programs.
8. When the client was readmitted, the readmission was audited to determine root cause and what steps could have been taken to mitigate or eliminate the root cause of readmission.
9. All patients who had hypertension, were discharged on daily blood pressure (BP) and or daily weight, or a stroke/heart patient were given as needed a BP monitor, oximeter, scale and providing documentation logs, as well as educated on its proper use.
10. Increased health literacy as shown by medication compliance and attending follow up clinic visits.
11. Gaps analysis which increased capacity trainings for CHWs such as National Society of Health Coaches Program, Bridges Out of Poverty, and Care Collaborative (community blood pressure educational encounter)
12. Development of a program model that can be replicated.
13. Increased awareness for cardiac and pulmonary rehab within the community.
14. CHW Program increased collaboration between agencies such as home health, skilled nursing facility, and pharmacy to coordinate care around a patient.

Sustained Impacts

- This grant strengthened the regional coalition by increasing members, and improved data sharing and partnerships between hospitals. PDHD piloted CHWs utilizing health information technology and exchanges in Kentucky to reduce readmissions. This will lay the framework for other programs to utilize.
- PDHD increased capacity in the area and increased readiness for CHW programs and models across the state. Partner agencies now have a base knowledge of the impact of CHWs and how CHWs can work with various agencies such as home health whereas prior many agencies felt this could be a competitive program.
- The hospitals have aligned some of their strategies with PDHD to increase health literacy of the patient population by using color zones. PDHD also seen one of the hospital's outreach nurses begin to ask the same screening questions as we do.
- Many of the CHW clients now have the tools in their toolbox to better understand and manage their chronic illness which will lead to sustained population health.

Learning Opportunities

This project utilized MediView, an ePCR to track follow-up care visits and social determinants addressed. This allowed the team to be more efficient with documentation as well as provided vast choices of data retrieval which has helped with evaluation. One of the challenges that the project had to overcome was data entry errors which impacted the data retrieval process. Through further training, the team was able to resolve these issues. Referrals from the hospitals have been a challenge off and on throughout the program partially due to staff turnover with Case Managers. It takes diligence with pursuing communication with Case Manager Directors and making the referral process as streamlined as possible. Referrals increased when the project included Stemi/Chest Pain Coordinators and Neuroscience Coordinator to the Transitional Care Task Force Meeting. This provided more hospital awareness. The team found by doing Meet and Greets (CHW meeting the patient in the hospital) and putting the CHWs phone number in the patient's phone there was fewer loss of contacts. Two and a half years of this grant was conducted during COVID, requiring the project to adaptrepeatedly to meet the needs of clients including all telephonic visits and porch drop offs.

Sheridan, County of

Practice Transformation through Team-Based Care

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PROJECT OVERVIEW

Goals & Objectives

The overarching goal of the Hoxie Medical Center (HMC) project was to implement a team-based approach to the delivery of integrated health care, focusing on the attributes of the Patient-Centered Medical Home (PCMH) model. Specific clinical objectives to be achieved by the end of the grant project included:

1. Body Mass Index (BMI) and follow-up plan documented as indicated for 50% of adults.
2. Colorectal cancer screening for 50% of patients aged 50-75.
3. Controlled hypertension for 75% of hypertensive patients aged 8-85.
4. Uncontrolled diabetes in fewer than 16% of diabetic patients.
5. Counseling and/or pharmacotherapy for 98% of tobacco using patients.
6. Screening for depression of 98% of patients 12 and older, with a follow-up plan documented for those screening positive.
7. Complete series of childhood immunizations for 80% of patients aged 2.
8. Dental sealants for 60% of patients aged 6-9.
9. Statin therapy for 85% of patients at high risk for cardiovascular events.

These goals align to Patient-Centered Medical Home certification in the following ways:

1. Focus on delivering comprehensive health care through a team-based approach.
2. Be intentional about developing relationships with patients, caregivers, and family members that consider the patient's cultural values and preferences, and socioeconomic experiences.
3. Employ coordinated, data-driven care strategies supported by electronic health record (EHR) use, data analytics and population health management.
4. Ensure access to expanding office hours as needed by patients, using telehealth, offering same day appointments, and educating patients about alternative care sites for emergencies.
5. Place a premium on care quality and patient safety by leveraging clinical decision support technologies, clinical guidelines, and alerts that flag patient charts for screenings or follow-up to avoid gaps in care.

Focus Areas

Behavioral/Mental Health, Cardiovascular Disease (CVD) Care Management, Chronic Disease Management, Prevention, Treatment and Management, Community-based Care Coordination, Diabetes Care Management, Health Education/Promotion and Disease Prevention, Health Screenings, Oral Health, Pediatric Care, Primary Care Services, Population Health, Substance Abuse Treatment and/or Education, Telehealth/Telemedicine, Transitions of Care

Counties Served

The project served Cheyenne, Decatur, Gove, Graham, Logan, Norton, Rawlins, Rooks, Sheridan, Sherman, Thomas, Trego and Wallace Counties, all in Kansas.

Target Populations

The target population for the program included all medical patients served by Hoxie Medical Center. These individuals may come from within or from outside of the health center's service area, as the center serves all individuals regardless of address. The target population experiences high rates of poverty, negative health outcomes, and multiple social determinants affecting health, and is challenged by access to affordable care.

Needs Addressed

The primary need for the target population was access, as those living in poverty who do not have insurance do not have access, except through HMC. Many low-income persons who purchase health insurance on the exchange opt for low-cost policies, which may have high copayments and deductibles, which they cannot afford. Health concerns include obesity, diabetes, asthma, high rates of heart disease and cancer, substance use, and mental illness. HMC identifies these needs through assessment and screening, and through communication with patients. This process has become more cohesive with the additional Certified Nursing Assistant (CNA) and Community Educator staff employed through this project.

Quality Improvement Stakeholders

Due to the nature of rural health and the consolidation of resources, the primary Quality Improvement Stakeholders involved in the ongoing success of the project were internal. These stakeholders included the internal health care teams comprised of providers, nurses, certified nurse assistants, medical assistants, educators, and administrative quality improvement staff. An important community stakeholder is the Sheridan County Health Complex, which includes HMC as its primary care provider, and the Sheridan County Critical Access Hospital for tertiary care and specialty referrals. This close association between HMC and the hospital allows care teams to coordinate seamless care transitions.

Evidence-Based Quality Improvement Model(s) or Promising Practices

- HMC used two evidence-based practices to implement its Rural QI program: Patient-Centered Medical Home (PCMH) and Team-Based Care. A PCMH is a care delivery model in which patient treatment is coordinated through a primary care provider. This model centralizes care and facilitates positive partnerships between a patient, their family as appropriate, and their primary medical provider. The PCMH model utilizes information technology to ensure patients receive coordinated care when and where they want it in a culturally appropriate manner.
- The Team-Based Care model expands access and delivers more efficient and effective services important high-quality care, such as patient education, self-management support, and care coordination. The Team-Based Care model improves communication by including the patient and their family as appropriate in developing priorities and nurtures teams to problem solve in new ways, learn from poor outcomes, and commit to continual quality improvement.

Services & Activities

HMC improved all project-related health outcomes but one. The health center developed a morning huddle routine with provider teams. These huddles included the Community Educator/ PCMH Registered Nurse (RN), social worker, provider, nursing staff and other beneficial integrated health members. HMC increased behavioral health visits by 160% at its primary clinic and 144% at its satellite location. HMC and the Sheridan County Hospital developed a bi-directional health information technology interface and secure email. The two organizations have access to the other's electronic health record and can send Consolidated Clinical Document Architecture (CCDA) such as imaging reports and content that carries a signature. HMC has progressed in providing patients with a summary of care document prior to their leaving the appointment, which involves providers completing documentation during the visit. This has improved patient satisfaction and has helped with patient compliance to the treatment plan. HMC has streamlined patient care duties by hiring two Certified Nursing Assistants (CNAs), who help provide a smoother and more efficient flow for the provider and the patient and increases communication and education.

PROJECT RESULTS

Outcomes
1. BMI and follow-up plan documented as indicated for 79% of adults, a 25% increase over baseline.
2. Colorectal cancer screening for 44% of patients aged 50-75, a 57% increase over baseline.
3. Controlled hypertension for 59% of hypertensive patients aged 8-85, a 28% increase over baseline.
4. Uncontrolled diabetes in 23% of diabetic patients, a decrease of 20% over bassline. This measure fluctuates among HMC's diabetic patient population, and the project continues to expect progress toward a goal of 16%.
5. Counseling and/or pharmacotherapy for 88% of tobacco using patients, a decrease in 9% over baseline; this measure fluctuates among tobacco using patients. The project will continue to utilize improved workflow and heightened communication to identify patients who use tobacco and target them for cessation counseling and/or pharmacotherapy.
6. Screening for depression of 93% of patients 12 and older, with a follow-up plan documented for those screening positive, a 16% increase over baseline. This improvement is reflective of the greater role of behavioral health in an integrated care model.
7. Complete series of childhood immunizations for 67% of patients aged 2, a 59% increase over baseline. Children received recommended vaccines, had a documented history of the illness, and documentation of a seropositive test result or an allergic reaction to the vaccine.
8. Dental sealants for 100% of patients aged 6-9, a 127% increase over baseline. This improvement is indicative of increased efforts to provide comprehensive, patient-centered care.
9. Statin therapy for 75% of patients at high risk for cardiovascular events; an 8% increase over baseline.

Sustained Impacts
HMC improved the efficiency of visit workflow and improved scheduling capacity. New visit protocols improve the patient experience and satisfaction, which decreases provider burnout and creates a sustainable staff. The Nurse Closer process allows for the nurse to conclude the visit and schedule follow up visits before the patient leaves, which improves continuity of care and adherence to treatment. HMC's no show rate has dropped from 6.6% to 3.2%. Overall patients are healthier with health care teams addressing screening and preventive care earlier. HMC provides patient education and connects patients to resources, closing the loop the make sure the patient received the services for which they were referred. HMC developed a controlled substance policy, educates providers and patients on the safe use of controlled substances and reduction of unused narcotics, and placed a drug take back box at the Hoxie location. The community has welcomed behavioral health through integrated care and tele-psychiatry has become more popular. HMC is on track to regain the capacity experienced in 2019 as COVID concerns lessen and has experienced a 24% increase in new patients over the last year.

Learning Opportunities
Implementing new visit protocols has been somewhat of a challenge, although results demonstrate success. Some patients prefer to see the nurse first rather than a CNA. Providers educate patients about the benefits of the new protocols and encourage acceptance. Some medical providers are reluctant to change and are hesitant to support the Nurse Closer process. Continued support for the model is making inroads with those who are change-resistant. Although HMC utilizes a warm handoff to the behavioral health provider, patients sometimes feel they must repeat themselves. There is not space in the exam rooms for a warm handoff for providers who use a scribe, so they must make a referral. Inconsistencies in the availability of behavioral health staff is challenging to the integrated care model as therapists are not always available to complete a warm handoff if they engaged in therapy. Overall, patients are more informed about their health care and feel more a part of the healthcare team. Key factors other communities may want to consider include the importance of

supportive medical leadership and the commitment to allow the time needed to transition as not all staff welcome change.

Tahoe Forest Health System Foundation

Behavioral Health Integration in Primary Care
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PROJECT OVERVIEW

Goals & Objectives

Project: Behavioral Health Integration in Primary Care

Goal: Increase early identification of mental health needs and access to behavioral health services 10% per year from objective baseline, through integration of mental/behavioral health into primary care clinics for Tahoe Forest Health System (TFHS) patients ages 12 and older and improve patient mental/behavioral health as evidenced through pre/post-depression screenings (August 1, 2019, to July 31, 2022).

1. Objective 1: 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 by July 1, 2020. Alignment: Healthy People 2020- MHMD-5

2. Objective 2: 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 year, August 1, 2019, to July 31, 2022. Alignment: Healthy People 2020- MHMD 11.1 and 11.2; NQF 0418

3. Objective 3: Increase the percentage 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 year, Aug 1, 2019, to Jul 31, 2022. Alignment: NQF 0418; Healthy People 2020- MHMD-6, 9.1 and 9.2

4. Objective 4: 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 year, August 1, 2019 to July 31, 2022. Alignment: Healthy People 2020- MHMD-10

Focus Areas

Behavioral/Mental Health

Counties Served

Placer, Nevada, El Dorado, Sierra, and Plumas Counties, CA and Washoe County, Nevada

Target Populations

Target Patient Population included 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: have a local zip code of residence, or a local primary care provider (PCP) listed as their PCP. Primary care clinics within TFHS include Family Practice, Internal Medicine, and Pediatrics clinics.

Needs Addressed

Community Health Needs Assessments (CHNA) completed in 2011, 2014, and 2017 identified unmet mental health needs. Data from the 2017 CHNA showed that over half of residents experienced one or more days with depressive symptoms in the two weeks prior to the survey and 4.5% are currently depressed according to the Patient Health Questionnaire. One in three residents had at least one day when mental health was not good in

the past month, an increase from previous surveys, 13% have a depressive disorder, and 10.4% have an anxiety disorder. Suicide was the leading cause of death in Placer County for youth ages 12 to 18, and the leading cause of death for all ages in both Placer County and Nevada County.

Quality Improvement Stakeholders

Consortium Partners are part of the Behavioral Health Advisory Group (BHAG) and include nonprofit service providers (Tahoe Forest Health System, Gateway Mountain Center, Sierra Mental Wellness, Tahoe Safe Alliance, Family Resource Centers), community coalitions (Tahoe Truckee Suicide Prevention Coalition, Community Collaborative of Tahoe Truckee), Nevada County Behavioral Health Department, Tahoe Truckee Unified School District and Truckee Superior Court. In addition, the project convened internal multidisciplinary work groups in the TFHS primary care, pediatrics, and OB/GYN clinics.

Evidence-Based Quality Improvement Model(s) or Promising Practices

The Chronic Care and IMPACT (Improving Mood - Promoting Access to Collaborative Treatment) models are evidence-based models proven effective in guiding program development and implementation to accomplish the proposed integration successfully. The IMPACT model was informed by the work on the Chronic Care model and has five essential elements:

1. Collaborative Care in Primary Care
2. Behavioral Health Professional as part of care team
3. Access to Psychiatrist
4. Use of a validated measurement tool (e.g., PHQ)
5. Treatment adjustments based on patient need

Services & Activities

This project initiated a multi-departmental committee to develop and implement a new, single workflow process. TFHS engaged and collaborated with community partners to support outreach efforts and streamline referrals between school, county, and community providers to improve access to care. A pilot study was conducted to evaluate changing from annual screenings to screenings at every adult Primary Care visit. TFHS then implemented a consistent PHQ screening workflow embedded into Primary Care, Pediatrics and Gynecology Clinics and increased the number of depression screenings in Primary Care (adults and pediatrics). The process for re-screening those with elevated depression scores was improved. Access to counseling and therapy services for patients with dual diagnosis of mental health and substance use was improved.

TFHS hired a total of four Behavioral Health Intensivists (BHI), including one that is bilingual and bi-cultural, and incorporated the support of a Community Health Advocate/Promotora to address health disparities and access to care. The project also implemented a BHI "Officer of the Day" to provide immediate consultation for patients experiencing suicidal ideation and other imminent mental health risks.

PROJECT RESULTS

Outcomes

1. The behavioral health intensivist (BHI) positions were established and have grown to 4 BHIs now servicing eight primary care clinics.
2. The number/proportion of unique patients who are screened annually for depression in primary care increased from 11.8% (1,211/ 10,292) at baseline to 48.6% (8,851/18,220) in year three.
3. The number/proportion of patients who have documented follow-up after a depression screening score of > 9 increased from 63.2% (108/171) at baseline to (1011/1269) 79.7% in year three.

4. The proportion of patients re-screened in primary care clinic 4 to 8 months after an elevated PHQ (>9) increased from 13.6% (23/169) at baseline to 40.3% (429/1064) in year 3 and depression remission (PHQ<5) rose from 21.7% (5/23) to 41.7% (179/429) in year three.
5. The number/proportion of patients with co-occurring disorders of opioid use and depression receiving behavioral health services (MAT) has increased from 32% (26/81) at baseline to (128/197) 65% in year three.

Sustained Impacts

As a result of the grant, TFHS has implemented primary care transformation that has created integrated roles with both behavioral health and primary care. There is now an enhanced focus on mental health as part of comprehensive care to help reduce stigma and support early identification through universal screening. The project has improved workflows related to depression screening, mental health, and identification of those at risk of suicide. Suicide-specific screening policies have been developed throughout the health system. TFHS now has improved data collection and disaggregation specifically related to depression to observe trends for subpopulations (sex, ethnicity, age, and income). There has been a culture shift toward sharing individual-level data directly with providers with comparison to the aggregated data. There is now a centralized scheduling model for behavioral health and a documentation model to align with billing codes. There is now an increased workforce capacity in the local service area specific to mental/behavioral health with bi-cultural/bi-lingual staff to ensure culturally competent approaches to patient care to promote health equity and address social determinants of health. And, for all of this effort, TFHS has accountability of the health system in responding to an identified community health need.

Learning Opportunities

- Multidisciplinary QI teams increase support for the initial pilot and the final accepted workflows.
- Access to referral resources is a necessity for implementing a behavioral health screening tool.
- Individual provider data sharing improved engagement with QI program.
- Community partner support enhanced program development and community acceptance.
- Limitations in the EHR and the impact of the COVID pandemic influenced the change in the final screening workflow. For example, screening every patient every visit is more applicable for all staff levels vs. identifying an annual screen. In addition, the increased rates of depression and anxiety as a result of the pandemic increased provider support for screening every patient every visit.
- The initiation of the BHI position resulted in a steady and continued increase in referrals to behavioral health. As a result, TFHS hired two additional full time BHIs over the course of the grant period. Currently the wait time for an initial appointment in behavioral health has increased to eight weeks. At this point, TFHS is exploring group therapy options to meet this increased demand.

Teche Action Board

Closing the Loop on Electronic Referrals: A Quality Improvement Initiative Using the Care Coordination Model
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PROJECT OVERVIEW

Goals & Objectives

The overall goal of this quality improvement project was to improve the quality of life in the rural communities by implementing an organizational strategy to effectively manage patient outcomes with electronic referrals systematically (EMPOWERS).

Objectives included:
1. Build upon the sound referral infrastructure developed in the pilot project and spread the evidenced-based interventions adopted from the Care Coordination Model (CCM)
2. Implement evidence-based strategies that ensure organizational accountability and increase patient support to achieve high quality referrals
3. Proactively manage referrals using designated referral clerks
4. Mitigate barriers and inefficiencies related to patient referrals and decrease gaps in care
5. improve the 90-day referral completion rate and increase patient, provider, and clinical support satisfaction
6. Improve preventive and disease specific screening rates and clinical outcomes
7. acquire and implement an electronic population health management platform to customize reports and extract data to meet reporting requirements.

Focus Areas

Chronic Disease Management, Prevention, Population Health, Care Coordination - Referral Management

Counties Served

St. Mary, Assumption, Lafourche, St. John the Baptist and St James in Louisiana

Target Populations

Target Population included 14,625 patients ages 18 years and older served by one of 8 rural primary care clinics. Patient demographic breakdown includes 32.92% Black, 58.77% White, 2.66% Native American, and 5.65% all other races. One hundred per cent lived below 200% of the federal poverty level and 40.4% lived below 100% of the FPL. Uninsured rates were 12% - 42%, Medicaid 35% - 60%, Medicare 3% - 30%, and Private Insurance 8%-24%. Top five diagnoses among patients were diabetes, hypertension, obesity, tobacco use, depression, and anxiety.

Needs Addressed

The project focused on eliminating barriers and on increasing organizational responsibility for referrals to increase capacity, improve access to specialty care and services, improve preventive screening rates and chronic disease management measures, and increase patient satisfaction with the referral process.

Quality Improvement Stakeholders

Internal and external stakeholders include, but not limited to patients, caregivers, providers, clinical support staff, referrals clerks, Teche Action Clinic Board of Directors, Chief Executive Officer, Chief Health Officer, Chief Health Information Officer, Director of Quality & Risk Management, Chief Financial Officer, and Chief Operations Officer.

Evidence-Based Quality Improvement Model(s) or Promising Practices

The MacColl Institute for Healthcare Innovation's Care Coordination Model (CCM) was developed to explain the process necessary for "high quality referrals and transitions" in the context of a patient-centered medical home (PCMH). The CCM is supported by the Agency for Healthcare Research & Quality (ARHQ) and part of the Safety Net Medical Home Initiative (SNMI). Based on evidence, the model identifies four areas that contribute to high-quality referrals, including Accountability, Patient Support, Relationships & Agreements, and Connectivity. Using the CCM as its framework, this project implemented evidence-based interventions aimed at improving patient support and organizational accountability for electronic referrals to redesign the referral process with the main clinic site's adult medicine department.

Services & Activities

This project strengthened the centralized referral infrastructure and spread evidenced based interventions adopted from the CCM to all facilities. Teche Action Board hired and trained projected referral staff for years 1-3, and provided ongoing trainings to clinical and support staff. In June 2020, Teche Action Board transitioned to a new electronic health record (EHR) and population health management platform and received superuser training on the system. Workflow and referral life cycle functions were revised, as well as policies and procedures, resource guides, auditing, the training manual, and reporting structure. The changes reflected the newly required steps that clearly identified the roles and responsibilities for everyone at each stage of the referral process. Teche Action Board revised the Referral Coordinator and Referral Clerk Job Descriptions and developed departmental Tiers for Staffing. The organization also implemented a routine auditing process to better assure staff adherence to the referral process and to inform training priorities. There were virtual trainings on the referral process and increased methods of communication such as emails, telephone conversations and team huddles. The project was successful in increasing the number of referrals completed each month throughout the project period.

PROJECT RESULTS

Outcomes

1. Organization-wide implementation of an evidenced-based referral process.
2. Built and transitioned to a new EHR in four months from the date of signing the contract.
3. Revised the referral processes including workflows, policies, procedures, training manuals, resource guides, tracking, auditing, and reporting resources to align with the new EHR.
4. Conducted live and virtual training for providers, referral, and clinical staff support.
5. Increased referral staff access to external specialists and health care facilities EHRs. There is on-demand access to external health records through the eClinical Works Electronic Health Exchange portal.
6. Increased referral completion rates and decreased gaps in care and consistently maintained or increased the referral completion rate.
7. Improvement in preventive and disease specific screening rates, chronic disease management measures, and annual wellness visits.
8. Improved ability to meet internal and mandatory reporting requirements.
9. Decreased the number of outstanding referrals in the legacy system by 50%.

10. Sustained an evidenced based quality improvement project for referral tracking and implemented several interventions and activities to improve the internal tracking of referrals.
11. Maintain departmental communication through emails, face-to-face communication, telephone, and team huddles.
12. Successfully conduct manual audits to validate the data received from the EHR report for the uniformed data system (UDS) report.
13. Increased patient satisfaction with referral process (patient surveys consistently 92% and above).
14. Increased provider and clinical support staff satisfaction (ongoing commendations regarding referral staff).

Sustained Impacts

We have strengthened our infrastructure and improved efficiency. As a result of the positive outcomes achieved, the referral department and positions were added to our organizational structure and provided services. This project help create an organization-wide culture change and have implemented and revised referral policies, procedures, protocols, and trainings. There has been a decrease in the workload of front-line clinical staff and increased patient access to referral staff. The project helped improve patient, provider, and clinical support staff satisfaction. The organization has sustained statistically significant 90-day referral closure rates while spreading the process organization-wide. There is now increased capacity to services, improved ability to report clinical outcomes, and decreased gaps of care. The new referral process has received local, state, and national recognition. Teche Action Board has presented on several platforms including ECRI, the Louisiana Primary Care Association, the Louisiana Colorectal Cancer Consortium, and the National Association of Community Health Centers.

Learning Opportunities

- Pilot Test: start small to iron out steps before spreading. This allowed the project to get provider and clinical support staff buy-in on a small scale which helped when it was time to spread. When a provider that was skeptical of the process or not supporting of the idea of a centralized department, the team was able to refer them to the provider champions involved in the pilot test.
- Transparency: we made our intent transparent across the organization from the start. The project team conducted an organizational needs assessment of the process and chose evidence-based interventions that would best address the gaps and problems identified. Board of directors down to front line staff were aware of the goals.
- Standardized Process: the project team learned continuous monitoring of staff adherence to the protocols as written is required and have developed an audit tool that is used to evaluate staff adherence. This allows the team to identify education and training needs.
- Redundancy: Paper-Based Referral Process required as back-up to electronic processes.
- Communications: Frequent ongoing communication, especially in team huddles and departmental meetings
- Continuous education and training: For all staff. Nothing trumps a well-trained staff.

Tri-County Health Network
Chronic Disease Outreach Program
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PROJECT OVERVIEW

Goals & Objectives
1. **Goal 1:** Improve health outcomes for those diagnosed with diabetes (DM) or cardiovascular disease (CVD) and contain costs by expanding access to evidence-based, coordinated health services in a rural, underserved three-county region. The objectives for this goal include:
   - Work with three 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 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, body mass index (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 after one year.
2. **Goal 2:** Develop a culture of continuous quality improvement (QI) among Tri-County Health Network (TCHNetwork) members. Objectives include:
   - Convene a Clinical Subcommittee comprised of seven members that meets 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 and promote proactive patient health management for chronic disease patients at the 3 partner clinics.

Focus Areas
Cardiovascular Disease (CVD) Care Management, Chronic Disease Management, Diabetes Care Management, Health Education/Promotion and Disease Prevention, Primary Care Services, Population Health, Social Determinants of Health

Counties Served
San Miguel, Ouray, and Montrose, Colorado

Target Populations
TCHNetwork's target population were those with cardiovascular disease and/or diabetes mellitus seeking care in the primary care setting at Basin Clinic, Uncompahgre Medical Center (UMC), Telluride Regional Medical

Center (TMC), or Telluride Whole Health. The target population lived and/or worked in Ouray County, San Miguel County, or the West End of Montrose County in rural, Southwestern Colorado.

Needs Addressed

Residents in this rural region face numerous barriers to health and factors that can lead to increased rates of chronic disease, including poverty, food insecurity, transportation barriers, tobacco use, a lack of providers, and a distrust of people from outside our community. The primary need the program focused on was food insecurity. Twelve to thirteen percent of families in each of our counties report food insecurity. Ten percent of residents in Montrose County have limited access to healthy foods, meaning they are low-income and do not live close to a grocery store. This is twice the state rate of 5%. Seventy-three percent of San Miguel, 65% of Ouray, and 41% of Montrose residents are eligible but not enrolled in SNAP.

Quality Improvement Stakeholders

The QI stakeholders involved in the project included representatives from TCHNetwork (network of healthcare providers and stakeholders): Basin Clinic (rural health clinic), TMC (non-profit medical facility), UMC (FQHC), and Telluride Whole Health (direct primary care provider). The project convened different teams comprised of staff representing different levels at TCHNetwork and partner clinics to ensure that QI was implemented and prioritized at all levels of the clinics. Project QI teams included:
- PHNs integrated at clinics
- Clinical Subcommittee, comprised of clinic medical directors
- Board of Directors, comprised of executive-level leadership from the clinics

Evidence-Based Quality Improvement Model(s) or Promising Practices

TCHNetwork and its partners utilized the evidence-based Chronic Care Management (CCM) model of quality improvement. By using CCM, the project worked to build a health system that supports chronic disease management. The primary activities of CCM include self-management support for patients, which was provided by the PHNs; decision support implemented by the Clinical Subcommittee; delivery system design using the Chronic Disease Registry and team huddles at the clinic; organization of healthcare system in the form of TCHNetwork's Board of Directors; clinical information system through the registry; and community through TCHNetwork's work outreaching to and building relationships with community-based and governmental organizations to improve the health of residents in the region.

Services & Activities

The activities implemented included:
- Integrated PHNs onto the clinical team at UMC, TMC, and Basin Clinic.
- Utilized PHNs to screen patients for social determinant of health needs and refer patients with a need to appropriate resources.
- Expanded a successful FoodRX pilot program at UMC, TMC, Basin Clinic, and Telluride Whole Health. Through FoodRX, participants with a chronic disease who wanted to make changes to their diet received $15 vouchers to purchase fruits and vegetables each week over the course of six weeks. Patients established a plan for healthy eating and received support, recipes, and discussed challenges/successes over the six weeks with the PHN. Participants that graduated received a bonus $30 voucher.
- Having PHNs work individually with patients to establish care plan goals to support the adoption of healthy lifestyle changes.
- Convened a Clinical Subcommittee comprised of the medical directors from partner clinics that met quarterly, discussed program outcomes, and identified best practices and evidence-based guidelines to implement across the region.
- Used a Chronic Disease Registry to support QI efforts and track patient risk factors and regional population health.

PROJECT RESULTS

Outcomes

Project outcomes include:

1. PHNs screened approximately 1,825 patients for social determinant of health needs and referred 100% of those with a need to relevant services using Community Resource Guides developed by TCHNetwork. Housing was the most common need reported by our patients, with 17% of patients reporting housing insecurity, followed by food, with 16% of patients screened reporting food insecurity.
2. 190 participants started FoodRX Program. 7 individuals are actively enrolled. Of the remaining 183, 92% completed the 7-week program.
3. 100% of patients who graduated from the FoodRX Program reported that they were eating more fruits and vegetables and 88% gained knowledge in purchasing fresh produce due to participation in the program.
4. 84% of patients with a chronic condition who engaged with a PHN reported increased skills to manage their chronic condition.
5. When asked to rate their overall health on a scale of 1-5 (with 1 being very unhealthy, and 5 being very healthy) prior to engaging with a PHN, the average rating by participants was 2.9. After working with a PHN, the average rating of participants across the 3 clinics increased to 3.6.
6. Among those who graduated FoodRX, we have seen promising immediate post-program outcomes including a 0.9% decrease in systolic and 3.8% decrease in diastolic blood pressure for those with blood pressure outside of normal parameters at program entry.
7. Of patients who engaged with a PHN, had a BMI outside of normal parameters during their first appointment with a PHN, and had a follow-up appointment 1 year after their initial engagements, 53% decreased their BMI. The average decrease is 8.86%.
8. Of those who engaged with a PHN and reported tobacco use at intake, 25% reported no longer using tobacco at a follow-up appointment.
9. Tracked 5 biometric health indicators (LDL, A1c, BMI, tobacco use, blood pressure) for 1,952 patients across 3 clinical sites for the 3-year period using the Chronic Disease Registry.

Sustained Impacts

Sustained impacts include longer-term improvements in the health status of community members as PHNs empower residents to understand their health; chronic disease; and how different behaviors, social determinants of health, and eating habits impact their overall health and wellbeing. Patients became familiar with and connected to local tools and resources to support healthy lifestyles—including FoodRX, Cooking Matters, and peer support from PHNs—which can further contribute to sustained, positive healthy changes. For clinical partners, sustained impacts include increased clinical understanding and buy-in for quality improvement, continued use of the registry to proactively manage patient health, integration of chronic disease management and quality improvement into clinical partners' culture, and improved clinical understanding of and relationships with community-based organizations and resources that address social determinants of health.

Learning Opportunities

Lessons learned include:

- When clinics are small and have limited staff, it is helpful to convene multiple clinics and have an external network that can support QI. On their own, each clinic may not have the time and resources to develop the infrastructure for and support the clinical team in performing QI.

- Implementing methods to evaluate changes in program services do not have to be complicated. Indeed, we found that the simpler methods to evaluate and assess the efficacy of changes is better.

Key factors for replication include:
- Involve staff from all levels of the clinic in QI efforts. Each member of the clinical team provides different insights on project activities, patient-level data, and population health.
- If implementing FoodRX, partner with multiple retailers to allow for more participant choice. Offer store tours to groups of participants to help them get more comfortable at the stores.
- Provide healthy recipes tailored to each participant's needs, including recipes that incorporate seasonal produce grown locally to allow participants to stretch their dollars, designed for the person's family size, and that are healthy given the participant's chronic disease.

United Methodist Health Ministry Fund

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PROJECT OVERVIEW

Goals & Objectives
The Kansas Frontier Community Health Information Network (KFCHIN) will work collaboratively to assess, measure and improve the patient experience for rural patients with diabetes. This work, combined with improved care coordination and other chronic disease management techniques, will improve clinical outcomes for this patient population. The network will share best practices and develop strategies to obtain value-based reimbursement designations such as Patient-Centered Medical Home (PCMH) designation.

Focus Areas
Chronic Disease Management, Diabetes Care Management, Health Education/Promotion and Disease Prevention

Counties Served
Clark, Ford, Greeley, Kearny, Meade, Phillips, Sheridan, Thomas, and Wallace in Kansas

Target Populations
The target population was rural and frontier residents who have type two diabetes. Network members are in health provider shortage areas and medically underserved areas in western Kansas.

Needs Addressed
The Patient Experience in Rural Kansas (PERK) project created new opportunities for patient engagement through the creation of patient experience groups and other promising practices to address diabetes. The project team shared these educational experiences among the rural and frontier members of the network and helped eliminate many of the barriers often associated with quality improvement strategies in very small organizations.

Quality Improvement Stakeholders
Critical stakeholders of the network included a critical access hospital, rural health clinics, federally qualified health centers, and frontier hospital.

Evidence-Based Quality Improvement Model(s) or Promising Practices
The primary quality improvement (QI) model used is the Plan Do Study Act (PDSA) model. The project also utilized the promising practice of semi-structured patient engagement groups in each of the communities.

Services & Activities
The project changed some of its objectives through the COVID-19 crisis. Activities included patient engagement groups, a robust shared learning platform, and collaboration with state agencies in Kansas. The project also engaged in some virtual support groups and staff training opportunities. Most of the sites were quite actively using continuous glucose monitors (CGM) in a professional capacity. The project team has shared policies, patient education materials, and other patient supports during this time.

PROJECT RESULTS

Outcomes
1. Conducted in-person or virtual training events for clinicians and staff in six locations.
2. Conducted patient engagement groups in six rural Kansas communities.
3. Conducted two virtual patient engagement groups.
4. Facilitated two virtual support groups.
5. Created an online support and resource sharing platform utilized by at least six organizations.
6. Participated in HRSA led training events.
7. Facilitated community exercise programs twice with six communities participating.
8. Provided a weekly email support listserv to at least 50 patients.

Sustained Impacts
The patient engagement group strategy is one that will continue to benefit chronic disease and health improvement efforts moving forward. The team also gained tremendously from the opportunity to share best practices in the network and often found network members resourcing with each other in uncertain staffing times. Probably the most impactful opportunity has been in working with continuous glucose monitors and the ability to learn from each other and provide improved care to patients using technology. Some of the more powerful, collaborative work recently has been in networking with other state agencies looking to improve statewide resources for diabetes. It is likely that the network's resource hub will be a platform continued through this work.

Learning Opportunities
This grant afforded invaluable opportunities to make the best of difficult situations during the COVID-19 crisis. The network was able to support providers and other staff members, provide resources and support patient education through project staff. Network members learned a great deal from each other and through the network. Highlights include shared data resourcing and IT training, continuous glucose monitoring (CGM) training, and training towards chronic care management. The ability to include information technology and data collection staff with this grant was a game changer and highly recommended with any network-based project. Having staff dedicated and knowledgeable about that work was a tremendous benefit.

Upland Hills Health

Transitional Care Management
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PROJECT OVERVIEW

Goals & Objectives

In recent years, Upland Hills Health (UHH) restructured to a hospitalist model, expanded its service area to include seven primary clinics, and converted all patient care areas to a shared electronic medical record (EMR), Epic. Despite significant growth and improvements over a short amount of time, continuity of care remained challenging - especially for patients hospitalized with congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and diabetes. There was an innate need for a more collaborative approach to coordinating care and an even greater need to increase communication with primary providers after a hospital stay. To improve the patient experience and quality outcomes, reduce readmission rates, and optimize reimbursement for services being provided, UHH saw the development and implementation of a Transitional Care Management (TCM) program as a prime opportunity to bridge the gap between the inpatient and outpatient worlds.

Focus Areas

Cardiovascular Disease (CVD) Care Management, Case Management, Chronic Disease Management, Chronic Obstructive Pulmonary Disease (COPD), Treatment and Management, Diabetes Care Management, Health Education/Promotion and Disease Prevention, Primary Care Services, Transitions of Care

Counties Served

Wisconsin counties served by the grant-funded project include Iowa, Grant, Lafayette, Dane, and Sauk. The hospital and three clinics are in Iowa county; there are also clinic locations in Grant, Lafayette, Dane, and Sauk counties. All clinics, except the one in Dane county, are considered Rural Health Clinics.

Target Populations

The target population includes all patients with a UHH primary care provider who are hospitalized. The project initially focused on Medicare patients with chronic conditions including CHF, COPD, and diabetes; however, UHH now offers post hospitalization care coordination services regardless of diagnosis, age, or payer. This includes patients who receive care at the hospital, as well as those hospitalized elsewhere, and provide services for at least 30 days.

Needs Addressed

Primary needs addressed with the target population include understanding of diagnosis, medications, and management of symptoms. TCM nurses provide reinforcement of education provided in the hospital, and ensure patients have the tools and resources to engage in meeting their health goals. UHH addresses unscheduled appointments and offer assistance with arranging transportation to appointments. UHH communicates timely updates on the patient's condition and any ongoing needs to the primary care provider.

Quality Improvement Stakeholders

- Internally, project stakeholders included a variety of patient care areas. The primary care clinic staff, inpatient care staff, and ED staff all played critical roles in the implementation of TCM. Staff involved with coding and billing were also key players. Additionally, Cardiac and Pulmonary Rehabilitation staff and a diabetic educator were involved. It was important to involve team members with a role in Quality Improvement and Data Analytics from early on.
- Externally, stakeholders in the project included local transportation agencies as well as Aging & Disability Resource Centers for the counties served by the project.

Evidence-Based Quality Improvement Model(s) or Promising Practices

UHH actively supports the use of several QI models, methods, and tools including the Plan, Do, Study, Act (PDSA) model, Lean principles, Root Cause Analysis, Process Mapping, and Failure Mode & Effects Analysis. When developing plans for implementation, the team sought to identify the parts of a process that were most in need of change, standardize work, and eliminate waste or gaps. Overall, the team found that equipping itself with a wide variety of tools and methods led to greater ability to problem solve.

Services & Activities

- Primarily, this grant funding allowed UHH to hire two experienced RNs to serve as care coordinators. With a combined 26 years of experience, these nurses possess the knowledge and skills to navigate the health record and perform a telephonic assessment to ensure patient safety, understanding, and resources to manage health conditions successfully. These nurses provide reassurance, advocacy, and support for patients and caregivers during a stressful and vulnerable time. Their attention to detail has resulted in the prevention of medication errors, an increase in sooner appointments with a primary provider, and have connected countless numbers of patients and caregivers with community resources and programs.
- Prior to this grant project, there were gaps in care following hospitalization and little interface between the hospital and clinic staff. TCM has helped to provide common ground, shared goals, and mutual understanding.

PROJECT RESULTS

Outcomes

1. Partnerships with other hospitals to improve Health Information Exchange processes led to automatic, electronic notification when a UHH patient was hospitalized elsewhere. This has nearly doubled the number of patients served by TCM.
2. By utilizing blocks in the clinic providers' schedule, 30-minute appointments are much more readily available to ensure a TCM appointment within 7-14 days of hospital discharge. Since 2020, the average length of time between hospital discharge and a TCM appointment at a UHH clinic has been 6.5 days.
3. With use of reports generated within the EHR, TCM nurses have been able to consistently provide telephonic follow up to >97% of discharged patients within two business days.
4. Despite readmission rates still being higher than desired for patients with CHF, COPD, and diabetes, a multi-disciplinary Readmissions Team meets biweekly to review all 30-day readmissions to identify root causes and opportunities for improvement. Four recurring root causes have been identified - patient/family readiness to transition to hospice, patient/family readiness to transition to skilled nursing facility, ineffective management of chronic health conditions, and AODA/mental health/availability of supportive resources.
5. Standardized documentation and consistent workflows across UHH clinics have helped to optimize TCM reimbursement. In 2020, UHH's clinics saw > $50,000 in direct revenue and an additional >

$45,000 in indirect revenue. In 2021, those numbers respectively increased to > $85,000 and > $63,000.

Sustained Impacts
Sustained impacts of this project include process improvements and positive changes in the way internal departments work together to serve mutual patients. Care gaps have been identified and staff have been more apt to collaborate to reach shared goals. The improved workflows and commitment to quality improvement will sustain, and data collected for the purposes of the grant project has already been applied to make improvements to smaller projects. Transitional Care Management, as a new service, will continue to provide care coordination at its current capacity. Patients, caregivers, and providers alike have come to see TCM nurses as their primary contact for help in navigating the health care system.

Learning Opportunities
Collaboration and communication are vital components to the success of any quality improvement project. The project team learned that you really can't communicate too much or too often - it's a two-way street, and communication must continuously flow in both directions. With multiple departments and individuals involved, it's important to be transparent on the "why" behind the work being done and the changes being made. Without that understanding, it's difficult to get the needed support and buy-in from others. Additionally, it's important to recognize that continuous improvement is a cyclical process with no beginning and no end; it is an ongoing effort that benefits all involved. It's a journey of ups and downs, changes made, and lessons learned. Even when unforeseen challenges are met (including a pandemic!), there are opportunities to adapt and overcome. Imperfect results aren't an indicator of failure; they're an indicator that the work isn't finished. Only with unwavering commitment and relentless teamwork can progress be made.

Upper Peninsula Health Care Solutions

UPlift Collaborative Care Program

G20RH33277 | Non-profit Organization | https://www.uphcs.org/

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PROJECT OVERVIEW

Goals & Objectives

- The goal of the UPHCS UPlift Collaborative Care Program was to improve patient health outcomes and patient engagement among members of the target population by implementing the Collaborative Care Model of Behavioral Health Integration into primary care clinics over the course of the three-year performance period.
- Outcome objectives included increasing the number of patients enrolled in integrated behavioral health services at participating clinics, increasing patient engagement, improving patient and provider experience metrics, increasing screenings for substance abuse, suicidality, treatment planning, and remission rates for patients with depression, and improvements to health outcomes like diabetes control, hypertension control, and body mass index (BMI).
- Process objectives include working directly with clinics to establish Behavioral Health Care Teams, establish patient panels, provide training, improve workflows, conduct self-assessments, and conduct process improvement work.

Focus Areas

Behavioral/Mental Health, Primary Care Services

Counties Served

The UPlift Program serves the fully rural counties of Alger, Luce, Mackinaw, and Schoolcraft in Michigan

Target Populations

The target population includes Medicaid eligible, Medicare eligible (or duel eligible) residents of Alger, Luce, Mackinac, or Schoolcraft Counties with comorbid diagnoses of chronic disease (diabetes, hypertension, etc.) and mental health disorders.

Needs Addressed

The primary need in the Upper Peninsula is improved access to specialists in the mental and behavioral health area. Rural residents in the region often have to travel out of the area for psychiatric services but don't always have the means to do so. Lengthy wait times for appointments delay treatment when patients need it most. The UPHCS UPlift Project helps to meet that need for additional mental and behavioral health services by better equipping primary care providers to provide those services for mild to moderate diagnoses in a way that is appropriate, evidence-based, and sustainable.

Quality Improvement Stakeholders

- Upper Peninsula Health Plan - Managed Care and Provider Services Organization
- Upper Peninsula Health Care Solutions, Inc. - Nonprofit Healthcare Collaborative
- Helen Newberry Joy Hospital - Gibson Family Health Clinic - Non-profit Health System
- Schoolcraft Memorial Hospital - Rural Health Clinic - Non-profit Health System

- Ortele Health Corporation – Tele-psychiatry Services Organization
- University of Washington - Department of Psychiatry and Behavioral Sciences - Advancing Integrated Mental Health Solutions (AIMS) Center - Public University
- Munising Memorial Hospital - Bay Care Medical Center - Nonprofit Health System

Evidence-Based Quality Improvement Model(s) or Promising Practices
- The UPHCS UPlift Project uses Lean for healthcare methodologies and Model for Improvement Plan-Do-Study-Act (PDSA) cycles to produce effective, efficient policies, procedures, and clinical workflows related to behavioral health integration for participating clinics.
- Lean uses a tightly structured approach to analyze workflow and is known to produce sustained, effective change in health care organizations. Lean is conducted by care teams that produce a systems diagram that identifies problems, analyzes root causes, and produces agreement on redesigned systems and processes. The team develops and completes an action plan, with defined deliverables.
- Model for Improvement is proven to accelerate improvement efforts. The model has two parts:
  - Three fundamental questions: What are we trying to accomplish? How do we know that change is an improvement? What changes can we make that will result in improvement?
  - The Plan-Do-Study-Act (PDSA) cycle to test change in real work settings.

Services & Activities
- The UPHCS UPlift team works directly with clinics to establish BH Care Teams consisting of physicians, BH Care Managers, and psychiatric consultants, establish patient panels of 25 patients in each clinic, provide training for BH Care Managers and physicians on the Collaborative Care Model, improve workflows using Lean methodology, conduct self-assessments including patient and physician experience surveys, and conduct process improvement work using PDSA cycles.
- In addition, UPHCS provided ECHO case-based learning sessions with a psychiatrist mentor for primary care physicians in the target region to discuss behavioral health topics and review cases with common behavioral health diagnoses in an all-teach-all-learn environment.

PROJECT RESULTS

Outcomes
1. Improved access to mental health services in Luce, Alger, Mackinaw, and Schoolcraft counties
2. Improved Depression screens (PHQ-9), including follow-up plans and documentation
3. Reduced Emergency Department utilization rates
4. Reduced A1c levels for patient diagnosed with diabetes
5. Improved BMI screening, along with documentation of follow-up plans
6. Reduced blood pressure levels for patients diagnosed with hypertension

Sustained Impacts
- Participating clinics defined processes for patient identification and referrals to behavioral health care coordination, integrated behavioral health records into their EHR systems and established billing procedures for Collaborative Care services that function as models for implementation in other clinics.
- The ECHO case-based learning sessions were so successful that UPHCS was able to obtain additional grant funding from the Michigan Health Endowment Fund to replicate the sessions covering additional topics including: pediatric mental health, medication assisted treatment for substance (SUD) and opioid use disorders (OUD), and trauma.

- This project has also improved community connections to expand behavioral health services across the UPHCS service region and provided a touchstone at the recent Upper Peninsula Behavioral Health Summit to promote the implementation of the Collaborative Care Model.
- Both participating clinics were able to leverage their participation to expand their behavioral health teams since the beginning of the grant project, as well as billable behavioral health care coordination and collaborative care for patients diagnosed with SUD/OUD, and soon for pediatric patients.

Learning Opportunities

A major lesson learned is how an approach can be adapted differently within different clinical settings even within the same region. One of the partner clinics utilized a consulting psychiatrist via telehealth technology for collaborative care, while the other partner clinic chose to only expand to behavioral health care coordination, as they have a psychiatric nurse practitioner in house. The diversity seen in this pilot project has offered insight into how resources and organizational support can affect the services offered in the primary care setting.

Westchester-Ellenville Hospital

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PROJECT OVERVIEW

Goals & Objectives

The overarching goals for this project were to combine clinical prevention screenings, nutrition counseling, and physical therapy to create lasting lifestyle changes that will improve and sustain good cardiovascular health. This program reduces the overall cardiovascular risk of a cohort of participants, who are tracked over the entire program, and improves heart health knowledge and preventive behaviors among 200-300 additional individuals in the area. The program uses enhanced provider training, expanded screening and patient engagement activities, and robust data tracking capabilities to increase use of effective clinical preventive services by people at risk for poor cardiovascular health outcomes. The project partners work together to identify and mitigate the impacts of adverse social and economic drivers of health, such as lack of affordable nutritious food and opportunities for exercise.

Focus Areas

Cardiovascular Disease (CVD) Care Management, Chronic Disease Management, Prevention, Treatment and Management, Health Education/Promotion and Disease Prevention, Health Screenings, Population Health

Counties Served

Ulster, Orange and Sullivan Counties in New York

Target Populations

The main target population for this grant was individuals in the Town of Wawarsing who are at increased risk of developing chronic or cardiovascular diseases (CVD).

Needs Addressed

Individuals in the town of Wawarsing experience cardiovascular disease at an increased rate when compared to neighboring towns and are also subjected to more negative barriers to health. This project focused on identifying those at higher risk of CVD and guiding them through healthy lifestyle changes to reverse that risk and make lasting health behavior changes.

Quality Improvement Stakeholders

The Ellenville Regional Rural Health Network is a consortium of partners consisting of Ellenville Regional Hospital (ERH), Ulster County Department of Health, and the Institute for Family Health. All of these partners were involved in the implementation of this project, as well as ERH internal departments including the Radiology and Rehab Departments.

Evidence-Based Quality Improvement Model(s) or Promising Practices

- There were two evidence-based models used to achieve the project goals including the Chronic Care Model (CCM) and the Community Health Worker-Health Educator Model (CHW). In her 2006 article, Kathryn Fiandt, FAANP, states that the CCM "is based on the assumption that improvement in care requires an approach that incorporates patient, provider, and system level intervention". According to

a systematic literature review, the six elements of CCM include health system or health organization, clinical information system (CIS), decision support, delivery system design, self-management support, and community linkages.

- The Rural Health Information Hub describes the CHW model as utilizing a CHW to provide screening and health education to the target population to assist with disease prevention and integration of healthy behaviors.

Services & Activities

The primary activities of this project included providing free calcium score CT scans (cardiac computed tomography (CT) for calcium scoring uses special x-ray equipment to produce pictures of the arteries) and carotid artery ultrasounds to individuals who present with elevated BMI, tobacco use, hypertension, diabetes or pre-diabetes, or are indicated to have an increased risk of heart attack or stroke as determined by the Centers for Disease Control and Prevention's (CDC's) Heart Age Calculator. The project used these two preventive screenings to identify individuals who were at greater risk of cardiovascular disease or incident, and then worked to reduce the patient's risk through clinically based lifestyle change programs. These programs included one on one nutrition counseling with a certified nutrition coach, a four-month physical therapy program called cardiac wellness PT, and individualized health coaching with a community health worker.

PROJECT RESULTS

Outcomes

1. 138 individuals enrolled to work one on one with a community health worker
2. 60 individuals enrolled in continuing (once a month or more) nutrition counseling, with many more receiving at least one consultation
3. Greater than 1,000 individuals accessed other Rural Health Network Programming such as physical activity classes, and nutrition or health education classes
4. To date, 1,255 individuals have received a free calcium scoring CT scan
5. 263 individuals received a free carotid artery ultrasound
6. 32 individuals enrolled in the four-month cardiac wellness PT program
7. Individuals who completed the cardiac wellness PT Program saw an average decrease in waist circumference of 1.17 inches, with the largest decrease being 3 inches
8. 208 individuals were screened for risk of heart attack or stroke using the CDC's heart age calculator at community events

Sustained Impacts

Since implementing this project, the number of individuals accessing the programs provided by the rural health network has more than tripled, allowing for a greater number of community members to feel empowered to take charge of their health behavior changes. Individuals enrolled in the program have self-reported a change in their belief that they can make incremental but lasting changes, and often report sharing details of the opportunities available to the community through the rural health network with their personal contacts. Community members often self-report to Rural Health Network staff a new understanding of the importance of secondary prevention methods to decrease the chances of developing new chronic diseases or worsening the status of existing ones.

Learning Opportunities

- At start, there were plans to implement a screening system for individuals receiving the calcium score CT scans and carotid artery ultrasounds and having a select population (those at risk of CVD) compensated for their scans while other patients may be charged. This screening process proved difficult to carry out and, in some instances, difficult to enforce. After dropping the screening process

and allowing all with a prescription from a primary physician to receive the scans free of cost it was found that this would benefit the hospital as those receiving preventive screenings would come back for further evaluations if their primary or cardiologist recommended.

- It was also found that in addition to the individualized health coaching available to the patients who were found to be at risk of CVD, it was vital to provide open classes and programs that could be accessed at no-charge to individuals who were wary of working with a CHW and preferred to carry themselves through the process of health-behavior change. Finding several venues at which these programs could be hosted also proved to be vital to our community that faces several transportation barriers to behavior change.