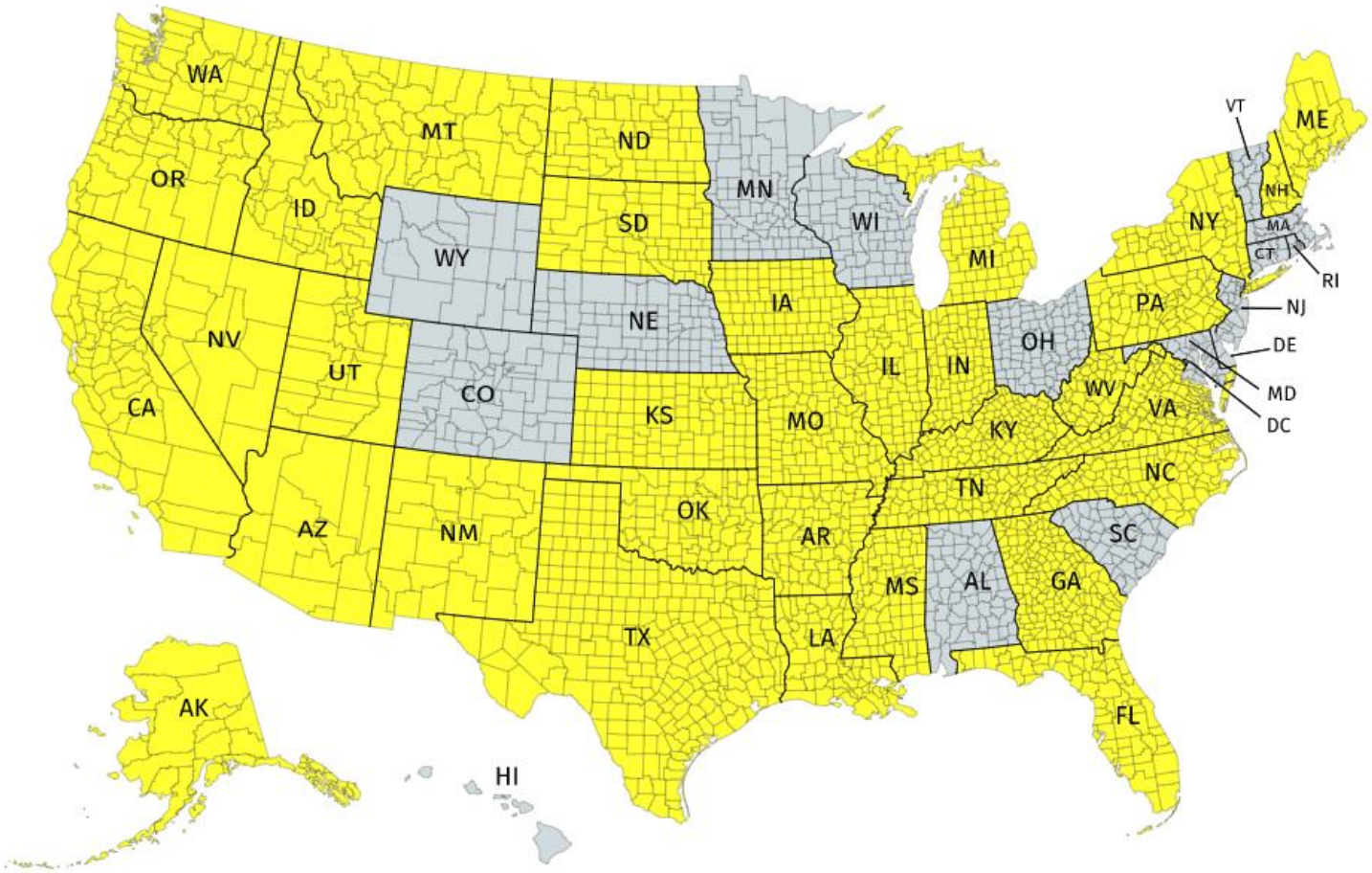
Rural Health Care Services Outreach Program

DIRECTORY 2021-2025



Highlighted states indicate locations of grant organizations

March 2022

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

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

Table of Contents

Introduction

The Rural Health Care Services Outreach Program is authorized by Section 330A of the Public Health Service Act (42 USC 254c(e)) and administered by the Health Resources and Services Administration's (HRSA's) Federal Office of Rural Health Policy (FORHP) Community-Based Division. The outreach program is a noncategorical community-based discretionary grant program aimed toward promoting rural health care services by enhancing health care delivery to rural underserved populations in the local community or region.

Through consortia comprising three or more local health care and social service provider partners, funded outreach projects collaborate with community partners to develop innovative approaches to challenges related to the specific health needs in rural areas that expand clinical and service capacity in rural communities.

The overarching goals for the outreach program are to:

- Expand the delivery of health care services to include new and enhanced services exclusively in rural communities;
- Deliver health care services through a strong consortium in which every consortium member organization is actively involved and engaged in the planning and delivery of services;
- Utilize evidence-based or promising practice models adapted to effectively address unique community rural health care; and
- Improve health and demonstrate health outcomes and sustainability.

As a result of the reauthorization under the 2020 CARES Act, the outreach program's 2021-2025 funding cycle now includes a longer funding cycle, increased from a three-year to a four-year performance period. While the program continues to exclusively serve rural populations, the program's eligibility requirements have also been expanded, allowing for rural and urban public, nonprofit, and for-profit health care organizations to serve as lead applicant organizations and partners, with a minimum of two-thirds or 66% of project partners required to be in a rural-designated area, as defined by HRSA's FORHP.

A new specialized funding track, the Healthy Rural Hometown Initiative (HRHI), has also been added to the program for the 2021-2025 funding cycle. The HRHI track is designed to target the underlying factors that drive rural health disparities related to the five leading causes of avoidable death (heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke). As in previous funding cycles, the outreach program will also continue to support awards under its regular outreach track for this funding cycle.

This *Directory* provides contact information and a brief overview of the 61 initiatives funded under the Rural Health Care Outreach Services grant program in the 2021-2025 funding cycle.

Authorized by Section 330A of the Public Health Service Act (42 USC 254c(e)), the Rural Health Care Services Outreach Program is a community-based grant program aimed toward promoting rural health care services by enhancing health care delivery to rural underserved populations in the local community or region.

Grantees by Track

Track	Grant Organization Name	State
HRHI	Adagio Health, Inc.	PA
HRHI	Arukah Institute of Healing, Inc.	IL
HRHI	Avera Health	SD
HRHI	Bi-State Primary Care Association, Inc.	NH
HRHI	Coastal Bend Wellness Foundation, Inc.	TX
HRHI	Columbia County Hospital District	WA
HRHI	Delta Health Alliance, Inc.	MS
HRHI	Great Mines Health Center	MO
HRHI	Health West, Inc.	ID
HRHI	Intermountain Health Care, Inc.	UT
HRHI	James Madison University	VA
HRHI	Louisiana Rural Health Association	LA
HRHI	Southcentral Foundation	AK
HRHI	Trustees of Indiana University	IN
HRHI	University of Arkansas System	AR
HRHI	Wirt County Health Services Association, Inc.	WV
Outreach	Access East, Inc.	NC
Outreach	AdvantagePoint Health Alliance – Great Lakes, LLC	TN
Outreach	AdvantagePoint Health Alliance Blue Ridge, LLC	TN
Outreach	Appling County	GA
Outreach	Bighorn Valley Health Center, Inc.	MT
Outreach	Canyonlands Community Health Care	AZ
Outreach	Catholic Health Initiatives – Iowa, Corp.	IA
Outreach	Cornerstone Care, Inc.	PA
Outreach	Creek Valley Health Clinic	AZ
Outreach	Dublin City Schools	GA
Outreach	Educational Service District 113	WA
Outreach	Family Health Centers	WA
Outreach	Family Health Council of Central Pennsylvania, Inc.	PA
Outreach	Goshen Medical Center, Inc.	NC
Outreach	Granville-Vance District Health Department	NC
Outreach	HealtHIE Georgia Corp.	GA
Outreach	Healthy Acadia	ME
Outreach	Healthy Communities Coalition of Lyon and Storey Counties	NV
Outreach	Heartland Rural Health Network, Inc.	FL
Outreach	Horizon Behavioral Health	VA
Outreach	Lake County Tribal Health Consortium, Inc.	CA
Outreach	MaineHealth	ME
Outreach	MaineHealth Care at Home	ME
Outreach	Mainline Health Systems, Inc.	AR

Track	Grant Organization Name	State
Outreach	Marysville Unified School District 364	KS
Outreach	Mercy Health Cincinnati, LLC	KY
Outreach	Michigan Center for Rural Health	MI
Outreach	Michigan Rural EMS Network	MI
Outreach	Miners' Colfax Medical Center	NM
Outreach	North Dakota State University	ND
Outreach	Northwest Iowa Mental Health Center	IA
Outreach	Oklahoma Foundation for Medical Quality, Inc.	OK
Outreach	Oneida Health Systems, Inc.	NY
Outreach	Oswego County Opportunities, Inc.	NY
Outreach	Otto Kaiser Memorial Hospital Foundation	TX
Outreach	Pennyroyal Healthcare Service, Inc.	KY
Outreach	Randolph County Caring Community, Inc.	MO
Outreach	Regents of the University of Idaho	ID
Outreach	Richland Medical Center, Inc.	MO
Outreach	Samaritan Pacific Health Services, Inc.	OR
Outreach	Santa Fe Recovery Center, Inc.	NM
Outreach	Tallahatchie General Hospital Medical Foundation	MS
Outreach	Tattnall County Board of Education, Inc.	GA
Outreach	Williamson Health & Wellness Center, Inc.	WV
Outreach	Worcester County	MD

Grantee Profiles

The following provides contact information and a brief overview of the 61 grant award recipients funded under the Rural Health Care Services Outreach Program grants for the 2021-2025 funding cycle. These include 16 awards made under the program's HRHI track and 45 regular outreach track awards to public, private and nonprofit entities across 35 states. Each profile presented includes the evidence-based or promising practices utilized, project description, project goals, and expected outcomes. Following the award recipient profiles, please refer to Appendix A for a list of awards by focus area and Appendix B for a list of awards by state.

Access East, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Non-profit Organization	252-847-2224	https://www.accesseast.org/	
Street Address	**City**	**State**	**Email**
2410 Stantonsburg Road	Greenville	NC	shantell.cheek@accesseast.org

Primary Consortium Partners

Name	State	Organization Type
Vidant Beaufort Hospital	North Carolina	Hospital (non-CAH)
Beaufort County Health Department	North Carolina	Health Department
Metropolitan Community Health Center	North Carolina	Federally Qualified Health Center (FQHC)

Focus Areas

Care Coordination	Chronic Disease Management
Population Health	

Target Population

The grantee will establish a stronger health network for all of the 47,000 residents of the county, including people in two key subpopulations of our target population: people who do not currently have a regular primary care provider, and the African American population. Four thousand people will become participants in our program through screenings and follow-up care.

Evidence-based/Promising Practice

Collective impact, Knowledgeable Neighbors, outreach and enrollment agent model, patient-centered medical homes, Closing the Loop, the North Carolina Tobacco Treatment Standard of Care, diabetes prevention program, Heart Healthy Lenoir, and Screen Out Cancer

Project Description

The purpose of the Rural Health Access Program (RHAP) is to increase access to care (clinical and supportive) and to reduce potentially avoidable trips to the emergency department (ED) in Beaufort County, in rural, eastern North Carolina. RHAP provides chronic disease management by using a mobile health unit to reach very rural populations and provide screening for medical and social needs, making referrals to partners and social-service providers, and navigating patients to health benefits and chronic-disease care management. Our goals are (1) Beaufort County Rural Health Outreach Consortium members coming together to establish a stronger health network for all of the residents of the county and reaching out through RHAP to (2) screen 4,000 people over four years and link those 4,000 participants to care, complete medical follow-up, improve self-care, decrease the burden of chronic disease, and use the ED less frequently. RHAP will meet the needs of Beaufort County in terms of racial and ethnic health disparities and barriers (social, cultural, infrastructure, etc.) that affect health status. RHAP will work with members of the target population to tailor outreach to the needs of people without medical homes and to reach all residents with chronic diseases. The goals of this outreach will be to educate the population and also to build relationships that will lead the people of Beaufort County to trust that there is no “wrong door.”

Project Goals

Goals and Objectives: The grantee will:

1. Establish a networked health-system infrastructure and work together to implement RHAP.
2. Send outreach and enrollment agents into the community in a mobile health unit to educate, screen, and connect participants to primary care providers (PCPs) and assistance in overcoming financial barriers to health care, as well as to support evidence-based treatment and follow-up for chronic diseases. The mobile health unit will be a significant asset for Beaufort County: a 35-foot vehicle with an exam room, health screening areas, video displays, as well as an area for nutrition education. Substantial research demonstrates that enhancing the network and deploying outreach and enrollment agents will decrease costs.
3. Increase access to care (clinical and supportive) in Beaufort County. Objective 1.1 Increase health literacy, care management, and enrollment in PCPs. Objective 1.2 Increase self-management of chronic diseases.
4. Decrease ED use for nonacute care in Beaufort County.

Expected Outcomes
1. 100% of participants will be linked to social support services. 2. 2% of participants will enroll with a primary care provider. 3. 15% improvement in Tobacco Use: Screening and Cessation Intervention. 4. 15% improvement in controlling high blood pressure. 5. 15% improvement in Comprehensive Diabetes Care: Hemoglobin A1c. 6. Decreased ED use by participants by 85% compared to baseline.

Adagio Health, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Non-profit Organization	412-253-8137	www.adagiohealth.org	
Street Address	**City**	**State**	**Email**
603 Stanwix Street, Suite 500	Pittsburgh	PA	tfrank@adagiohealth.org

Primary Consortium Partners

Name	State	Organization Type
Life's Journey OB-GYN (Penn Highlands Healthcare)	Pennsylvania	Hospital (non-CAH)
Pennsylvania Breast Cancer Coalition	Pennsylvania	Non-profit Organization
Family Planning Plus	Pennsylvania	Rural Health Clinic
Adagio Health Medical Offices	Pennsylvania	Rural Health Clinic

Focus Areas

Care Coordination	Health Education/Promotion and Disease Prevention
Health Screenings	

Healthy Rural Hometown Initiative (HRHI)

Cancer	

Target Population

Early Detection and Access to Care: A Women's Health Initiative will serve 1,500 women primarily aged 40 and older in 10 rural Pennsylvania counties that are at risk of forgoing necessary breast cancer screenings and/or at risk for not accessing critical vaccinations such as influenza, pneumonia, Tdap, and COVID-19. Patients may be uninsured or insured through public assistance or commercial insurance.

Evidence-based/Promising Practice

The design of the Early Detection and Access to Care: A Women's Health Initiative is influenced by Mammography Promotion and Facilitated Appointments Through Community-based Influenza Clinics, an evidence-based intervention model approved by the National Cancer Institute's Evidence-Based Cancer Control Programs (EBCCP).

Project Description

Early Detection and Access to Care: A Women's Health Initiative will promote breast cancer screening through outreach and engagement efforts conducted at community vaccine clinics organized by consortium members. Care navigators will facilitate scheduling of mammogram appointments and will follow patients through the continuum of care. Uninsured and underinsured patients will be enrolled in one of Adagio Health's two cancer screening programs to remove financial barriers to screening. Care navigators will screen patients for other barriers to care, social determinants of health, and risk factors for breast cancer. Care navigators will assist uninsured patients diagnosed with breast cancer in applying for Medicaid through the Breast and Cervical Cancer Prevention and Treatment Program (BCCPT).

Project Goals

1. Decrease the rate of breast cancer incidence to women primarily aged 40 and older by increasing screening and early detection of breast cancer.
2. Reduce breast cancer disparities by race, ethnicity, age, and socioeconomic status.
3. Connect 100% of patients diagnosed with breast cancer to treatment services through private insurance, Medicare, Medicaid, or the BCCPT.
4. Coordinate programs to reduce or remove physical barriers to health care services among the target population by increasing the number of referrals to other health, social service, and community-based organizations.
5. Coordinate the ongoing delivery of free breast cancer screening services and vaccines, based on evidence-based guidelines, for the same cohort of consortium partners over the three years.

6. Create or support existing partnerships and sustain a cancer screening prevention coalition with members from diverse sectors for sharing best practices, program successes for replicability, funding opportunities for collaboration, and support in the funded 10-county project region.

Expected Outcomes

The project will decrease breast cancer mortalities in the 10-county service area by increasing access to breast cancer screening services that are collocated with community-based vaccine clinics. The project will also increase vaccination rates for influenza, pneumonia, Tdap, and COVID-19 vaccines.

AdvantagePoint Health Alliance – Great Lakes, LLC

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Hospital (non-CAH)	906-449-1500	www.advantagepointhealth.com	
Street Address	**City**	**State**	**Email**
580 W. College Avenue	Marquette	MI	julie.kelly@mghs.org

Primary Consortium Partners

Name	State	Organization Type
Upper Great Lakes Family Health Center	Michigan	Federally Qualified Health Center (FQHC)
DLP Marquette General Hospital, LLC	Michigan	Hospital (non-CAH)
DLP Marquette Physician Practices Inc.	Maine	Hospital (non-CAH)
Portage Hospital, LLC	Michigan	Hospital (non-CAH)
Portage Physician Practices Inc.	Michigan	Hospital (non-CAH)
Acquisition Bell Hospital, LLC	Michigan	Critical Access Hospital (CAH)
Bell Physician Practices Inc.	Michigan	Hospital (non-CAH)

Focus Areas

Care Coordination	Chronic Disease Management
Health Education/Promotion and Disease Prevention	Population Health
Primary Care	Reducing non emergent ED visits

Target Population

Our program will address the unmet health needs of uninsured adults aged 19-64 years of age and senior emergency department (ED) “superusers” who are Medicare beneficiaries in Marquette and Houghton counties of Michigan. Approximately 61% of the population meets this age demographic. Nearly 25% of adults aged 18-39 have not identified a personal health care provider, and close to 20% of persons in these counties are identified as persons in poverty. The size and rural (isolated) nature of the coverage area for the proposed services make travel to and from health care services difficult or impossible.

Evidence-based/Promising Practice

The project will be utilizing the Rural Health Information Hub’s Community Health Workers Toolkit as well as support and referrals from our Consortium Task Force for implementation of the grant.

Project Description

AdvantagePoint Health Alliance’s Great Lakes Community Health Worker Program will address barriers that prevent rural at-risk populations from accessing primary care, specialists, and hospital care in a way that reduces avoidable emergency use and hospitalizations, producing better outcomes for patients and our rural communities. This program will provide benefits to other service area providers by assisting with their patients’ barriers to seeking care and patient referrals. Community health workers will serve in a care management role to this vulnerable population and will be effective because they are members of the community.

Project Goals

To decrease the nonemergency use of an emergency department by superusers for primary care services.

Expected Outcomes

1. During the four-year grant period, 100% of enrollees will receive referrals to primary care services, and 75% of enrollees will keep their initial primary care referral appointment.
2. During the four-year grant period, 100% of enrollees who need social services to support their access to primary care will receive referrals, and at least 75% of enrollees will keep their initial appointment.
3. During the four-year grant period, ED visits for nonurgent primary care services will decrease by 40% for enrollees.

AdvantagePoint Health Alliance Blue Ridge, LLC

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Hospital (non-CAH)	434-799-3838	www.advantagepointhealth.com	
Street Address	**City**	**State**	**Email**
1500 Fulton Heights	Danville	VA	monica.crews@lpnt.net

Primary Consortium Partners

Name	State	Organization Type
Piedmont Access to Health Services, LLC	Virginia	Federally Qualified Health Center (FQHC)
Danville Regional Medical Center, LLC	Virginia	Hospital (non-CAH)
Martinsville Physician Practices, LLC	Virginia	Rural Health Clinic
DLP Twin County Regional Healthcare, LLC	Virginia	Hospital (non-CAH)
DLP Twin County Physician Practices, LLC	Virginia	Rural Health Clinic
Gateway Health Alliance Inc.	Virginia	Hospital (non-CAH)

Focus Areas

Care Coordination	Chronic Disease Management
Health Education/Promotion and Disease Prevention	Population Health
Primary Care	Reducing non emergent ED visits

Target Population

The program will address the unmet health needs of emergency department (ED) overusers in the following cities and counties in rural southern Virginia: Carroll, Franklin, Galax, Grayson, Henry, Martinsville City, and Patrick. This population ranks low in access to health care and positive health outcomes.

Evidence-based/Promising Practice

The consortium partners have been participating in a similar community health worker (CHW) program that has been very successful in producing the outcomes that are expected from this grant, which is to decrease ED use by 40% in the “superuser” population using the ED for nonurgent primary care services.

Project Description

AdvantagePoint Health Alliance–Blue Ridge Community Health Worker Program will address ED overutilization by identifying barriers such as social determinants of health that prevent this population from receiving primary care, specialists, and hospital care in a way that reduces avoidable emergency use and hospitalizations, producing better outcomes for patients and our rural communities. This program will provide benefits to other service area providers by assisting with their patients’ barriers to seeking care and patient referrals. CHWs will serve in a care management role to this vulnerable population and will be effective because they are members of the community.

Project Goals

To build a sustainable CHW program to decrease the nonemergency use of an ED by superusers who would be better served by primary care services. Improve access to primary care services. Appropriately refer clients to Social Services for needed services.

Expected Outcomes

1. During the four-year grant period, 100% of CHW program participants will receive referrals to primary care services, and 75% of participants will keep their initial primary care referral appointment.
2. During the four-year grant period, 100% of CHW program participants who need social services to support their access to primary care will receive referrals.
3. During the four-year grant period, at least 75% of CHW program participants who receive a referral to social services will keep their initial appointment.
4. During the four-year grant period, ED visits for nonurgent, primary care services will decrease by 40% for CHW program participants.

Appling County

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Health Department	912-285-6002	https://www.sehdph.org	
Street Address	**City**	**State**	**Email**
283 Walnut Street	Baxley	GA	Derek.Jones@dph.ga.gov

Primary Consortium Partners

Name	State	Organization Type
East Georgia Healthcare Center	Georgia	Federally Qualified Health Center (FQHC)
Appling Healthcare System	Georgia	Hospital (non-CAH)
Appling County Extension	Georgia	County Government
Altamaha Area Agency on Aging	Georgia	Aging Services
Temple of the Higher Calling	Georgia	Faith Based Organization
Share Health Southeast Georgia	Georgia	Non-profit Organization

Focus Areas

Diabetes	Heart Disease

Target Population

Low-income, uninsured, or underinsured residents of Appling County, Ga., with modifiable risk factors for cardiovascular disease (CVD) or diabetes.

Evidence-based/Promising Practice

Interactive Interventions for Blood Pressure Management — The use of digital devices to improve blood pressure control for patients. Diabetes Education and Empowerment Program (DEEP) — Medicare-approved diabetes self-management program. Walk A Weigh — Research-tested weight-management program. Tai Chi for Health — Evidence-based program effective in achieving general health and fitness. SNAP-ED — U.S. Department of Agriculture program to encourage healthy eating choices among individuals receiving Supplemental Nutrition Assistance Program (SNAP) benefits.

Project Description

The purpose of Appling Partners in Health (APH) is to ensure access to health care, improve access to resources, and engage in strong collaborative alliances, leading to a healthier community. To achieve its purpose, APH will focus on two of the leading causes of morbidity and mortality in Appling County, Ga.: CVD and diabetes. Deaths from CVD alone account for 34% of all deaths, much higher than the state rate of 29.3%. Diabetes is the seventh-leading cause of death in Appling County and combined, these diseases account for a large proportion of hospital stays that could have been prevented with appropriate outpatient care. In addition to appropriate outpatient care, CVD and diabetes can be prevented and controlled with lifestyle changes that focus on increased physical activity and good nutrition. Well over a third of Appling adults are obese and physically inactive. Partners will utilize three approaches to reducing CVD and diabetes: Digital interactive monitoring for low-income, uninsured, and underinsured patients with diabetes or CVD; healthy eating and physical activity programs targeting high-risk patients; and community-level educational and outreach programs to increase awareness of residents of the importance of healthy eating and physical activity in reducing and managing CVD and diabetes. APH benefits from its members' involvement in the Coalition for a Healthy Appling County (CHAC), formed in 2017 to improve health outcomes and reduce disparities among Appling County's residents. Over the past four years CHAC has laid the foundation for community involvement in health promotion activities. A CHAC needs assessment conducted in 2019 provided valuable insights into disparities by census tract in educational attainment, poverty, and household demographics that were used to form APH strategies. APH is guided by the realization that health disparities must be addressed to achieve health equity. Our intent is to make services more accessible through place-based education and outreach initiatives and coordination of clinical and community educational programs aimed at reducing comorbidities for CVD and diabetes.

Project Goals

1. Reduce morbidity and mortality from CVD and diabetes by ensuring access to health care and improving access to resources, offering comprehensive care coordination, evidence-based educational programs, and support for participants who have been diagnosed with CVD or diabetes or have modifiable risk factors for these conditions.

2. Develop mechanisms to effectively support and sustain the project once grant funds end.

Expected Outcomes

1. Increase self-efficacy in self-management of CVD and diabetes among the target population by 65%.
2. Reduce risk for CVD and diabetes by promoting healthy lifestyles and implementing accessible, appropriate health promotion activities focused on improving nutrition and increasing physical activity for those with modifiable risk factors for CVD and diabetes.
3. By the end of grant funding, decrease emergency department (ED) visit rate for high blood pressure and hypertensive heart disease from three-year 2018-20 baseline of 659.2 per 100,000 to a rate of 550 per 100,000.
4. Decrease the ED visit rate for diabetes from three-year 2018-20 baseline of 485.3 to 350 per 100,000.
5. By the end of grant funding, decrease the discharge rate for high blood pressure and hypertensive heart disease from three-year 2018-20 baseline of 659.2 to 575 per 100,000.
6. Decrease the discharge rate for diabetes from the 2018-20 baseline of 259 to the state rate of 225.

Arukah Institute of Healing, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Mental Health Provider	815-872-2943	www.arukahinstitute.org	
Street Address	**City**	**State**	**Email**
535 Elm Place	Princeton	IL	tkammerer@princeton-il.com

Primary Consortium Partners

Name	State	Organization Type
Perfectly Flawed Foundation	Illinois	Non-profit Organization
St. Margaret's Hospital	Illinois	Hospital (non-CAH)
Princeton Police Department	Illinois	Law Enforcement Agency
OSF St. Claire Hospital	Illinois	Critical Access Hospital (CAH)
Bureau County Sheriff	Illinois	Law Enforcement Agency
Putnam County Sheriff	Illinois	Law Enforcement Agency
LaSalle County Sheriff	Illinois	Law Enforcement Agency
Spring Valley Police Department	Illinois	Law Enforcement Agency
Ottawa Police Department	Illinois	Law Enforcement Agency

Focus Areas

Care Coordination	Mental Health

Healthy Rural Hometown Initiative (HRHI)

Substance Use	Unintentional Injury

Target Population

Our rural population (18-30) with substance use disorder/mental illness (SUD/MI) who are not typically accessing services or are frequent users of emergency department/law enforcement resources. The project will focus on communities having a majority Hispanic population, intending to connect them with services. The project will also focus on junior high and high school–age (12-18) children, providing relevant prevention education.

Evidence-based/Promising Practice

The Living Room model is an evidence-based program, proven effective for connecting those in need of services with services via peer support and clinical staff in a nonjudgmental, easily accessible setting. Most Living Room programs focus on mental health only; however, this program will also include SUD. Harm reduction will be a critical part of the effort, ensuring safe use practices for those in active use. Because our population lacks access to public transportation, mobile services will be provided, meeting people where they are and, if needed, transporting them to treatment or appointments. Care coordination, job assistance, and medical attention will also be implemented in the programming through our consortium partnerships. The WORTH program is a promising practice, utilizing short videos focused on prevention in the junior high and high school population.

Project Description

Construction of a "Living Room" space within our service area to provide access to care for those with SUD/MI seeking help. The grant will staff this facility with mental health clinicians, lived experience recovery specialists, medical professionals, and care coordination personnel. Mobile services will also be available throughout the coverage area via a vehicle purchased through the grant. Harm-reduction efforts will provide safe use guidelines to those in active use. The program will provide medication-assisted treatment (MAT) along with counseling for those with SUD who seek the service. Prevention efforts aimed at junior high and high school–age children will be provided through the WORTH video program. Short videos discussing subjects such as substance abuse, mental health, physical health, etc., will be distributed to participating schools in the service area. Within the service area are several communities that have a significant Hispanic population. There will be focused efforts in those communities on reducing stigma among that population and providing inclusive, appropriate services where needed. The programming will be bilingual, and efforts to hire bilingual staff are under way. There are six law enforcement partners and two hospitals in the consortium, all of whom

are directly impacted by SUD/MI. The program intends to divert utilizers of these services to the Living Room where they can receive appropriate care.

Project Goals

1. Increase access. Create a Living Room to provide access to individuals who are at high risk for OUD/SUD-related injury.
2. Increase capacity and improve quality. Increase the connectivity and integration of the SUD/OUD workforce, enabling wraparound, patient-centered treatment.
3. Enhance Self-driven wellness. Empower and activate individuals to drive their own health, form healthy daily habits and coping skills, and engage in high-frequency lived-experience social connection.

Expected Outcomes

The consortium expects to construct the Living Room in our rural setting, continuing to sustain the services provided through this funding opportunity beyond the term of this grant. Continued implementation of harm-reduction strategies, care coordination, mental health and substance abuse counseling, and quality-of-life services will improve the health of our targeted population. Specifically, significant decreases in deaths due to unintentional overdose and suicide are expected. Through prevention efforts in our school-age population it is expected to see a reduction in substance use and an increase in utilization of mental health and substance abuse counseling services. There is an expected reduction in the stigma surrounding mental illness and substance abuse.

Avera Health

Lead Organization Information			
Lead Applicant Organization Type	**Phone**	**Organization Website**	
Health Department	605-322-3988	www.avera.org	
Street Address	**City**	**State**	**Email**
3900 W. Avera Drive	Sioux Falls	SD	rhonda.wiering@avera.org

Primary Consortium Partners		
Name	**State**	**Organization Type**
Avera Queen of Peace Hospital	South Dakota	Hospital (non-CAH)
Brookings Health System	South Dakota	Hospital (non-CAH)
Access Health – Mitchell	South Dakota	Federally Qualified Health Center (FQHC)

Focus Areas	
Care Coordination	Chronic Disease Management
Telehealth/Telemedicine	

Healthy Rural Hometown Initiative (HRHI)	
Chronic Lower Respiratory Disease	Heart Disease

Target Population

The target patient population will include adults recently discharged, newly diagnosed, or chronically ill cardiac patients with congestive heart failure (CHF) living in an 86-county rural area.

Evidence-based/Promising Practice

The applicant's model for Care Transitions aligns with the evidenced-based Eric Coleman Model of Care Transitions utilizing remote patient monitoring technology. This program supports patients newly diagnosed in their transition back home after discharge to prevent rehospitalization. Additionally, the Sutter Model for Patient Engagement will be leveraged for enrolled patients and the PDSA Quality Improvement Model will be utilized for continuous quality improvement. The program work will work closely with the North Central Heart Congestive Heart Failure program to align interventions and reinforce medical therapy guidelines according to CHF practice standards.

Project Description

The rural population served by this program represents some of the most high-risk patients discharged from hospitals: namely, those with cardiac conditions requiring specialty care and heart surgery. Through remote home monitoring, the proposed intervention seeks to reduce health disparities related to access to care and enhance health outcomes for rural patients in the service area diagnosed with CHF. This remote patient monitoring (RPM) model will place telehealth units in the rural homes of recently discharged, newly diagnosed, or chronically ill cardiac patients. The technology includes a tablet or a mobile app, scale, blood pressure monitor, and pulse oximeter. The system uses Bluetooth biometric remote monitoring, real-time video calls, phone calls, and Health Insurance Portability and Accountability Act–secure texting. Patients use peripherals (scale, blood pressure cuff, and oximeter) to measure vital signs, such as their weight and blood pressure, the results of which are transmitted to the tablet and a virtual dashboard that will be monitored by staff at Avera@Home. The platform also includes daily symptom surveys, medication reminders, and text and video communication with the RPM team. Staff members monitor patient data on a daily basis and connect with participants when their health metrics fall outside the scope of established parameters to provide guidance and support and to connect them with medical personnel as needed.

Project Goals

1. Complete a comprehensive community assessment by the end of the planning year (April 30, 2022).
2. Conduct all planning-year activities to establish a coordinated RPM service to improve safety and outcomes for eligible CHF patients by April 30, 2022. Enroll 75-plus adult patients in RPM program activities, and increase enrollment by 75 patients each year for three years.
3. Provide access to RPM by experienced care teams for all enrolled patients and coordinate the services and expertise of each of the consortium partners toward the management of CHF by May 1, 2022.

4. Establish baseline measures and improve overall health outcomes for CHF patients enrolled in the project by August 31, 2022, and ongoing throughout the implementation period. Measurements include but are not limited to biometrics, health indicators, emergency and hospital encounters, cost of care, and compliance with care plan.
5. Track and assess the efficacy of the project and disseminate program results toward a sustainable coordinated care transition model by April 30, 2023.

Expected Outcomes

Increase patient access to RPM services. Increase CHF biometrics reporting. Improve patient compliance with plan of care. Increase and improve tracked health indicators. Achieve fewer CHF complications. Enhance quality of life for rural CHF patients. Decrease admissions to emergency department and/or hospital readmission rates. Increased confidence in patients' self-management of CHF. Decrease costs for patients and health systems. Project replication in other geographies with other patients or disease burdens.

Bighorn Valley Health Center, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Federally Qualified Health Center (FQHC)	406-665-4103	www.onechc.org	
Street Address	**City**	**State**	**Email**
10 4th Street West	Hardin	MT	carolyn.pollari@onechc.org

Primary Consortium Partners

Name	State	Organization Type
Hardin School District 17&1	Montana	School District
Hardin High School	Montana	School District
Crow Agency Public School	Montana	School District
Wyola School District 29	Montana	School District
Bighorn County Public Health Department	Montana	Health Department

Focus Areas

School-based Health

Target Population

Target population: residents of Bighorn County, Mont., with a focus on two high-risk subpopulations — American Indians and school-age youth. The county's population in 2019 was 13,338, of whom 66% self-identified as American Indian and Alaska Native, and 24.4% are school-age youth between the ages of 5 and 18 years.

Evidence-based/Promising Practice

School-based Health Centers

Project Description

The Big Horn County Rural Health Care Services Outreach Program (RHCSOP) Consortium brings together six existing community-based organizations galvanized around the common priority of establishing school-based health centers (SBHCs) in three community school settings, with the aim to produce measurable improvements in health and academic outcomes in Big Horn County, Mont. The target population is the county residents, with a focus on two high-risk subpopulations, American Indians and school-age youth. Anticipated outcomes include expanding access for students, staff, and community members to integrated health care, including mental health care and substance use disorder (SUD) treatment; improving screening rates for depression, sexually transmitted infections (STI), and SUD among our school-age youth; increasing access to comprehensive family planning education and birth control for school-age youth; and improving academic outcomes by fostering a supportive school climate.

Project Goals

1. Create a communitywide infrastructure for effective action to deploy the SBHC model at three community schools.
2. Increase access to a system of school-based integrated health care that offers evidence-based approaches to medical, behavioral health, and oral health care.
3. Increase rates of screening and referral for treatment for depression and substance use among school-age youth.
4. Increase access to comprehensive family planning education and birth control for school-age youth.
5. Increase rates of screening and treatment for STI.
6. Improve academic outcomes by fostering a supportive school climate.

Expected Outcomes

Expected outcomes include expanding access for students, staff, and community members to integrated health care, including mental health care and SUD treatment; improving screening rates for depression, STIs, and SUD among our school-age youth; increasing access to comprehensive family planning education and birth control for school-age youth; and improving academic outcomes by fostering a supportive school climate.

Bi-State Primary Care Association, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Non-profit Organization	802-229-0002	www.bistatepca.org	
Street Address	**City**	**State**	**Email**
61 Elm Street	Montpelier	VIT	hlabun@bistatepca.org

Primary Consortium Partners

Name	State	Organization Type
Lamoille Health Partners	Vermont	Federally Qualified Health Center (FQHC)
Little Rivers Health Care	Vermont	Federally Qualified Health Center (FQHC)
NOTCH (Northern Tier Center for Health)	Vermont	Federally Qualified Health Center (FQHC)

Focus Areas

Care Coordination	Chronic Disease Management
Primary Care	

Healthy Rural Hometown Initiative (HRHI)

Heart Disease	

Target Population

Patients in the rural communities of Franklin, Lamoille, and Orange counties of Vermont who are at risk for, or are experiencing, early stages of, cardiovascular disease (CVD) along with food insecurity.

Evidence-based/Promising Practice

Our consortium builds from evidence-based programs using food access and improved diet quality to reduce risk of disease. A previous HRSA-funded planning project allowed us to study a variety of approaches, and each participating partner is drawing from best practices in models using prepared meals, produce prescriptions, local food collaboratives, and healthy eating initiatives tied to a retail grocery store environment.

Project Description

Each participating consortium member has a different food-based model, based on pre-existing community partnerships and local resources. However, all will build the common process elements of:

1. Screening for food insecurity using a clinically validated screen (Hunger Vital Sign) and recording results in the electronic health record;
2. Documenting patient engagement points through offer of referral, referral, and program participation/completion;
3. Dietary change; and
4. Change in clinical indicators connected to CVD. Consortium members will share best practices, meet in peer-based learning opportunities with other health care programs focused on improving health outcomes through diet-based interventions, and connect with subject matter experts in the field.

Project Goals

The overall clinical goal is to reduce common risk factors related to CVD, including food insecurity and reduced diet quality, elevated blood pressure, uncontrolled A1c levels, and elevated body mass index. We hope to impact these factors in 100 to 200 rural patients over the course of the program. (Note: many of the interventions are at the household level, so for each patient reached there is multiplier factor for the household. Also, some interventions include a community health aspect and would also reach a larger number of individuals with less-intensive services.) Our project also has the underlying goal of establishing processes that connect food access interventions to individual patients' health outcomes. We believe these connections will help practices tailor and modify their approach in response to clinical data, along with building a structure to support sustainable reimbursement in the future and can be applied across different intervention types.

Expected Outcomes

FQHC screenings for food insecurity will increase, targeted patients will utilize food-based resources provided (multiple metrics), targeted patients will show improvements in blood pressure control and (for comorbid patients) diabetes control, observed changes in dietary patterns and CVD risk factors will indicate potential for long-term savings in total cost of health care for enrolled patients.

Canyonlands Community Health Care

Lead Organization Information			
Lead Applicant Organization Type	**Phone**	**Organization Website**	
Federally Qualified Health Center (FQHC)	928-645-9675	https://canyonlandschc.org/	
Street Address	**City**	**State**	**Email**
827 Vista Avenue	Page	AZ	jo.tate@cchcaz.org

Primary Consortium Partners		
Name	**State**	**Organization Type**
Zions Way Home Health	Arizona	Health Department
Page Eye Center	Arizona	Rural Health Clinic
Chilchinbeto Chapter House	Arizona	Non-profit Organization

Focus Areas	
Care Coordination	Diabetes
Health Education/Promotion and Disease Prevention	Health Equity
Population Health	

Target Population

The Page and Chilchinbeto/Kayenta Diabetes Education Consortium will serve 400 males and females, aged 18 and over, with uncontrolled diabetes (A1c greater than 9) in the remote communities of Page and Kayenta/Chilchinbeto in northern Arizona. Our program will serve African Americans, Caucasians, Latins, Native Americans, and Pacific Islanders.

Evidence-based/Promising Practice

The project will use a Clinical Partnership Model and Self-Management Model. The Clinical Partnership Model will allow providers to collaborate with a range of health care providers and community organizations to extend the reach of services, increase access, and improve coordination of diabetes care. The Self-Management Model will provide a six-week workshop for individuals with chronic conditions to learn skills and strategies to manage their health. The workshop is designed for people with one or more chronic conditions such as diabetes. Classes are taught in community settings such as senior centers, churches, libraries, and hospitals.

Project Description

The purpose of the Page and Chilchinbeto/Kayenta Diabetes Education Consortium is to continue to fill gaps in health care and support services to ensure access to patient-oriented medical services, community outreach and education, medication counseling, and specialty services to residents of our communities. Our consortium will support the development and delivery of integrated care that prevents the impacts of the potential complications of diabetes. The project will provide a culturally responsive, patient-centered, integrated system of care for diabetic patients, serving Coconino and Navajo counties. A multidisciplinary team will deliver all required services, including:

1. Community outreach and health education to affected diabetics and their families at various locations including community gathering places such as Chapter Houses, churches, community meetings, and libraries;
2. Screenings and assessments at local clinics in Page, Chilchinbeto, and Kayenta counties, and other least restrictive off-site locations, using both direct care and telemedicine technology;
3. In-person clinical pharmacy services at the Page clinic, including one-on-one sessions with pharmacists. Remote clinical pharmacy services in Chilchinbeto clinic; and
4. Medical case management to coordinate care, as needed, with specialty service providers and other wraparound service providers, including nutrition counseling, mental health services, traditional medicine, eye exams, wound care, and fitness education.

Project Goals

1. To formally convene the Page and Chilchinbeto/Kayenta Diabetes Education Consortium and establish mechanisms for coordination of care and referral for services for diabetics in Page and Kayenta/Chilchinbeto to reach those with uncontrolled diabetes (A1c greater than 9) and strengthen the capacity, operations, and sustainability of the consortium partners to reach program sustainability.

2. Increase community presence of partners, using community health workers, to improve identification of affected individuals through outreach, education, and health promotion activities.
3. Enhance screening, assessment, and follow-up care by expanding the use of telehealth and collaborating with Canyonlands Healthcare's other programs.
4. Improve patient adherence to medication guidelines, monitoring recommendations, and lifestyle changes that can enhance glucose control for diabetes.
5. Minimize miscommunication and misunderstandings in the provider-patient relationship outside of clinical visits.
6. Reduce the burden of follow-up on providers.
7. Reduce the burden of travel time and distance on rural patients and their families.
8. Improve the quality of life for patients diagnosed with diabetes.

Expected Outcomes

Through expanded outreach, education, and targeted health promotion activities, awareness of services available for diabetics in the service area will increase and a greater number of individuals at risk for the complications of uncontrolled diabetes will be identified and targeted for education and clinical pharmacy services. These individuals will subsequently have increased access as consortium partners will be using more inclusive methods to provide patient-centered, culturally responsive diabetes services with its partners to increase physical activity and ensure patients receive eye exams. These services will include outreach, education, screening and assessment in the least-restrictive environments, case management, primary medical care, eye exams, and rehabilitation/exercise services, as well as pharmacy counseling and wraparound services, such as behavioral and oral health. Individuals at risk and patients will demonstrate improved health outcomes, as measured by changes in A1c and other outcome and process measures. Health and social service gaps will be reduced through expanded use of telemedicine, which can minimize the barriers to accessing care.

Catholic Health Initiatives – Iowa, Corp.

Lead Organization Information			
Lead Applicant Organization Type	**Phone**	**Organization Website**	
Hospital (non-CAH)	515-358-9154	https://www.mercyone.org/aco/	
Street Address	**City**	**State**	**Email**
1449 NW 128th Street, Suite 110	Clive	IA	aco@mercydesmoines.org

Primary Consortium Partners		
Name	**State**	**Organization Type**
MercyOne Population Health Services Organization	Iowa	Hospital (non-CAH)
MercyOne Centerville Medical Center	Iowa	Critical Access Hospital (CAH)
Ringgold County Hospital	Iowa	Critical Access Hospital (CAH)
EveryStep	Iowa	Non-profit Organization

Focus Areas	
Advance Care Planning	Health Care Workforce
Population Health	Primary Care

Target Population

The target population for this project is adults in South Central Iowa, specifically those residing in Appanoose and Ringgold Counties. Adults aged 65 and older will be our subpopulation of focus.

Evidence-based/Promising Practice

This project is utilizing two primary evidence-based/promising practices: the Respecting Choices evidence-based model of advance care planning (ACP) and the Five Wishes evidence-informed approach to creating an ACP.

Project Description

This project, titled Rural Patient Outreach through advance care planning (ACP), will expand health care delivery by increasing access to, and use of, ACP services in two rural counties in South Central Iowa. ACP is a process of documenting decisions about the care a person wishes to receive when they are unable to make decisions for themselves. MercyOne Population Health Services Organization (PHSO), an urban entity, supports this work by providing a program manager (who is a resident of a rural southern Iowa community) and completing the grant administrative requirements. The project consortium is a partnership between two Critical Access Hospitals and associated clinics, and a nonprofit home health and hospice provider that serves both target counties. Designated members of each of these organizations will attend Respecting Choices facilitator training. This training will support a shared understanding within the consortium of ACP and how to structure an ACP conversation with patients and family members. The consortium members will also select staff to train as Respecting Choices instructors. This will enhance ownership and engagement, allowing for sustainability of this program after the grant ends. Each member of the consortium will work with their stakeholders to design ACP workflows, including standardized documentation and a referral protocol to a certified facilitator. The members will discuss their progress at consortium meetings, providing a platform for shared learning, constructive feedback, and innovation. The consortium will also work together to develop patient education and a marketing plan to inform residents of the community of the importance and availability of ACP.

Project Goals

Overarching Project Goal: To increase the use and understanding of ACP by residents and health care providers in two rural Iowa counties. Project Goal 1: By 2025, deliver improved ACP health care services through a strong consortium as evidenced by every consortium member organization actively engaged in the planning and delivery of improved ACP program activities. Project Goal 2: Expand delivery of ACP services as evidenced by increased number of advance directives documented in the MercyOne Centerville Medical Center and Ringgold County Hospital with Mount Ayr Medical Clinic's medical records in rural South Central Iowa by 2025. Project Goal 3: Improve ACP health care delivery services utilizing Respecting Choices evidenced-based model with Five Wishes and Iowa Physician Order for Scope of Treatment (IPOST) evidence-informed advance directives.

Expected Outcomes

The project will increase the number of documented advance care plans for the rural target population. Members of the consortium will standardize ACP documentation and integrate ACP into standard services. Providers will code for ACP services, improving quality scores and financial sustainability. Respecting Choices facilitator and instructor training will build the capacity within the consortium to expand access to ACP services and will support sustainability. ACP will become a valued norm in each community.

Coastal Bend Wellness Foundation, Inc.

Lead Organization Information			
Lead Applicant Organization Type	**Phone**	**Organization Website**	
Federally Qualified Health Center (FQHC)	361-814-2001	www.cbwellness.org	
Street Address	**City**	**State**	**Email**
2882 Holly Road	Corpus Christi	TX	alisonj@cbwellness.org

Primary Consortium Partners		
Name	**State**	**Organization Type**
Christus Spohn Hospital – Kingsville	Texas	Hospital (non-CAH)
Christus Spohn Hospital – Al	Texas	Hospital (non-CAH)
Christus Spohn Hospital – Beeville	Texas	Hospital (non-CAH)
Texas Tropical Behavioral Health	Texas	Mental Health Provider
Coastal Plains Community Center	Texas	Mental Health Provider
Coastal Bend Regional Advisory Council	Texas	Non-profit Organization

Focus Areas	
Care Coordination	Health Education/Promotion and Disease Prevention

Healthy Rural Hometown Initiative (HRHI)	
Substance Use	Unintentional Injury

Target Population

The program will serve 4,400 minority residents in rural areas within the South Texas counties of Aransas, Bee, Brooks, Duval, Jim Wells, Kleberg, Kenedy, Live Oak, McMullen, Refugio, and San Patricio:

1. Who are at risk for, have been diagnosed with, or are in treatment or recovery for opioid use disorder (OUD);
2. Their families or caregivers; and
3. Community members including health care providers and law enforcement.

Evidence-based/Promising Practice

The evidence-based promising practice models being used are care coordination, community health workers, prevention and treatment of substance use disorders, and services integration.

Project Description

Project REACH (Rural Education and Awareness for Community Health) is an innovative community approach that delivers evidence-based and promising models to support activities that expand options for substance use disorder (SUD)/OUD services across the spectrum. It helps residents in the target rural area to prevent SUD/OUD, access treatment, and move toward recovery. Coastal Bend Wellness Foundation, in strategic alliance with consortium members, reinforces a coordinated systems approach to strengthen and expand SUD/OUD prevention, treatment, and recovery services in high-risk rural communities.

Project Goals

The goals of Project REACH are to develop and implement a comprehensive service delivery model for:

1. Prevention and early intervention services to minimize the potential for the development of OUD/SUD;
2. Treatment of OUD/SUD to improve retention and health outcomes; and
3. Peer recovery support of an individual with OUD/SUD to promote and sustain long-term recovery.

Expected Outcomes

The expected impact on the target population is positive long-term health outcomes and long-term changes to the health care delivery system. REACH has the potential to have long-term impact, including reducing morbidity from opioids, maintenance of substance use treatment and recovery, reducing the proportion of people who use opioids, policy implications for universal screening and treatment of SUD/OUD across the health care delivery system, equitable access to naloxone, and mitigation of barriers to care through the design and development of evidence-based and promising practice models.

Columbia County Hospital District

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Critical Access Hospital (CAH)	509-382-2531	Columbia County Health System	
Street Address	**City**	**State**	**Email**
1012 S. 3rd Street	Dayton	WA	www.cchd-wa.org

Primary Consortium Partners

Name	State	Organization Type
Walla Walla Community Hospice	Washington	Non-profit Organization
Elk Drug	Washington	Pharmacy
Southeast Washington Aging and Long-Term Care	Washington	Non-profit Organization
Pullman Hospital	Washington	Hospital (non-CAH)
Washington State Department of Rural Health	Washington	Health Department
Columbia County Public Health	Washington	Health Department

Focus Areas

Chronic Disease Management	

Healthy Rural Hometown Initiative (HRHI)

Chronic Lower Respiratory Disease	Heart Disease

Target Population

Patients over the age of 50 with a diagnosis of chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD), and or congestive heart failure. The area served is Columbia County and Waitsburg, Wash., which is the public hospital district. We are hoping that over the three-year period, approximately 400 patients will engage the program.

Evidence-based/Promising Practice

Promoting team-based care to improve hypertension control, implementing clinical decision support system, integrating community health workers on clinical care teams and in the community, community pharmacists and medication therapy management, and COPD readmission prevention

Project Description

The Columbia County Public Hospital District No. 1 (CCPHD) has a strong commitment to delivering high-quality, effective health services for our small rural communities. The consortium has a long history of working with community partners to address population health challenges and using a data-driven approach to identify areas of need and craft solutions. The consortium is well positioned to implement a Healthy Rural Hometown Initiative. CCPHD will implement the Partners Improving Patient Health (PIPH) Program, which will focus on approximately 400 patients with CVD and/or COPD. Primary activities for this program will include community education events, smoking cessation classes, medication management and oversight by the local pharmacist, along with establishing individualized care plans that will meet the patient's goals. The team has put together a community survey to get patients' feedback on what their challenges are in maintaining their health care.

Project Goals

1. Improve the health of individuals who have been diagnosed with or are at high risk of developing heart or respiratory disease.
2. Improve access to health care services to rural residents.
3. Establish a framework for sustainable delivery of health care services through partnerships with community and regional organizations and payers.

Expected Outcomes

The goals and objectives for the CCPHD PIPH program align directly with the Healthy People 2030 goals of improving respiratory and CVD in adults. Specifically, the PIPH program will target improving cardiovascular health in adults (HDS-01), increasing control of high blood pressure in adults (HDS-05), reducing heart failure hospitalizations in adults (HDS-09), and reducing emergency department visits for COPD in adults (RD-06).

Cornerstone Care, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Federally Qualified Health Center (FQHC)	724-943-3308	www.CornerstoneCare.com	
Street Address	**City**	**State**	**Email**
7 Glassworks Road	Greensboro	PA	RRinehart@CornerstoneCare.com

Primary Consortium Partners

Name	State	Organization Type
Blueprints	Pennsylvania	Non-profit Organization
Washington Health System Greene	Pennsylvania	Hospital (non-CAH)
Carmichaels Area School District	Pennsylvania	School District
Central Greene School District	Pennsylvania	School District
Jefferson-Morgan School District	Pennsylvania	School District
Southeastern Greene School District	Pennsylvania	School District
West Greene School District	Pennsylvania	School District
Southwest Pennsylvania Area Health Education Center	Pennsylvania	Area Health Education Center (AHEC)

Focus Areas

Diabetes	Care Coordination
Health Education/Promotion and Disease Prevention	

Target Population

Our target population includes Greene County's overweight and obese youth and their caregivers, as well as 50 Cornerstone Care patients enrolled in the Healthy Options, Nutrition, Exercise, Youth (HONEY) project diagnosed with obesity, hypertension, diabetes, and/or heart disease.

Evidence-based/Promising Practice

The Coordinated Approach To Child Health (CATCH) promising practice model was selected by the consortium because it is adaptable to our area, provides the broad scope of early childhood to 12th-grade learning plans, and has been proven successful in health improvements in the school environment. Over 120 peer-reviewed scientific publications support the effectiveness of CATCH in increasing physical activity and healthy eating reducing overweight status and obesity.

Project Description

The HONEY project will focus on obesity, including prevention initiatives in childhood and care management for Cornerstone Care patients diagnosed with obesity along with diabetes, hypertension, and heart disease who enroll in the HONEY project. The program will feature curricula for three specific areas: preschool through eighth-grade students and their parents; students grades 9-12 with focus on nutrition education, exercise, and counseling programs; and, at the community level, the program will feature a broader preventive education focus. Cornerstone Care integrated care coordination services will be used to monitor the impact of grant activities on program participants. In addition, collaboration with Washington Health Systems will occur to lessen the impact and emergency department usage by 50 Cornerstone Care patients who have a diagnosis of diabetes, obesity, and/or heart disease who are enrolled in the HONEY project.

Project Goals

1. Reduce the body mass index for overweight children participating in the HONEY and youth aged 3-17 years old as demonstrated by the CDC BMI Percentile Calculator for Child and Teen.
2. Decrease the frequency of emergency department usage by 50 Cornerstone Care patients enrolled in the HONEY project who have a diagnosis of diabetes, obesity, and/or heart disease. We hope to have an impact on this through providing patients diagnosed with obesity with the same education pieces from CATCH.

Expected Outcomes

The final long-term impact of this project includes reductions in the incidence of overweight and obese individuals and the number individuals diagnosed with diabetes; reduced obesity-related illnesses; reduced complications from diabetes such as amputations,

vision loss, dialysis, etc.; reduced incidence of heart disease; improved health literacy, reduced death rates due to diabetes and diabetes related illness; and reduced the number of youths diagnosed with type 2 diabetes.

Creek Valley Health Clinic

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Federally Qualified Health Center (FQHC)	435-900-1104	www.creekvalleyhc.com	
Street Address	**City**	**State**	**Email**
20 S. Colvin Street	Colorado City	AZ	joanne.zitting@creekvalleyhc.com

Primary Consortium Partners

Name	State	Organization Type
Navy	Arizona	Federally Qualified Health Center (FQHC)
Arizona State University	Arizona	Federally Qualified Health Center (FQHC)

Focus Areas

Chronic Disease Management	Diabetes
Health Education/Promotion and Disease Prevention	Mental Health
Primary Care	Unintentional Injury

Target Population

The program will serve the residents living at or below 200% of Federal Poverty Guidelines (FPG) residing in the service area of Colorado City (Mohave County, Ariz.), Hildale (Washington County, Utah), and surrounding rural areas (9,500 to 10,500 residents). Three predominant underlying factors that contribute to current health disparities among this population include geography, educational attainment, and the religious/cultural history within the service area.

Evidence-based/Promising Practice

The primary evidence-based model used in this program will be the Transtheoretical Model (TTM), which will expand delivery of culturally responsive, trauma-informed medical, behavioral, and substance abuse treatment to community members, allowing for modified treatment plans based on the patient's decision-making and willingness to change behavior.

Project Description

Creek Valley Cares Consortium is composed of three organizations that share the common mission to improve the health and safety of the service area through accessible health and social services. These partners include:

1. Creek Valley Health Clinic, a federally qualified health center providing primary, preventive, and behavioral health services in accordance with HRSA's health center program;
2. Navvy, a rural-based, marketing and social media management company experienced in community outreach and health education; and
3. Arizona State University, providing doctoral student rotations to focus on chronic disease management and patient outcomes. The primary activities to achieve project success include the expansion of access to medical and behavioral health services, the improvement of clinical measures each year, decreasing local uninsured rates each year, decreasing mortality from drug overdose, decreasing mortality from accidental injury and death, and improving community health literacy. Sixty-seven percent of the consortium members are local, and all members have the capacity and commitment to work closely together to achieve these shared objectives.

Project Goals

1. Expand Access to Health Services: Increase access to medical and behavioral health services by a minimum of 1% per year for the entire project period. Two specific objectives have been defined to effectively achieve this goal: (a) Increase access to primary care services. (b) Increase access to behavioral care services.
2. Improve the following clinical measures by a minimum of 1% each year: (a) depression screening and follow-up planning, (b) patient control of high blood pressure, (c) patient control of diabetes (A1c), and (d) patient screening and cessation resources for tobacco use.
3. Improve Community-Specific Goals, Outreach, and Engagement. Four specific strategies/objectives have been defined to effectively achieve this goal: (a) decrease local uninsured rate by a minimum of 1% each year, (b) decrease mortality from drug overdose to the national average by the end of the project period, (c) decrease mortality from accidental injury to the national

average by the end of the project period, and (d) improve community health literacy and understanding of consortium focus areas by reaching 250 or more community residents each year through outreach events and activities.

Expected Outcomes

Expanded access of medical and behavioral health services for residents of Washington (Utah) and Mohave (Ariz.) counties; reduced service area percentage of uninsured patients through targeted eligibility outreach and enabling services; and improved clinical measures related to screening for depression and follow-up planning, control of high blood pressure, control of diabetes, and preventive care and screening of tobacco use. Decreased local mortality rate from drug overdose to the national average by 2025 through increasing access to behavioral health, trauma, and substance abuse services. Reduce unintentional injury deaths to the national average by 2025 through education on underage driving; drug and alcohol-impaired vehicle use; the importance of seat belts, car seats, and helmets; and other community-specific topics on injury and accidental death prevention.

Delta Health Alliance, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Non-profit Organization	662-686-3842	https://deltahealthalliance.org/	
Street Address	**City**	**State**	**Email**
435 Stoneville Road	Stoneville	MS	mwilliams@deltahealthalliance.org

Primary Consortium Partners

Name	State	Organization Type
Leland Medical Clinic	Mississippi	Hospital (non-CAH)
Greenwood Leflore Hospital	Mississippi	Hospital (non-CAH)
Delta Family Medical Clinic	Mississippi	Critical Access Hospital (CAH)
Mississippi Department of Health	Mississippi	Critical Access Hospital (CAH)
Early Head Start and Health Start Child Care	Mississippi	Critical Access Hospital (CAH)
Univ. of Mississippi Center for Population Studies	Mississippi	Federally Qualified Health Center (FQHC)
Univ. of Memphis Center for Cmty. Research/Eval	Tennessee	University

Focus Areas

Substance Use	Infant Health & Early Childhood Health

Healthy Rural Hometown Initiative (HRHI)

Unintentional Injury	

Target Population

Families in the four counties served by this initiative are long familiar with a lack of resources blocking their access to health care and reducing overall quality of life. Communities are 65.7% Black, and 30.2% live in poverty. Of the 10,352 children under the age of 5 in our service area, 46.7% live in poverty, outstripping the state average of 31.1%, and more than twice the national average of 21.5% of infants, toddlers, and children. Rural communities include 142,583 individuals; 65.7% of residents are Black, 30.2% live below the poverty level, and 59.6% of families with children under the age of 18 are single-mother homes.

Evidence-based/Promising Practice

Delta Safe Families Collaborative (DSFC) will replicate the Child Care Health Advocate (CCHA) model for injury prevention advocated by the American Academy of Pediatrics and successfully deployed in five California counties in 111 childcare centers. The rationale for selecting this model is:

1. Its potential to directly impact needs identified in both facility settings and home settings in our community;
2. Its similarity to other programs employing community-based educators that we have successfully used in the region and for which our families are familiar, increasing its potential to succeed;
3. The degree to which it actively engages with the communities served;
4. Its relatively low cost of implementation and maintenance; and
5. The ease of replication to neighboring communities if proven effective.

Project Description

The DSFC is a community-based, rural outreach program aimed at reducing the high incidence and impact of unintentional injuries (UIs) by expanding and enhancing health care delivery, education, and policies for rural underserved populations in the Mississippi Delta, specifically the wholly rural Mississippi counties of Leflore, Sunflower, Warren, and Washington. The consortium has developed a multigenerational strategy that will track the same set of individuals throughout the four-year period to determine the effectiveness of our collaborative's activities in producing long-term, sustainable improvements in reducing unintentional injuries, focusing initially on pregnant women, new parents, infants, toddlers, and children. The program seeks to improve the delivery of health care services through a three-pronged strategy involving:

1. A strong collaborative approach in which every consortium member organization (representing clinics, hospitals, and state agencies) is actively involved and engaged in the planning and delivery of services;
2. Ongoing community engagement in the identification and prioritization of needs, development of services, and continuous quality improvement of programs; and

3. Use of an innovative, evidence-based model to reduce the incidence of unintentional injuries in rural communities.

Project Goals

The collaborative's goals are as follows:

1. Actively engage with consortium members, rural childcare centers, families, and communities to complete a comprehensive community assessment to identify needs relating to unintentional injuries, then use those findings to update project work plan and develop program tools to position our program to begin delivering services.
2. Observe a 20% reduction in the number of overall unintentional injury deaths among infants, toddlers, and children (aged 0-5) in our targeted rural communities.
3. Observe a 20% reduction in the number of overall unintentional injury deaths among all residents of targeted communities, with a focus on pregnant women and new parents.
4. Collect data, and analyze and evaluate outcomes of the project, comparing to similar rural areas. Disseminate results and finalize a sustainability plan for ongoing operations.

Expected Outcomes

Expected outcomes of the project include statistically significant improvements pre- to post- in number and scope of higher-quality written health and safety policies at childcare centers; number of playgrounds that comply with safety recommendations; percentage of families with consistent and proper use of car seats; incidents of poisonings and accidental drug ingestion; percentage of homes with smoke detectors, childproof locks, furniture brackets, etc.; educational outreach measures on Back to Sleep safety, firearm safety, and bath safety; and parental injury prevention measures including incidences of domestic abuse, falls, motor vehicle safety, and perceptions of safety in the home.

Dublin City Schools

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
School District	478-290-5711	www.dublincityschools.us	
Street Address	**City**	**State**	**Email**
205 Shamrock Drive	Dublin	GA	reanna.osburn@dcsirish.com

Primary Consortium Partners

Name	State	Organization Type
Laurens County Board of Health	Georgia	Health Department
Fairview Park Hospital	Georgia	Hospital (non-CAH)
Macon Coliseum Hospital	Georgia	Hospital (non-CAH)
Joy Clinic	Georgia	Free Health Clinic
Dr. Ambrose	Georgia	Dentist
Laurens County Family Connection	Georgia	Non-profit Organization
Dublin Housing Authority	Georgia	Housing Authority
Laurens County DFCS	Georgia	Social Services
Department of Juvenile Justice	Georgia	Juvenile Justice Services

Focus Areas

Health Education/Promotion and Disease Prevention	Oral Health
School-based Health	

Target Population

The project serves all 2,298 students, prekindergarten through 12th grade, enrolled in the Dublin City School System, and their parents/guardians. Approximately 90% of the students are African American, 5% multiracial, 2% Hispanic, 5% White, and 1% other. The project service area is the city of Dublin, Ga.

Evidence-based/Promising Practice

Evidence-based or promising practice models included are student-focused dental education and outreach services, substance abuse and violence prevention education (Mendez Too Good for Drugs and Too Good for Violence curricula), abstinence-centered sexual risk avoidance education (Choosing the Best curriculum), and mentoring.

Project Description

Funding from the Rural Health Care Services Outreach Program will empower the Dublin City Student Wellness Initiative Consortium to increase access to essential dental education and outreach services and provide substance abuse and life skills education (including mentoring) for students, grades prekindergarten through 12, in the Dublin City School System. The services include dental-focused prevention education, an annual dental screen, and students identified as needing dental care subsequently receiving it; evidence-based, substance abuse and violence curricula for students in grades K–12; evidence-based abstinence-centered, sexual risk avoidance education for students in grades 6-12; follow-up mentoring services for a minimum of 100 male students in grades 6-12; and parent education outreach activities (in-person and virtual) regarding family violence, bullying, substance abuse, and other at-risk behaviors and how to access available local resources to assist the child and family. All of the engaged partners actively serve on the Dublin City Student Wellness Initiative Consortium and are providing a variety of resources, support, and assistance for the project. This support includes providing classrooms, meeting rooms, school clinic space, office space, and use of furniture and technology for project staff; providing dental services on-site at the schools and at the health department; providing dental clinic services; utilizing the services of dental hygiene students; providing referrals to the project; assisting with project-related community outreach and parent education; and accepting referrals from the project.

Project Goals

1. Provide preventive dental education and outreach services for children, aged 3-18 years, and their parents residing in the city of Dublin.

2. Provide substance abuse and life skills education for students, grades kindergarten through 12, enrolled in the Dublin City School System and their parents.

Expected Outcomes

It is expected that 100% of the students will receive ongoing dental health education and have access to regular dental services, and this will result in a decrease in the percentage of students needing dental services following an annual dental screening. In addition, the following outcomes are expected: reduced percentage of students in grades 1-12 who receive at least one disciplinary referral during the school year, reduced percentage of students in grades 6-12 who drank alcohol during the past 30 days, reduced percentage of students in grades 6-12 who engaged in binge drinking in the past 39 days, reduced percentage of students in grades 6-12 who used marijuana during the past 30 days, reduced percentage of students in grades 6-12 who used other drugs during the past 30 days, increase the percentage of students in grades 6-12 who think substance abuse is risky, and reduced teen pregnancy rate.

Educational Service District 113

Lead Organization Information			
Lead Applicant Organization Type	**Phone**	**Organization Website**	
Non-profit Organization	360-464-6700	www.esd113.org	
Street Address	**City**	**State**	**Email**
6005 Tyee Drive SW	Tumwater	WA	apyke@esd113.org

Primary Consortium Partners		
Name	**State**	**Organization Type**
Elma School District	Washington	School District
Summit Pacific Medical Center	Washington	Critical Access Hospital (CAH)
Elma Family Dental	Washington	Rural Health Clinic

Focus Areas	
Health Education/Promotion and Disease Prevention	Mental Health
Oral Health	Primary Care
School-based Health	Telehealth/Telemedicine

Target Population

The program will serve over 650 Elma Elementary School students in Grays Harbor County, Wash. Elma Elementary School students range in age from 4 years old to 10 years old (prekindergarten to fifth grade). Over 70% of the students qualify for free and reduced-price lunch, 20% of the students have a disability, and 12% percent are English language learners.

Evidence-based/Promising Practice

This program integrates three evidence-based models, including:

1. Youth Mental Health First Aid to teach the skills to respond to mental illness and substance use.
2. Schools That Care promising practice approach, which supports rural students and families by establishing intervention teams and implementing assessment, communication, and strategic planning.
3. Madison Outreach and Services through Telehealth (MOST) Network's telemedicine component, which will be used to provide health services via video conferencing and special equipment with local systems of care navigators to support health services that will increase equitable access to health care and decrease the amount of time that adult caregivers need to support health-related appointments.

Project Description

This program will connect Elma Elementary School students to school-based medical, mental health, and dental services through a consortium of local health care providers. School-based health services will include health education, preventive physical health care, treatment of minor short-term illnesses and injuries, and ongoing chronic medical condition management. Mental health screenings, brief intervention support services, and referral to treatment will also be provided, along with oral health screenings and referral to treatment. Health insurance enrollment assistance will also be available through the school-based health center. This program will advance Elma Elementary School students' and families' equitable access to primary medical, mental health, and dental services. School-based health services will be available to all enrolled students at Elma Elementary School, with targeted interventions focused on connecting with low-income families in the Elma School District (who do not have a health care home).

Elma Elementary School will have an on-site school-based health care team made up of a student assistance navigator to coordinate care and a student assistance professional to provide prevention and early intervention mental health services to students. These staff will work closely with the school nurse and school counselor, along with other student support staff. This care team will coordinate care with partnering medical and dental care providers in the community to provide high-quality, comprehensive care, with limited disruptions to class time. Telehealth appointments will be available daily for medical appointments. Primary medical care providers will be scheduled for in-person clinic days at the school on a regularly established schedule, based-on service needs. Oral health screenings will be conducted in person in the fall and spring and follow-up services will be coordinated through the school-based health center. Consortium partners include Elma School District, Summit Pacific Medical Center, and Elma Family Dental. The consortium partners will promote a health care system redesign at the individual and community levels.

Project Goals
The overarching goal of this program is to advance Elma Elementary School students' and families' equitable access to primary medical, dental, and mental health care and services. More specifically, the program goals include: 1. Expanding and supporting daily health care services to Elma Elementary School. 2. Delivering daily health care services through consortium members actively involved and engaged in program planning and delivery. 3. Employing evidence-informed models in the delivery of health care services to Elma Elementary School. 4. Demonstrating improved health and academic outcomes and program sustainability annually.
Expected Outcomes
Outcomes of this initiative will include: 1. Increased health care literacy among education professionals and community; 2. Increased equitable access and utilization of primary medical, mental health, and dental services; 3. Improved system of care informed by local individual and community medical, mental health, and dental concerns; and 4. A sustainable and scalable model.

Family Health Centers

Lead Organization Information			
Lead Applicant Organization Type	**Phone**	**Organization Website**	
Federally Qualified Health Center (FQHC)	509-422-5700	www.myfamilyhealth.org	
Street Address	**City**	**State**	**Email**
1003 Koala Avenue	Omak	WA	Jhernandz@fhc.us

Primary Consortium Partners		
Name	**State**	**Organization Type**
Confluence Health	Washington	Non-profit Organization
Mid Valley Hospital	Washington	Critical Access Hospital (CAH)
Encompass Home Health & Hospice	Washington	For Profit Organization

Focus Areas	
Care Coordination	Health Education/Promotion and Disease Prevention
Health Equity	Population Health
Specialty Care	Telehealth/Telemedicine

Target Population

Residents of Okanogan County, Wash., living with a chronic or serious illness that threatens the quality of life of patients and support persons. Displayed difficulty with symptom management, high risk for emergency services and hospitalization, and desire to utilize local services and support opportunities. Disproportionately, elderly, low-income homes, native American and Hispanic/Latin persons. Common diagnoses include end-stage renal disease, congestive heart failure, chronic obstructive lung disease, dementia, and cancers.

Evidence-based/Promising Practice

Community-based palliative care is specialized care for patients with serious illness delivered where patients are located. This is critical to providing care over a large, sparsely populated rural county such as Okanogan County. The utilization of a multidisciplinary team allows flexibility and best utilization of billing and provider skills. The palliative team will deliver services in clinics, through home visits, and through Critical Access Hospitals. Telehealth and follow-up telephone and electronic communication will ensure efficient and timely communication and more access to providers by clients and families. The utilization of community partners and a network of health and information systems will allow access to timely updates to care plans, and transitions of care in more knowledgeable and efficient manner through care planning and interdisciplinary teamwork. Education resources are shared through partners and community resources to provide educational opportunities to providers, partners, and community members.

Project Description

Okanogan Palliative Care Consortium (OPCC) is a partnership of community agencies formed in 2018 to realize palliative care services in Okanogan County in Washington. Palliative care is a specialized, multidisciplinary approach in care of people living with serious illness. Palliative care is appropriate for any person, at any stage of illness with symptoms or distress related to their disease process. Palliative care addresses need in multiple domains, including emotional, psychological, spiritual, and physical. OPCC has developed strong community partnerships. These partners have demonstrated an investment in the project through patient referrals and collaboration in educational outreach, shared technology platforms, and networking. OPCC has integrated with Family Health Centers as an administrative home, which allows billing and access to a shared electronic medical record system. OPCC has partnered with Honoring Choices Pacific Northwest to train community facilitators to offer advance care planning workshops, with a special focus on culturally appropriate outreach to Latin communities. Washington state Aging and Long-Term Support Administration provides resources for patient and community needs, evaluations for support services, and community education. To better serve historically marginalized communities in the county, OPCC is training community health workers at Family Health Centers in palliative care principles and is also assisting in designing a community health worker program within the Colville Confederated Tribes. Clinical services are underway, seeing four to six new patients monthly while sustaining ongoing patients until discharge. OPCC offers ongoing palliative care education to health care providers and community members through classes, on-site education, and email *Palliative Pearls* bimonthly. For providers with a particular interest in learning more, OPCC offers learning

through the Center to Advance Palliative Care (CAPC) through partnership with Confluence Health. OPCC facilitates monthly advance care planning (ACP) service to the community.

Project Goals

1. Expand palliative care access:
   - Integrate centralized electronic medical records system.
   - Establish palliative care telehealth options for patient care and education.
   - Centralize project administration within Family Health Centers.
   - Establish palliative care accessible within clinics, homes, hospitals, and residential facilities throughout the county.
   - Utilize palliative care practices that meet cultural and linguistic needs of Latin and Native American residents.
   - Recruit palliative staff and develop network.
2. Provide palliative care education to the OPCC team, partners, care providers, and community members.
   - Provide education utilizing access to books, telehealth, online courses, email, on-site offerings, and community events.
   - Utilize resources that allow for language, literacy, and individual learning requirements of community.
3. Advance care planning:
   - Provide patient and provider education and assistance with completion of documents that reflect values and beliefs, entered into medical records through direct referral and community events.
4. Create a financially sustainable community-based palliative care service:
   - Develop and grow partnerships, including existing relationships with Department of Health, HRSA, Robert Wood Johnson Foundation, and local medical systems.
   - Utilize centralized billing system, through partner, Family Health Centers

Expected Outcomes

1. Capacity building for patient volume; initiating service at 50-60 patients annually in Year 1, with an expected volume caseload increase of 50% annually.
2. Utilization of culturally appropriate service and tools in partnership with diverse community populations, including, but not limited to, language-appropriate ACP tools, disease-specific education, and integration and support of community health workers in the community.
3. Increased palliative care education opportunities to community health care service providers.
4. Community resources for aging, chronic illness, ACP, and palliative care tools using partners and community networks.
5. Growth of understanding and completion of ACP documents, and submission to medical records of provider of record.
6. Sustainability of palliative care service: Focus on reduction of costs per patient; reduction of emergency department visits and hospital admissions; reduction in avoidable spending; and new funding strategies, including partnerships, contract payments, grants, and fundraising

Family Health Council of Central Pennsylvania, Inc.

Lead Organization Information			
Lead Applicant Organization Type	**Phone**	**Organization Website**	
Non-profit Organization	717-761-7380	www.fhccp.org	
Street Address	**City**	**State**	**Email**
1003 Koala Avenue	Omak	PA	info@fhccp.org

Primary Consortium Partners		
Name	**State**	**Organization Type**
Confluence Health	Washington	Non-profit Organization
Mid Valley Hospital	Washington	Critical Access Hospital (CAH)
Encompass Home Health & Hospice	Washington	For Profit Organization

Focus Areas	
Care Coordination	Oral Health

Target Population

Low-income pregnant/post-partum women and children aged 1-5 who receive Women, Infants, and Children (WIC) services at Family Health Council of Central Pennsylvania sites in the three-county region.

Evidence-based/Promising Practice

The project, SUN Smiles, will use the Pathways program, which is rated as an effective intervention by the Rural Health Information Hub. The SUN Smiles program will follow the Pathways model as designed, focusing on the oral health pathway. The model uses local community health workers (CHWs) to provide enrollment and navigation services, and implements individualized strategies to address long-standing health problems.

Project Description

The purpose of the proposed project, SUN Smiles, is to improve dental outcomes among Family Health Council of Central Pennsylvania's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) clients in rural Snyder, Union, and North Cumberland counties. (The counties are collectively referred to as the "SUN Counties" and are located in Central Pennsylvania.) WIC clients will be routinely screened for dental need and referred to CHWs to assist with Medicaid enrollment, to help identify dental providers and make appointments, to arrange transportation, and to provide any other support that is needed to access dental care.

Project Goals

1. Reduce the proportion of adults and children with active or untreated tooth decay.
2. Increase the proportion of children, adolescents, and adults who use the oral health care system.
3. Increase the proportion of people with dental insurance.
4. Reduce the proportion of persons who are unable to obtain or are delayed in obtaining necessary dental care.
5. Reduce the proportion of children aged 1-5 who report dental problems.

Expected Outcomes

The proposed project will:

1. Reduced proportion of clients with tooth decay.
2. Increased use of the oral health system.
3. Increased proportion of clients with dental insurance.
4. Reduced proportion of people unable to obtain or delaying oral health care.
5. Reduced proportion of children aged 1-5 with dental problems.

Goshen Medical Center, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Federally Qualified Health Center (FQHC)	910-267-1942	http://www.goshenmedical.org/	
Street Address	**City**	**State**	**Email**
412 SW Center Street	Faison	NC	TMaynor@goshenmed.com

Primary Consortium Partners

Name	State	Organization Type
First Health Physician Group	North Carolina	Health Care Network
Hope Family Medicine, PLLC	North Carolina	Family Medicine Practice
Monarch	North Carolina	Mental Health Provider

Focus Areas

Heart Disease	Oral Health
Primary Care	Substance Use

Target Population

The target population is vulnerable, uninsured, underserved, low-income residents of Stanly County, with a focus on cardiovascular health, heart disease, suicide prevention, dental care, and COVID-19.

Evidence-based/Promising Practice

The Health-able Communities Program was developed to address the need to expand health care access for remote residents. Goshen Medical Center (GMC) will use a consortium of health care providers to augment traditional health care delivery services to offer a diverse set of health care offerings. The Health Wagon was developed to address the need for health care access for the medically underserved. GMC will utilize a mobile clinic that will be staffed with a provider who uses the SBIRT model (Screening, Brief Intervention, and Referral to Treatment), which is an evidence-based integrated behavioral health approach for early detection and intervention for patients at risk for depression, anxiety, alcohol and/or drug use, and suicide risk.

Project Description

Through Project HOPE, GMC will station a mobile medical, dental, and behavioral health clinic in Stanly County five days a week to provide sliding-fee health care services to vulnerable populations, including outreach, cardiovascular screenings, behavioral health screenings, dental screenings, and COVID-19 testing and vaccines when available. GMC will refer patients to FirstHealth Montgomery Memorial Hospital for specialist services, Monarch for behavioral health services, and Hope Medical Associates for evaluation of cardiovascular and heart disease patients with primary care needs that exceed the capability of GMC's mobile clinic. Consortium members will also refer patients to GMC and other consortium members, as appropriate.

Project Goals

1. Improving cardiovascular health.
2. Reducing heart disease prevalence.
3. Preventing suicide.
4. Increasing dental screenings.
5. Increasing COVID-19 testing and vaccinations.

Expected Outcomes

The expected outcome is the opening of a permanent Federally Qualified Health Center (FQHC) location in Stanly County. There is not a community health center or FQHC in Stanly County at this time, and there is only one primary care physician in this area. The focus on cardiovascular health, heart disease, suicide prevention, dental care, and COVID-19 has allowed this collaboration to explore the need for additional primary services in Stanly County. By working with the consortium partners, it is expected that the permanent location will have enough patients to justify the opening and will likely still leave a portion of the county residents served by Hope Medical. Through the consortium, all partners have shown that they can benefit from working with each other to provide better primary care services. This allows the hospital emergency department to be freed from patients coming for nonemergency concerns. This has allowed Goshen to assess that there is a need for a permanent FQHC location.

Granville-Vance District Health Department

Lead Organization Information			
Lead Applicant Organization Type	**Phone**	**Organization Website**	
Health Department	252-492-7151	www.gvph.org	
Street Address	**City**	**State**	**Email**
101 Hunt Drive	Oxford	NC	wsmith@gvdhd.org

Primary Consortium Partners		
Name	**State**	**Organization Type**
Cardinal Innovations (Now Vaya)	North Carolina	Mental Health Provider
Maria Parham Health	North Carolina	Hospital (non-CAH)
Warren County Health Department	North Carolina	Health Department
Community Care of North Carolina	North Carolina	Non-profit Organization
Children's Development Services Agency	North Carolina	Non-profit Organization
Department of Social Services (DSS)	North Carolina	Non-profit Organization
FVW Opportunity/FGV SmartStart	North Carolina	Non-profit Organization
Public Schools (Granville, Vance, Warren counties)	North Carolina	School District
Visions Behavioral Health	North Carolina	Mental Health Provider
Law Enforcement (city and county agencies)	North Carolina	Non-profit Organization
County Detention Ctrs (Granville, Vance, Warren)	North Carolina	Non-profit Organization
District Court/DA Offices (Granville, Vance, Warren)	North Carolina	Non-profit Organization
Daymark Recovery and Recovery Innovations	North Carolina	Non-profit Organization
NC Harm Reduction Coalition	North Carolina	Non-profit Organization
Correctional Behavioral Health	North Carolina	Mental Health Provider

Focus Areas	
Mental Health	Substance Use
Unintentional Injury	

Target Population

Adults and adolescents in the proposed service region who struggle with access to mental health and substance use treatment (most often those with Medicaid and those with no insurance).

Evidence-based/Promising Practice

The 2016 report of the American Psychiatric Association and the Academy of Psychosomatic Medicine on dissemination of integrated care within adult primary care settings states that there is expert consensus that all effective Collaborative Care Models share four core elements:

1. Team-driven;
2. Population-focused;
3. Measurement-guided; and
4. Evidence-based.

Moreover, the combination of these four elements provides for greater accountability and quality improvement. Collaborative Care — This model represents a combination of two evidence-based models shown to improve access to evidence-based mental health treatments for primary care patients:

1. The Collaborative Care model; and
2. Integrated core principles/elements of the evidence-based Chronic Care Model.

Project Description

The proposed approach, called Integrated Care Outreach Network (ICON), includes providing behavioral and mental health services through primary care in the designated rural region and will be implemented within the context of the consortium's evolving initiatives. By bringing mental health services to primary care, ICON believes behavioral health disorders can be normalized and treatment destigmatized, while simultaneously, access for patients can be increased by making evidence-based mental health services available in patients' regular primary care clinics. The overall population of focus will be adults and adolescents residing in the proposed region, which includes Granville, Vance, and Warren counties, and struggle with access to mental health and substance use treatment (most often those with Medicaid and those with no insurance).

Project ICON will leverage the skills and insights of the consortium to bring collaborative and sustainable solutions required to stem this epidemic by integrating all stakeholders — public health, criminal justice, human services, and the private sector. This collaborative approach will galvanize the region's stakeholders to perform as a community with the goal of incorporating multifaceted strategies, such as community education and engagement, provider training, telehealth, and multidisciplinary teamwork, which will aid the consortium in dismantling the remaining barriers to behavioral and mental health treatment and opiate use disorder prevention, treatment, and recovery.

Project Goals

1. Expand the clinical mental health workforce at one consortium site to increase access to care for low-income and uninsured adults in the targeted three-county region.
2. Create and implement a plan for clinical practice and culture change that includes collaborative care monitoring, trauma-informed care, and behavioral health integration across programs.
3. Engage stakeholders and consortium members in advocacy for policy and systems changes that would improve the quality of and access to collaborative care.
4. Work with consortium partners to assess and identify referral opportunities for youth and adolescents who struggle to access behavioral health services in the region.

Expected Outcomes

To enhance health care service delivery for the local rural and underserved population based on the needs of our region. To find and document viable pathways to care for both adults and youth in the region. Deliverables will include a strategic plan, assessment plan, sustainability plan, annual performance measures report, noncompeting continuation report, final program assessment, and final closeout report. At the close of the four-year period, improved access to collaborative care at Granville Vance Public Health and across the rural network will have been realized.

Great Mines Health Center

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Federally Qualified Health Center (FQHC)	573-438-9355	https://gmhcenter.org/	
Street Address	**City**	**State**	**Email**
1 Southtowne Drive	Potosi	MO	groeback@gmhcenter.org

Primary Consortium Partners

Name	State	Organization Type
Washington County Ambulance District	Missouri	Emergency Ambulance Service
Mineral Area College	Missouri	Community College

Focus Areas

Chronic Disease Management

Healthy Rural Hometown Initiative (HRHI)

Heart Disease

Target Population

The target population of the Mobile Integrated Healthcare (MIH) Network is adult high-need/high utilizers of emergency services at risk of or diagnosed with heart disease in Washington County, Mo.

Evidence-based/Promising Practice

Mobile integrated health care (aka community paramedicine) is the evidence-based practice that will be implemented. It will be integrated with the patient-centered medical home model, using evidence-based practices and approaches to include Million Hearts and team-based care for heart disease management; Screening, Brief Intervention, and Referral to Treatment (SBIRT); and the Plan-Do-Study-Act (PDSA) tool for quality.

Project Description

MIH is a patient-centered, innovative delivery model, offering on-demand, needs-based care and preventive services delivered in the patient's home or mobile environment. Community paramedicine is an evolving field in rural areas to reduce the use of emergency medical services (EMS) for nonemergent 911 calls, hospital emergency department utilization, and health care costs. In rural areas like Washington County, community paramedics can also fill gaps in the local delivery system due to shortages of primary care physicians and long travel times to the nearest hospital or clinic.

The partnership between Great Mines Health Center and Washington County Ambulance District is the only one of its kind in Missouri, where the ambulance district sends out a community paramedic to homes of patients to check on them and then links them to Great Mines Health Center for needed services and to serve as the patient's medical home. Joint protocols will be established with engagement of the medical directors from both organizations for preauthorized standing orders.

The MIH model maximizes use of telehealth equipment, which trained Washington County Ambulance District staff bring into the patient home to allow for real-time data documentation in Great Mines Health Center's electronic health system and for real-time visits with Great Mines Health Center's providers. These preventive measures have a significant impact on patient health and costs, and significantly reduce emergency department utilization for the patients served.

Project Goals

The goals of the MIH Network are to:

1. Test and refine the evidence-based MIH model with at least 450 individuals for heart disease, and for other leading causes of death as resources allow, within high-need/high-utilizer populations in Washington County.
2. Increase workforce education, training, and capacity that supports MIH service delivery to improve population health and lower overall costs to the health care system.
3. Develop strong relationships and partnerships between health care providers and key local, regional, and state stakeholders to further support development, sustainability, and replication of the MIH model in Missouri.

Expected Outcomes

The anticipated outcomes of the MIH Network are:

1. Improved access to and quality of health care delivery for 450 or more high-need/high-utilizer populations that lead to improved health outcomes for 100% of the target population served.
2. A new and replicable model of care for heart disease and other leading causes of death as resources allow, with demonstrated cost savings that can be replicated statewide.
3. A reduction in emergency department transports of 25% or more for heart disease (and other leading causes of death as resources allow) for high utilizers of emergency department services.
4. Improved patient engagement, self-management, and medication reconciliation of the 450 individuals to be served.
5. Reduced spread of and exposure to COVID-19 by safeguarding high-risk patients in their homes.
6. Increased enrollment in Medicaid and other forms of health insurance by the currently uninsured population as a result of recent

Health West, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Non-profit Organization	208-232-7862	https://www.healthwestinc.org/	
Street Address	**City**	**State**	**Email**
500 S. 11th Avenue Suite 400	Pocatello	ID	athomson@healthwestinc.org

Primary Consortium Partners

Name	State	Organization Type
Power County Hospital District	Idaho	Federally Qualified Health Center (FQHC)
Power County EMS	Idaho	Rural Health Clinic
Southeastern Idaho Public Health	Idaho	Health Department
The Hospital Cooperative	Idaho	Non-profit Organization
Portneuf Medical Center	Idaho	Federally Qualified Health Center (FQHC)
Health West Inc.	Idaho	Non-profit Organization

Focus Areas

Chronic Disease Management	Diabetes
Health Education/Promotion and Disease Prevention	Population Health

Healthy Rural Hometown Initiative (HRHI)

Chronic Lower Respiratory Disease	Heart Disease

Target Population

The program will serve an estimated 400-500 residents of Power County, Idaho (designated rural health provider shortage area) over the course of the program who have:

1. No primary care provider;
2. A chronic health condition such as diabetes, heart disease, etc.; and
3. Spanish as a primary language, plus condition 1 or 2.

Evidence-based/Promising Practice

Health West is a recognized patient-centered medical home (PCMH). This model of care will be expanded throughout the project, bringing the members of the collaboration together as a community medical neighborhood. The focus of the project is on total patient care and chronic disease management. The ABCs of cardiovascular care (aspirin, blood pressure control, cholesterol management, and smoking cessation) along with the Chronic Care Model (CCM) for the prevention and management of diabetes and other chronic conditions will be incorporated with culturally sensitive outreach efforts to improve health outcomes for the population in Power County, Idaho.

Project Description

Purpose: To expand the PCMH services from the local FQHC to encompass the whole county, thereby enabling a community-based program aimed toward promoting rural health care services by enhancing health care delivery to the rural underserved populations in Power County.

This project leverages and builds upon the strengths of the community to develop a network that will work through a consortium of local health care and social service providers to develop innovative approaches to challenges related specifically the health needs in the county. This new working collaboration will not only expand clinical and service capacity, it will also improve the overall wellness of the rural population.

Project Goals

The goals of the Great Rift Rural Health Network are to:

1. Reduce the prevalence of chronic disease in Power County, Idaho, through implementation of educational and outreach activities, the ABCs of cardiovascular care, along with chronic health care and diabetes management techniques.
2. Design a program through community support and driven by health care improvement goals, along with a sustainability plan, to ensure project successes carry on after project end.

3. Create a patient-centered medical neighborhood that can reach vulnerable populations and improve health outcomes through the delivery of new and enhanced services specifically targeted to the needs of the rural underserved in the county.

Expected Outcomes

By tracking the target population and the results of the community partner outreach efforts, we will determine the effectiveness of these outreach efforts, quantified as a goal of a 10% increase in participants with a Primary Care Provider within two years of project start (i.e., what programs will most effectively increase access to care for participants by 10% by 2022?). Through educational efforts regarding insurance, care options, and health care for chronic illness. By creating culturally sensitive educational approaches, this goal by can be achieved by 2022. A sustainability plan will be implemented by April 2025.

Expanding the PCMH model of care will help all members of the project consortium transition to value-based care while educating patients on self-care and self-management of their conditions. Focusing on the ABCs will improve cardiovascular health and lower the number deaths due to heart disease in the target population.

HealthIE Georgia Corp.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Non-profit Organization	706-782-0764	www.HealtHIEGeorgia.org	
Street Address	**City**	**State**	**Email**
456 Bull Frog Lane	Clayton	GA	marenfro@outlook.com

Primary Consortium Partners

Name	State	Organization Type
HealtHIE Georgia Community Center of Baxley	Georgia	Rural Health Clinic
Pineland Community Service Board	Georgia	Mental Health Provider
Bacon County Hospital and Health System	Georgia	Critical Access Hospital (CAH)
Cox Family Medicine	Georgia	Rural Health Clinic

Focus Areas

Care Coordination	Individuals with Disabilities
Mental Health	Maternal and Child Health
Primary Care	Substance Use

Target Population

The consortium serves a medically underserved five-county region facing high rates of poverty, unemployment, and a lack of health insurance. Low-income levels, geographic isolation, and lower-than-average educational attainment levels all impact overall health, wellness, and quality of life in this medically underserved region. The Southeast Georgia five-county region includes Appling, Bacon, Clinch, Jeff Davis, and Wayne counties. This population is 100% rural, and 100% a Medically Underserved Area. The consortium serves the following subpopulations: individuals with disabilities, pregnant women, and children and adolescents.

Evidence-based/Promising Practice

The consortium will utilize a rural health model, Community Outreach Intervention Network Services (COINS), designed by the project director, Dr. Knicole Lee, to address the need for a broad consortium-based intervention model for rural at-risk patients based on 15 years of experience practicing primary care in rural Georgia as a family nurse practitioner. The COINS model incorporates numerous evidence-based care delivery strategies supported by the What Works for Health online resource, released by the Robert Wood Johnson Foundation in 2016, including behavioral health primary care integration, telemedicine, and tele–mental health services.

Project Description

The proposed project will increase public awareness of available health care services in the five-county region, expand behavioral health offerings, and leverage telehealth opportunities to meet local needs and enhance coordination and communication among consortium providers.

Access to affordable, quality health care is important to physical, social, and mental health. High-quality care in outpatient and inpatient settings can help protect and improve health and reduce the likelihood of receiving unnecessary or inappropriate care. However, such care can be harder to attain in rural areas than in urban or suburban communities. Adopting and implementing strategies that reduce barriers to care and better match providers to community needs can increase access to high-quality care.

Project Goals

1. Expand the delivery of health care services to include new and enhanced services.
2. Deliver health care services through a strong consortium in which every consortium member organization is actively involved and engaged in the planning and delivery of services.
3. Utilize community engagement and evidence-based or innovative, evidence-informed models in the delivery of health care services.
4. Improve population health and demonstrate health outcomes and sustainability.

Expected Outcomes

1. Increase the proportion of children with developmental delays who get intervention services by age 4.

2. Reduce the proportion of adults with disabilities who experience serious psychological distress.
3. Reduce the proportion of adults with disabilities who delay preventive care because of cost.
4. Increase the proportion of people with substance use disorder and mental health disorders who get treatment for both.
5. Increase the proportion of children and adolescents with symptoms of trauma who get treatment.
6. Increase the proportion of adults who get recommended evidence-based preventive health care.
7. Increase the proportion of adolescents who had a preventive health care visit in the past year.
8. Increase the proportion of people with a usual primary care provider.
9. Increase the proportion of adults whose health care provider checked their understanding of the information provided.
10. Increase the use of telehealth to improve access to health services.

Healthy Acadia

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Non-profit Organization	207-667-7171	https://www.healthyacadia.org/	
Street Address	**City**	**State**	**Email**
140 State Street	Ellsworth	ME	caroline.bloss@healthyacadia.org

Primary Consortium Partners

Name	State	Organization Type
Eastern Maine Medical Center	Maine	Hospital (non-CAH)
Northern Light Maine Coast Hospital	Maine	Hospital (non-CAH)
Northern Light Blue Hill Hospital	Maine	Critical Access Hospital (CAH)
Mount Desert Island Hospital	Maine	Critical Access Hospital (CAH)
Down East Community Hospital	Maine	Critical Access Hospital (CAH)
Pleasant Point Health Center	Maine	Federally Qualified Health Center (FQHC)

Focus Areas

Maternal and Child Health	Substance Use
Infant Health & Early Childhood Health	

Target Population

The PROSPER Initiative serves women, children, and families in a two-county, 100% rural region of eastern Maine: Hancock and Washington counties. The target population is 100 women with substance use disorder (SUD) during the pre-, peri-, and postnatal periods surrounding the births of their babies. Within that is the other target population: the babies and young children themselves.

Evidence-based/Promising Practice

PROSPER is adopting the Substance Exposed Infants framework, medication-assisted treatment, care navigation, and multiple evidence-based clinical and education and training intervention strategies, including Eat, Sleep, Console; Neonatal Resuscitation Program (NRP); and STABLE (which stands for the six assessments and care modules of the program: sugar, temperature, airway, blood pressure, lab).

Project Description

The PROSPER Initiative is designed, implemented, and delivered across Hancock and Washington counties by a collaborative partnership comprising Healthy Acadia, Northern Light Eastern Maine Medical Center, Northern Light Blue Hill Hospital, Northern Light Maine Coast Hospital, Mount Desert Island Hospital, Down East Community Hospital, Maine Families, and Pleasant Point Health Center. Working together, PROSPER partners will improve care coordination among partnering hospitals and other sites while also creating a community health navigation team to provide compassionate, person-centered navigation, mentoring, guidance, education, advocacy, referrals, and more across the service area. Further, the initiative provides training to professionals, families, and community members to increase understanding and awareness of the specific needs of pregnant and parenting women with SUD.

Project Goals

1. Develop and steward the PROSPER Consortium, in alignment with the existing, community-based Downeast Substance Treatment Network (DSTN), ensuring a strong, multisector, collaborative committed to building and sustaining the project from May 1, 2021, through April 30, 2025.
2. Implement the community health navigation team to expand and improve pre-, peri-, and postnatal and early childhood systems, services, and outcomes for families with SUD and their children (from pregnancy through age 3) by June 2021.
3. Implement clinical, family, and community trainings and education to expand and improve pre-, peri-, and postnatal and early childhood systems, services, and outcomes (from pregnancy through age 3) from Aug. 1, 2021, through April 30, 2025, to benefit at least 200 mothers with SUD, at least 200 babies, and their families.
4. Improve care coordination among partnering hospitals and health centers in order to improve pre-, peri-, and postnatal and early childhood systems, services, and outcomes for families with SUD and their children (from pregnancy through age 3) from Oct. 31, 2021, through April 30, 2025, to benefit at least 200 mothers with SUD, at least 200 babies, and their families.

Expected Outcomes

The PROSPER intervention strategies aim to improve outcomes for women with SUD and their babies across key domains of interest including access to care; health promotion and disease management; mental/behavioral health; education, training, and outreach; prevention; service delivery and utilization; and developmental, health, and well-being outcomes.

Priority outcomes include:

1. Improved pre-, peri-, and postnatal health outcomes for mothers;
2. Healthier babies at birth and throughout the early childhood years;
3. Greater success in sustaining SUD recovery for mothers;
4. Increased protective factors and resilience for mothers and children, thereby setting the foundation for greater health and well-being throughout their lives; and
5. Improved social determinants of health for families.

Healthy Communities Coalition of Lyon and Storey Counties

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Non-profit Organization	775-246-7550	www.healthycomm.org	
Street Address	**City**	**State**	**Email**
209 Dayton Valley Road	Dayton	NV	roots@healthycomm.org

Primary Consortium Partners

Name	State	Organization Type
Nevada Health Centers Inc.	Nevada	Federally Qualified Health Center (FQHC)
Dayton Pediatric Dentistry	Nevada	Dental Provider
South Lyon Medical Center	Nevada	Critical Access Hospital (CAH)

Focus Areas

Diabetes	Health Education/Promotion and Disease Prevention
Primary Care	Oral Health
Telehealth/Telemedicine	Food Pantries

Target Population

The target population for oral health are students K–12, adults and their families who are low-income, and at-risk students in Lyon County who are uninsured or underinsured. The target population for primary care coordination and connections are clients within each of the three Healthy Communities Coalition (HCC) food pantries, many of whom are low-income, uninsured, underinsured, or homebound. The target population for outreach clinics and health fairs is inclusive of individuals of all ages, as well as migrant farm workers and their families in Yerington, Silver Springs, and Dayton who have difficulty accessing health care resources.

Evidence-based/Promising Practice

The Hub approach for this initiative is supported by many different evidence-based practices, and studies including Caring School Community; Communities That Care; Coordinated, Intensive Medical, Social, and Behavioral Services; integration of behavioral health team and consulting psychiatrist; Cardiovascular Disease: Interventions Engaging Community Health Workers; Mental Health First Aid; motivational interviewing; Project Success (school-based prevention and treatment program); and community health workers.

Project Description

The purpose of this project is to continue to support and evolve the Health and Wellness Hub (HWH). The HWH is a consumer-centered school and community-based hub that coordinates the delivery of health care and social services for all members of the community, including the most vulnerable. Decision-makers and leadership from the schools, providers, county agencies, and community-based nonprofits comprise the HWH. The HWH has the infrastructure to connect individuals and families to health and social services that are evidence-based and/or documented as high-quality, while avoiding duplication of services. Through this project, HCC, in conjunction with the Rural Nevada Health Network (RNHN), is leveraging existing partnerships to pair pantry clients to a Federally Qualified Health Center primary care physician via telehealth. This grant supports the HWH so that all available resources are utilized and leveraged for enhancing health care delivery in rural Nevada communities so that population health flourishes and collaboration is the norm amongst all — local, regional, and state — providers in the county. This involves a deepening of partnerships within HCC to implement a comprehensive patient-centered health system throughout Lyon County, Nev. This system, which utilizes community health workers and resource coordinators as the central engines for health care service delivery, begins with prevention and has wellness as an outcome. To achieve this, HCC is implementing the following evidence-based practices: promotora or lay health workers, care coordinator/managers, community organizer and capacity builders, as well as members of care delivery teams. To continue building on its demonstrated achievements thus far, HCC will continue its role as the primary convener and organizing influence of the Health and Wellness Hub.

Project Goals

1. This project aims to improve the quality of health care delivery in rural areas through strengthened collaboration and coordination by coordinating and facilitating local meetings of stakeholders, partners, and coalition members to improve access to and quality of health care provided in rural areas.

2. This project aims to leverage community health workers (CHWs) and partner agencies to expand the quality and delivery of health care services to food pantry clients in Lyon County.
3. This project aims to broaden delivery of health care services via outreach events in Lyon County.

Expected Outcomes

The expected outcomes for this program are to enhance the rural health delivery model of care in Lyon County. The expected outcome on the target population will be to increase the number of children and adults who receive sealants, varnish, and dental health education, while decreasing the number of children with cavities in targeted schools. Through the telehealth portion of this program, HCC expects to see an increased number of homebound food pantry clients referred to telehealth and receiving services. HCC also expects to see an increase in insurance coverage, as CHWs frequently help connect people to insurance through care coordination services. The work with UNR Medical School and their rural outreach clinics at the food pantry locations also gives food-insecure populations the opportunity to be referred to a medical provider and become an established patient with a care provider through a UNR medical school student who is overseen by a preceptor. The committed membership of both the RNHN and the HWH serves to strengthen connections between partner agencies, focusing on the needs of local rural populations.

Heartland Rural Health Network, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Rural Health Clinic	863-494-8409	www.hrhn.org	
Street Address	**City**	**State**	**Email**
425 S. Pine Street	Sebring	FL	valeria.rivera@hrhn.org

Primary Consortium Partners

Name	State	Organization Type
Vince Sica	Florida	Hospital (non-CAH)
Danyiell Tanner	Florida	Rural Health Clinic
Kristin Casey	Florida	Health Department
Denise Grimsley	Florida	Hospital (non-CAH)
Sheila Hernandez	Florida	Rural Health Clinic

Focus Areas

Care Coordination	Primary Care
Telehealth/Telemedicine	

Target Population

The target population of the Hardee-DeSoto Community Health Worker (HD CHW) Program is the minority population, including the Hispanic/Latin, a subset of the minority population, of Hardee and DeSoto County, with a particular emphasis on those 18-64 years of age.

Evidence-based/Promising Practice

The HD CHW Program will utilize the following evidence-based/promising practice model: FORHP evidence-based toolkit Rural Care Coordination using community health workers (CHWs) as care coordinators with the enhancements of custom initial assessments, personalized case management that includes periodic check-ins utilizing motivational interviewing and warm hand-offs for clinical and nonclinical needs. To achieve this goal, we will utilize a complementary set of strategies to include:

1. Decreasing barriers to health care;
2. Appropriate health resource utilization with CHW-supported navigation;
3. Increasing quality of care across participating health care providers;
4. Creating opportunities for positive changes;
5. Improving health communication in the target population; and
6. Addressing long-term sustainability and viability.

Project Description

The goal and purpose of the HD CHW Program is to empower and support the target population to improve access to care while making it easier for the target population to navigate the appropriate channels to receive all needed and requested care, improving their overall impression of their current health status.

Project Goals

1. Heartland Rural Health Network staff will conduct heavy outreach efforts and marketing throughout Hardee and DeSoto counties during the first three months of the grant to generate self-referrals to the program.
2. Enrolled patients needing additional services, whether they are clinical or nonclinical, will be referred to the appropriate consortium partner, or if no partner has been identified for the needed service, the CHW will assist in any way possible to provide appropriate assistance.
3. Periodic follow-up surveys will ask if the patient feels that there has been an improvement in the quality of care they are receiving in the community compared to before and since joining the program.

Expected Outcomes

1. One hundred percent of newly enrolled patients find care through one of the pathways of care (annually). Benchmark: 12 patients per month.
2. Fifteen percent or less of newly enrolled patients report experiencing barriers to care utilizing referred pathway (annually).

3. Seventy-five percent of enrolled patients report getting wellness check annual exams (end of Year 1, increasing by 5% every year to reach 90% by end of Year 4).
4. Seventy-five percent of enrolled patients who report being pregnant during their first trimester to their CHW received early prenatal care (annually).
5. One hundred percent of enrolled patients are aware of the importance of prenatal care and the pathways of care we have for prenatal care (annually).
6. One hundred percent of enrolled patients identifying as current tobacco users are referred to cessation classes.
7. Ten percent decrease in emergency department misutilization by target population (annually).
8. Sixty-five percent of enrolled patients report establishing a primary care provider through the HD CHW Program (annually).
9. Seventy-five percent of enrolled patients report an increase in the quality of care they are receiving in the community compared to before the program (annually).

Horizon Behavioral Health

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Mental Health Provider	434-948-4831	www.horizonbh.org	
Street Address	**City**	**State**	**Email**
2215 Langhorne Road	Lynchburg	VA	jennifer.smith.ramey@horizonbh.org

Primary Consortium Partners

Name	State	Organization Type
20th District Adult Probation and Parole	Virginia	Law Enforcement Agency
Bedford County Department of Social Services	Virginia	Mental Health Provider
Amherst County Department of Social Services	Virginia	Mental Health Provider
Blue Ridge Regional Jail Authority	Virginia	Law Enforcement Agency

Focus Areas

Mental Health | Substance Use

Target Population

Adults aged 18 and older with a serious mental illness (SMI) or SMI and substance use disorder (SUD) residing in Amherst County or Bedford County, Va. We propose to serve 30 clients in Year 1, and 40 clients in years 2-4.

Evidence-based/Promising Practice

Illness Management and Recovery (IMR) is an evidence-based practice designed to provide clients with an SMI or SMI-SUD diagnosis the knowledge and skills necessary to cope with aspects of their mental illness while maintaining and achieving goals in their recovery. IMR is a curriculum in which a trained mental health practitioner uses psychoeducation, behavioral tailoring, relapse prevention training, and coping skills training to assist in symptom management and goal formulation. There will not be modifications to the model.

Project Description

The consortium will use cross-sector community collaboration to deliver the evidence-based IMR model to adults with SMI or SMI-SUD. This project addresses two broad population health goals: to increase years of life and the quality of those life years (i.e., a personal sense of physical and mental health and the ability to react to factors in the physical and social environments) and to reduce the disparities in health outcomes among adults with an SMI or SMI-SUD, including subgroups that are associated with significant disparities in both mortality and health-related quality of life (i.e., race/ethnicity, socioeconomic status (SES), gender, and geography). Horizon proposes to enhance the delivery of health services in Amherst and Bedford counties by expanding service capacity through an innovative approach that combines empirically supported cross-sector collaboration models with evidence-based mental health and substance use treatment. IMR is an evidence-based practice.

Project Goals

This project addresses two broad population health goals: (1) to increase years of life and the quality of those life years (i.e., a personal sense of physical and mental health and the ability to react to factors in the physical and social environments) and (2) to reduce the disparities in health outcomes among adults with an SMI or SMI-SUD, including subgroups that are associated with significant disparities in both mortality and health-related quality of life (i.e., race/ethnicity, SES, gender, and geography). Horizon proposes to enhance the delivery of health services in Amherst and Bedford counties by expanding service capacity through an innovative approach that combines empirically supported cross-sector collaboration models with evidence-based mental health and substance use treatment.

Expected Outcomes

The goals of IMR are:

1. For clients to learn about mental illnesses and strategies for treatment.
2. Client understanding the illness, including symptoms, possible course, and probable long- and short-term outcomes.
3. Medication education, medication adherence, and symptom management.
4. Reducing relapse and rehospitalizations by identifying early warning signs and developing a relapse prevention plan.
5. Learning to create networks of social support to enhance recovery.

6. Learning coping strategies for persistent symptoms. IMR's expected outcomes include increased social connection with peers, increased awareness of recovery as a personal experience, and increased utilization of coping skills.

Intermountain Health Care, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Hospital (non-CAH)	801-442-4541	https://intermountainhealthcare.org	
Street Address	**City**	**State**	**Email**
5171 S. Cottonwood Street, Bldg 1 No. 400	Murray	UT	sarah.diefendorf@imail.org

Primary Consortium Partners

Name	State	Organization Type
Cassia Regional Hospital	Idaho	Critical Access Hospital (CAH)
Intermountain Cassia Regional Hospital Paramedics	Idaho	Critical Access Hospital (CAH)
Family Health Services Corp.	Idaho	Federally Qualified Health Center (FQHC)
South Central Public Health District	Idaho	Health Department

Focus Areas

Care Coordination	Chronic Disease Management

Healthy Rural Hometown Initiative (HRHI)

Chronic Lower Respiratory Disease	Heart Disease

Target Population

The target population is all residents in Cassia County, Idaho, a HRSA-designated rural county. Project REACH focuses on community members who are low-income, uninsured, or use Medicaid. It is anticipated that 250 eligible patients will be enrolled annually.

Evidence-based/Promising Practice

Project REACH will use its evidence-based implementation, informed in part by the community needs assessment conducted in Year 1. This evidence-based implementation includes three evidence-based/promising practices:

1. Community paramedicine;
2. Community health workers (CHWs); and
3. Teach-back Toolkit.

The community paramedicine program is led by the CHW, a licensed paramedic. The hospital's electronic health records flag emergency department (ED) visits, and if a resident qualifies the resident is referred to the program. This includes residents with heart disease and/or chronic lower respiratory disease (CLRD) with more than two inpatient stays in 24 months for a related condition or more than two ED visits in the last 24 months for a related condition. Residents who are identified as being a more moderate risk are referred to the care coordination program. The CHW will follow up with any referral within 48 hours of discharge. Telehealth is used to support the care continuum by providing access to specialists via telehealth either at Family Health Services Corp. or within the resident's home.

Project Description

Project REACH comprises a community paramedicine project and a care coordinator project. It provides services for Cassia County residents with poor health outcomes as a result of heart disease and CLRD. When a resident presents with either of these chronic health conditions at Cassia Regional Hospital, Family Health Services Corp., or South Central Public Health District, they are referred to the Project REACH coordinator, who links them to appropriate services.

Residents are categorized as being at high or medium risk based on the number of in-residence stays and/or ED visits they have had in the last 24 months as a result of heart disease and/or CLRD. High-risk residents are connected to the CHW for enrollment in the community paramedicine program, which consists of home visits from the CHW. Medium-risk residents are admitted to the community care coordination program and receive phone calls from the CHW. Those enrolled in both projects receive a review of discharge instructions and medications, disease-management education, assistance with medication adherence, specialty and primary care appointment scheduling help, and appointment follow-ups. The CHW ensures the resident's home is safe from hazards and that they have access to food. Those in need of a medical home are referred to and enrolled with the Family Health Services

Corp., where they can also receive specialty medical care via telehealth. Tools and materials are also created as needed (e.g., resident information cards, referral forms, etc.). Through Project REACH, the following social determinants of health may also be addressed: income, health literacy, primary language, ethnicity, sexual orientation or gender identity, access to transportation, access to telehealth at home, living arrangements, insurance status, homelessness, and more.

Project Goals

Project REACH is designed to improve the health outcomes of those with heart disease and CLRD in the target area. Project REACH is designed to engage participants in chronic disease management, thereby improving their overall health while reducing their ED utilization and the 30-day readmission rates for this population.

Goal: Reduce health disparities related to heart disease and CLRD in Cassia County, Idaho. The goal will be achieved through the following objectives:

1. Throughout the project period, expand the delivery of health care services through community engagement and a strong consortium in which every member (new and existing) is actively involved and engaged in the planning and delivery of paramedicine services in rural Cassia County.
2. In years 2-4, improve population health and resident health outcomes through implementing evidence-based or innovative, evidence-informed models.
3. Beginning in Year 2, demonstrate sustainability through cost savings and reduced hospital admission rates, preventable ED visits, and increased Medicaid billing capacity.

Expected Outcomes

Project REACH will reduce inappropriate ED utilization, reduce the 30-day readmission rates for heart disease and CLRD residents at Cassia Regional Hospital, improve blood pressure control, and increase workforce training in the target area.

1. Thirty-day readmission rates related to heart disease at Cassia Regional Hospital will be reduced from 11.7% to 6.5% by the end of Year 4 project period.
2. Thirty -day readmission rates related to CLRD at Cassia Regional Hospital will be reduced from 12.3% to 6.5% by the end of Year 4 project period.
3. ED visits related to heart disease at Cassia Regional Hospital will be reduced by 2% in Year 2, 4% in Year 3, and 6% in Year 4 (baseline 5486 (2019).
4. Eighty percent of patients 18-85 years of age who had a diagnosis of hypertension and who remain in the program at least 90 days will have an adequately controlled blood pressure.

James Madison University

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Academic Institution	540-568-1735	www.jmu.edu	
Street Address	**City**	**State**	**Email**
755 Martin Luther King Jr. Way	Harrisonburg	VA	atwoodkc@jmu.edu

Primary Consortium Partners

Name	State	Organization Type
Valley Health Page Memorial Hospital (PMH)	Virginia	Critical Access Hospital (CAH)
PMH Free Clinic	Virginia	Non-profit Organization
PMH Rural Health Clinic	Virginia	Rural Health Clinic

Healthy Rural Hometown Initiative (HRHI)

Substance Use	Unintentional Injury

Target Population

The project focuses on residents of Page County, Va., with an emphasis on addressing barriers to services for minority and marginalized persons.

Evidence-based/Promising Practice

1. Medication-assisted treatment (MAT)
2. Cognitive behavioral therapy (CBT)

Project Description

The Interprofessional MAT Expansion Rural (IMATER) initiative will promote rural health care services through training and will enhance service delivery by increasing access to MAT services in Page County, Va., a Health Professional Shortage Area for the discipline of mental health. James Madison University will partner with a federally designated rural health care clinic and the Page Free Clinic to provide counseling and nursing services required to maintain and increase access to MAT services offered by Valley Health Page Memorial Hospital physicians. In addition, the IMATER initiative will produce and disseminate professional development modules to students and professionals related to rural interprofessional primary and behavioral health care.

Project Goals

1. Increase access to MAT services for substance use by increasing CBT services and nursing care coordination services in Page County.
2. Significantly improve health outcomes and reduce the use of other medical services.
3. Increase the number of mental health and nursing service providers in rural Health Professional Shortage Areas.

Expected Outcomes

1. Establishment of a network of supporting treatment services in and around the local community.
2. A 114% increase in the number of individuals receiving MAT services.
3. An increase in the number of individuals from minority and marginalized groups receiving MAT services.
4. IMATER participants demonstrating a 75% reduction in the utilization of other medical services.
5. IMATER participants demonstrating a 50% reduction in health care costs.
6. Seventy-five percent of professional service providers who complete the professional development modules demonstrating improved knowledge of rural health and interprofessional primary and behavioral health care.
7. Fifty percent of professional service providers completing the training modules reporting an increase in willingness to provide services to rural areas.

Lake County Tribal Health Consortium, Inc.

Lead Organization Information			
Lead Applicant Organization Type	**Phone**	**Organization Website**	
Rural Health Clinic	707-263-8382	www.lcthc.com	
Street Address	**City**	**State**	**Email**
925 Bevins Court	Lakeport	CA	gaustin@lcthc.org

Primary Consortium Partners		
Name	**State**	**Organization Type**
La Voz de Esperanza Centro Latino	California	Mental Health Provider
Lake County Office of Education	California	School District

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

Target Population

Native American, Spanish-speaking, and bilingual clients of Lake County Tribal Health, La Voz de la Esperanza Centro Latino, or Lake County Office of Education will participate. The project is open to the elderly, low-income, minority, trauma-exposed, and rural underserved populations. The plan is to recruit 50 participants annually and enroll them in the evidence-based Chronic Disease Self-Management Program (CDSMP) and Diabetes Self-Management Program, with approximately 200 total participants enrolled throughout the grant with 140 completing (70% completer goal).

Evidence-based/Promising Practice

The project utilizes the evidence-based Stanford-Lorig Chronic Disease Self-Management Program (CDSMP) and Diabetes Self-Management Program as its centerpiece. This will be supported by evidence-based after-care programs: Walk with Ease, What Can I Eat, HomeMeds, the Path to Forgiveness, and REACH curricula.

Project Description

The project utilizes the evidence-based Stanford-Lorig Chronic Disease Self-Management Program (CDSMP) and Diabetes Self-Management Program and after care to provide opportunity for tribal, Latin, trauma-exposed, and other underserved populations to better manage chronic health conditions, such as diabetes, heart disease, asthma, cancer, etc. The project fills a gap in local services for the Latin community to benefit from high-quality, evidence-based health services in their own language. The project aligns with Tribal Health's mission to promote positive changes in the physical, spiritual, emotional, and social health status of the Native population and communities they serve through culturally sensitive health care services.

Project Goals

1. Promote equitable standard of care among underserved populations by significantly increasing access for tribal (Indian/Alaska Natives) and Latins, including rural/displaced with comorbidities, and trauma-exposed patients, to the Chronic Disease Self-Management Education (CDSME) Programs.
2. Those among these underserved populations who complete CDSME and after-care programs will increase their physical activity, improve social connections, and demonstrate improvement and/or maintenance in clinical health measures of A1c, weight, and/or blood pressure.

Expected Outcomes

In general, a reduction of health disparities among tribal, Latin, trauma-exposed, and other underserved subgroups is anticipated. Outcomes would facilitate efficacy in managing chronic conditions and providing linkage to resources that address basic needs and create opportunity for social and cultural connection. Positive changes in health will be evidenced by A1c and blood pressure measures, as well as weight maintenance.

Louisiana Rural Health Association

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Non-profit Organization	985-369-3813	https://lrha27.wildapricot.org/	
Street Address	**City**	**State**	**Email**
133 Highway 402 / P.O. Box 387	Napoleonville	LA	fontenot@lrha.org

Primary Consortium Partners

Name	State	Organization Type
T-Cell Analytics	Louisiana	LLC – Rural Healthcare Strategic Consulting
Louisiana Tech University	Louisiana	Public Research University
Fragments	Louisiana	LLC – Marketing and Best Practices

Focus Areas

Diabetes

Healthy Rural Hometown Initiative (HRHI)

Heart Disease

Target Population

The target patient population for this project is patients 18 and older diagnosed with diabetes mellitus or heart disease, as defined by the provided ICD-10 codes, enrolled in chronic care management programs in collaborating rural health clinics throughout Louisiana.

Evidence-based/Promising Practice

Telehealth, chronic care management, and quality improvement in chronic care management

Project Description

The Louisiana Rural Health Association (LRHA) recognized the need to improve rural clinics' capacity to adapt to the growing telehealth environment long before COVID-19. Therefore, LRHA partnered with T-Cell Analytics, Louisiana Tech University, Fragments, LLC, and more than 120 rural health clinics, long-term care facilities, and schools to improve rural Louisiana's telehealth infrastructure. The partnership has received nearly $1.75 million in funding from the USDA and the Delta Regional Authority (DRA) to purchase telehealth equipment and provide staff training on telehealth basics and the virtual chronic disease–management program. Over 24% of the 160 rural health clinics in Louisiana have agreed to participate in the telehealth project.

In addition, we will add a layer of data analytics and quality improvement to chronic care management services provided by Louisiana Tech University, along with expanded patient education resources. Our statewide project includes the following rural parishes: Allen, Avoyelles, Beauregard, Bienville, Caldwell, Cameron, Catahoula, Claiborne, Concordia, East Carroll, Evangeline, Franklin, Jackson, Jefferson Davis, La Salle, Lincoln, Madison, Morehouse, Natchitoches, Red River, Richland, Sabine, St. Landry, St. Mary, Tensas, Vernon, Washington, Webster, West Carroll, and Winn. All of the parishes identified are defined as rural by the HRSA Rural Health Analyzer. Using the data generated through quality improvement processes, the providers can improve patient compliance with chronic disease–management services and identify at-risk individuals needing additional intensive services.

Project Goals

1. Generate actionable quality improvement data by using analytics to identify hypertensive and diabetic patients at rural health provider clinics who are not fully benefiting from chronic disease management and/or realizing improved outcomes.
2. Implement strategies to target patients not fully benefiting from chronic disease–management programs and increase engagement in their care.
3. Improve heart disease outcomes across Louisiana.

Expected Outcomes

1. Actionable quality improvement data that can identify hypertensive patients at participating rural health clinics who could benefit from chronic care management.
2. Patients who are engaged in their care through telehealth technology.
3. Improved hypertension outcomes across Louisiana.

MaineHealth Care at Home

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Non-profit Organization	800-660-4867	www.mainehealthcareathome.org	
Street Address	**City**	**State**	**Email**
15 Industrial Park Road	Saco	ME	rabel@mhcah.org

Primary Consortium Partners

Name	State	Organization Type
Coastal Healthcare Alliance	Maine	Hospital (non-CAH)
Spectrum Generations – Healthy Living for ME	Maine	Non-profit Organization

Focus Areas

Care Coordination	Chronic Disease Management
Chronic Lower Respiratory Disease	Health Education/Promotion and Disease Prevention

Target Population

Project COPD intends to serve adults living in the Maine counties of Knox and Waldo who are diagnosed with chronic obstructive pulmonary disease (COPD) with associated risk factors that indicate an increased probability of hospital readmission and/or emergency department utilization. This region of coastal Maine has a population that is older than the state average (which is the nation's highest) and lives in rural areas with higher rates of chronic disease, including chronic-obstructive pulmonary disease.

Evidence-based/Promising Practice

The project will employ a variation/combination of the Coleman Care Transitions Intervention model and the COPD Readmission Prevention Program that demonstrated efficacy at Genesis HealthCare System in Zanesville, Ohio. Additional models to be utilized are from Project Enable (palliative care/telehealth), the National Consensus Project (palliative care), and Living Well with COPD (via MaineHealth).

Project Description

Project COPD represents a collaborative effort between a regional home health and hospice agency, MaineHealth Care at Home; the regional health system, Coastal Healthcare Alliance; and the regional Area Agency on Aging, the Central Maine Area Agency (CMAAA) on Aging. The project intends to implement a number of evidence-based practices and models through a joint delivery method with the intention of reducing the rate of hospitalization and emergency department utilization while improving quality of life and health outcomes for people diagnosed with COPD in the rural Knox and Waldo counties of Maine.

Palliative care nurse practitioners from Coastal Healthcare Alliance will work together with home health care nurses and administrative staff to identify, track, and provide wraparound services to qualifying patients with the oversight of a physician. Service delivery will be supported by a nurse navigator who will assist patients and families through transitions of care. In addition, self-guided chronic disease–management tools will be made available to all enrolled patients through the Central Maine Area on Aging's Chronic Disease Self-Management Program under Healthy Living for ME, an entity of the agency.

Project Goals

1. Improve the quality of health care services available to patients with COPD residing in underserved rural areas of Knox and Waldo counties.
2. Establish the efficacy of a COPD nurse navigator program in facilitating seamless transitions of care across health settings by hiring a dedicated registered nurse into this role to track the patient through their care plan.
3. Expand access to innovative telehealth technology for patients discharged from home health services through continued monitoring.
4. Improve access to palliative care throughout the disease trajectory by connecting patients to home health care nurses and palliative care nurse practitioners concurrently.
5. Enhance current COPD patient and caregiver training efforts offered by consortium partner CMAAA.
6. Develop strategic plan, assessment, and reporting/sustainability for palliative services in the region to improve the long-term availability of the service.

Expected Outcomes

Reduced rate of hospital admissions and emergency department utilization due to exacerbation of COPD.
Improved timeliness of hospice admissions for patients with end-stage COPD and/or completed advance directives. Increase in the number and percentage of home health patients receiving palliative care consultations. Increase in the number of patient referrals and visits to physicians, outpatient clinics, and behavioral health services. Increased number of referrals to Center for Tobacco Independence smoking cessation services and other community health resources. Increased success in providing seamless transitions of care across health settings. Definition of an effective model of care utilizing home-based palliative care, nurse navigation, and telehealth for replication in treating chronic care illness.

MaineHealth

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Health Department	207-779-3136	https://www.mainehealth.org/franklin-community-health-network	
Street Address	**City**	**State**	**Email**
105 Mt. Blue Circle, Suite 1	Farmington	ME	tharty@fchn.org

Primary Consortium Partners

Name	State	Organization Type
NorthStar Emergency Medical Services	Maine	Health Department
Western Maine Community Action	Maine	Non-profit Organization
St. Joseph's Parish	Maine	Non-profit Organization
Rangeley Region Health and Wellness Partners	Maine	Non-profit Organization
HealthReach Community Health Centers	Maine	Federally Qualified Health Center (FQHC)

Focus Areas

Care Coordination	Chronic Disease Management
Health Education/Promotion and Disease Prevention	Health Screenings
Population Health	Telehealth/Telemedicine

Target Population

The target population includes poor, rural, and medically underserved individuals who face significant challenges in accessing community resources and health care, particularly the isolated rural elderly and those with one or more chronic illnesses. The service area includes Franklin County and nine surrounding towns in four other counties.

Evidence-based/Promising Practice

The project is based on several national models and tools, including (1) the National Association of Emergency Medical Technicians (NAEMT) Mobile Integrated Toolkit. (2) Abbeville County, S.C., Community Paramedic Program. (3) Minnesota Ambulance Association: Community Paramedicine. (4) The Principals of Establishing a Mobile Integrated Healthcare Practice toolkit developed by the Mobile Integrated Healthcare Practice Collaborative. (5) Lonely No More is a program of the Gateway Center of Excellence in Rural Health in Goderich, Ontario. (6) The Penn Center for Community Health Workers. (7) North Country Health Consortium, in New Hampshire.

Project Description

Healthy Community Coalition (HCC), in coordination with the Rural Health Action Network (RHAN) of greater Franklin County, will implement a multifaceted outreach program to improve health outcomes among the rural poor living with chronic conditions in greater Franklin County, Maine. The project will (1) enhance quality and improve access to new and existing community and health care resources; (2) expand and strengthen trainings for community health extenders, and expand and stabilize a highly skilled workforce to meet the unmet needs of Franklin County's most vulnerable populations; (3) improve overall health and well-being for vulnerable populations in Franklin County, as demonstrated by improved health outcomes and community impact and measured by decreased hospitalizations, reduced emergency department visits, and reduced costs of health care; and (4) promoting program sustainability through collaboration, shared communication, and community capacity building.

RHAN's mission to coordinate and improve the quality of and access to essential health care and social services in greater Franklin County, and its vision to evolve, adapt, and respond to changing health care needs and trends in the region, align directly with program goals. Network members are fully engaged, meet and communicate regularly, and will contribute to project activities in order to achieve outcomes.

Project Goals

1. Expand the delivery of health care services to include new and enhanced services exclusively in rural communities.
2. Deliver health care services through a strong consortium in which every consortium member organization is actively involved and engaged in the planning and delivery of services.

3. Utilize community engagement and evidence-based or innovative, evidence-informed models in the delivery of health care services.
4. Improve population health and demonstrate health outcomes and sustainability.

Expected Outcomes

The goals, objectives, and expected outcomes of the project will result in expanded access to quality services; expanded training for community health extenders; and decreased hospital admissions, emergency department use, and costs. The project will lead to improved communication and care coordination across project partners. The project anticipates a reduction in health care costs resulting from reduced hospital readmissions and emergency department use. Cost reduction across partner organizations is expected through shared services and reduction in service overlap and duplication. The overarching long-term impact of the proposed program will be improved health outcomes and health status of the most vulnerable populations in the target area, achieved through improved access to essential health care and social services, and a coordinated and collaborative approach to an enhanced rural health care delivery system.

Mainline Health Systems, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Federally Qualified Health Center (FQHC)	870-538-5414	www.mainlinehealth.net	
Street Address	**City**	**State**	**Email**
223 North Main Street	Portland	AR	aanthony@mainlinehealth.net

Primary Consortium Partners

Name	State	Organization Type
Arkansas Rural Health Partnership	Arkansas	Non-profit Organization
Bradley County Medical Center	Arkansas	Critical Access Hospital (CAH)
Ashley County Medical Center	Arkansas	Critical Access Hospital (CAH)
Chicot Memorial Medical Center	Arkansas	Critical Access Hospital (CAH)
Community Health Centers of Arkansas	Arkansas	Non-profit Organization
DePaul Community Health Center	Louisiana	Federally Qualified Health Center (FQHC)
Arkansas SHARE Arkansas Department of Health	Arkansas	Health Department

Focus Areas

Population Health

Target Population

Mainline Health Systems Inc. (MHSI) and the Critical Access Hospitals (CAHs) have identified 229 patients to be included in the target population. This population is defined as low-income and medically vulnerable with 92% covered by public insurance, has a greater percentage of African Americans than the region as a whole, is primarily older adults, and has a large percentage who struggle with health literacy. This target population has a high incidence of heart disease, obesity, diabetes, and mental health issues.

Evidence-based/Promising Practice

The Penn Center for Community Health Workers IMPaCT Model. This model was developed and implemented in an urban setting and will benefit people living in the service region. The model will be adapted to allow the community health workers (CHWs) to provide services in a variety of ways in this extremely rural region of Arkansas. For people with transportation issues, services can be provided either in the home or through telehealth. CHWs can also arrange for transportation for patients to come to a clinic site if they are uncomfortable with in-home or electronic communication. In the Arkansas Delta, access to internet services is a significant barrier to receiving telehealth services. Again, CHWs can provide intensive care management services in the home or at a clinic site, and the consortium and its partners will advocate to expand telecommunications networks to rural areas.

Project Description

MHSI serves a medically vulnerable population that is predominantly low-income; has a higher percentage of African Americans than the broader region and the state; has lower levels of educational attainment; and has a high prevalence of chronic disease, including heart disease, diabetes, mental illness, and substance use disorders. In the Arkansas Delta, transportation is one of the most significant barriers to care facing the population, as there are no public transportation systems and limited on-demand services to transport people to a health care facility. Most people rely on personal transportation, which can also be a challenge, as many families either own only one vehicle (which is often unreliable) or do not own a vehicle at all and must rely on friends and neighbors to drive them to a medical visit. Oftentimes, people are not able to access their primary care provider because they cannot get a ride during business hours, and as an alternative, utilize the local emergency departments (EDs) for issues that could be more appropriately managed in a primary care setting. In addition, because patients are not receiving regular check-ups for their chronic conditions, both the rate of inpatient admissions and the rate of readmission within 30 days of discharge have increased. MHSI and three CAHs have joined together with DePaul Community Health Centers (DCHC), the Community Health Centers of Arkansas (CHCA), the Arkansas Rural Health Partnership (ARHP), and Arkansas SHARE (the State Health Alliance for Records Exchange) to create an innovative approach to identifying the issues facing these patients and provide services in a way that meets the patients' needs with the goal of improving health outcomes and teaching patients to utilize health care resources in a more appropriate way that will reduce the cost of care and create efficiencies across the health care system.

Project Goals
1. Improve health outcomes for MHSI patients who utilize the ED for primary care or have multiple inpatient admissions for the same condition. 2. Lower the cost of care for IMPaCT patients. 3. Create a self-sustainable model that can be replicated with other rural primary care providers.
Expected Outcomes
CHWs will provide intensive care management that includes management of all chronic disorders, an assessment of the patient's social determinants of health, and barriers to care. The consortium expects that through this intensive intervention process, patients will be able to address issues they face that keep them from managing their chronic disorders, will begin to more appropriately utilize health care resources, and will ultimately improve their health outcomes. Once the patients actively start managing their chronic conditions and scheduling regular appointments and follow-up, the consortium believes this will reduce the number of ED visits for primary care and reduce the number of readmissions necessary to restore a patient's health, thus reducing the overall cost of care. The consortium, through its advocacy work provided by the CHCA in conjunction with the Arkansas Community Health Workers Association (ACHWA), will lobby insurance companies; Arkansas Medicaid; and local, state, and national legislators to adapt reimbursement mechanisms for these services. At a minimum, the costs for CHWs should be allowed under value-based models.

Marysville Unified School District 364

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
School District	785-292-4453	https://www.usd364.org/	
Street Address	**City**	**State**	**Email**
211 S. 10th Street	Marysville	KS	philishas@bluevalley.net

Primary Consortium Partners

Name	State	Organization Type
Barnes Hanover Linn USD No. 223	Kansas	School District
Pawnee Mental Health Services	Kansas	Mental Health Provider
Marshall County Health Department	Kansas	Health Department
Washington County Health Department	Kansas	Health Department
Blue Valley Technologies	Kansas	Communications Organization

Focus Areas

Mental Health	Substance Use
School Based - Mental Health	

Target Population

The target population for the Creating Caring Schools (CCS) initiative is 1,101 prekindergarten through 12th-grade students who attend USD No. 364 in Marysville, Kan. (Marshall County), and USD No. 223 in Hanover and Linn, Kan. (Washington County).

Evidence-based/Promising Practice

The evidence-based/promising practice models being adopted in the Creating Caring Schools initiative include the Kansas Multi-Tier System of Supports (MTSS) and Kansas Social-Emotional Character Development Model Standards (SECD). Specific evidence-based programs and services being integrated into the initiative include Second Step's Social Emotional Learning, the Second Step Bullying Prevention Unit, and the Second Stepchild Protection Unit, all of which will be administered to prekindergarten through fifth-grade students. Other programs and activities incorporated within the MTSS framework include Youth Mental Health First Aid (sixth through12th grade), alcohol education (ninth grade), and Catch My Breath (fifth through 12th grade).

Project Description

Similar to other exclusively rural areas, Marshall and Washington counties and their communities within face diverse and numerous health challenges. The Creating Caring Schools initiative illustrates the need for and support of awareness, education, prevention, and early intervention efforts as integral instruments in alleviating the ongoing mental health issues of students and their families within Marshall and Washington counties. The overall focus of the Creating Caring Schools initiative is to strengthen the mental health support network for students and their families by providing resources that build protective factors, decrease risk factors, and optimize success. The goals, objectives, and activities are designed to do just that. With the framework being implemented, schools will provide students and families with a foundation for achieving a healthy status.

Project Goals

The goals of the Creating Caring Schools initiative are:

1. To promote a school climate and culture conducive to student learning and teaching excellence.
2. To provide evidence-based education and behavioral and mental health services to students and educators.
3. To engage and empower students, families, and communities to improve mental health status through prevention and early intervention efforts by ensuring access to appropriate, quality mental health services.

Expected Outcomes

Expected outcomes for the Creating Caring Schools initiative:

1. Increased percentage of mental health services offered to students and their families.
2. Increased percentage of schools closing their gap in the student-to-mental health professional ratio.
3. Increased percentage of referrals for appropriate resources provided to students and their families.
4. Increased number of districts with written policies and procedures that are enforced.

5. Increased percentage of district staff, administration, project staff, and health education action partners with an increased understanding of mental health practices and how to deliver and implement those practices in a school setting.

Mercy Health Cincinnati, LLC

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Critical Access Hospital (CAH)	606-726-2113	www.mercy.com	
Street Address	**City**	**State**	**Email**
60 Mercy Court	Irvine	KY	dstepp@mercy.com

Primary Consortium Partners

Name	State	Organization Type
Juniper Health Care	Kentucky	Federally Qualified Health Center (FQHC)
White House Clinics	Kentucky	Federally Qualified Health Center (FQHC)
Kentucky River Foothills	Kentucky	Federally Qualified Health Center (FQHC)
Mercy Primary Care	Kentucky	Rural Health Clinic
Estill Medical Clinic	Kentucky	Rural Health Clinic
New Vista	Kentucky	Mental Health Provider
Estill County Emergency Services	Kentucky	Non-profit Organization
Estill County Board of Education	Kentucky	School District
Estill County Health Department	Kentucky	Health Department
Kentucky Homeplace	Kentucky	Non-profit Organization
Estill Development Alliance	Kentucky	Non-profit Organization
Hospice Care Plus	Kentucky	Non-profit Organization
U.S. Acute Care Solutions	Kentucky	Non-profit Organization
Kentucky Regional Health Information Organization	Kentucky	Federally Qualified Health Center (FQHC)

Focus Areas

Mental Health	Substance Use

Target Population

The Project HOME Network supports program activities in the eastern Kentucky counties of Estill, Lee, and Powell. Each of these counties has been designated by the Health Resources and Services Administration (HRSA) as a Medically Underserved Area (MUA). These counties are ranked among the least healthy counties in Kentucky for health outcomes, have an average of 30% in poor or fair health (compared to Kentucky at 22%), and have six poor mental health days (in past 30 days) compared to Kentucky at five. The overdose rate for these three counties combined increased by 77% from the prior period of Jan. 1, 2020 through Sept. 30, 2020 to the current period.

Evidence-based/Promising Practice

Mobile integrated health care (MIH) is a model of health care delivery that builds upon earlier community paramedicine models and supports cost-effective deployment of health professionals into community settings for purposes of delivering patient-centered, need-targeted health care. As an important health innovation, MIH has been found to result in reduced emergency medical service transports, emergency department (ED) admissions, and inpatient hospital admissions through the proactive assistance of patients in the management of their health and adherence to prescribed therapeutic regimens and behavior modification strategies. Within health care, there is also a movement for substance use disorders to be understood as chronic health conditions, similar in their course to other chronic conditions like diabetes and hypertension, with alternating periods by which individuals engage in health-compromising behaviors (problematic drug use), abstinence, exacerbation and relapse, and reentry into treatment (National Institute of Drug Abuse, 2012).

Project Description

In the 2019 Overdose Fatality Report prepared by the Kentucky Justice and Public Safety Cabinet, Estill County recorded the highest rate of overdose deaths in the state, with an age-adjusted death rate of 81 deaths per 100,000 population. This and similar statistics communicate the level of need within these communities. The Healing Empowering and Living Program (HELP) initiative is

intended to change further community trajectories relative to the prevalence of substance and opioid use disorders within the Project HOME Network service area.

Based on historical data, it is anticipated that the Quick Response Team (QRT) staff will encounter and engage an average of five to six overdose patients per week. The centerpiece of the HELP initiative will be the QRT, which will comprise a community paramedic, behavioral health consultant, and peer support specialist. This team, along with the project director and administrative assistant, will be responsible for developing and coordinating the activities in the work plan. The QRT will support upstream interventions and provide accessible, community-based care to anticipate, prevent, and relieve the disease-related symptoms of addiction and serious mental illness within a private environment.

This program will address substance and opioid use disorder by:

1. Providing substance use and opioid use disorder information and resources to the community;
2. Distributing Naloxone to patients in the ED and community that are being treated for opioid overdose and substance use disorder;
3. Helping patients and their families to navigate and access community services, other resources, and adopt healthy behaviors; and
4. Provide mental health counseling, treatment, and referral for those patients with substance use disorder and opioid use disorder.

Project Goals

1. Develop an integrated comprehensive prevention plan to decrease opioid use disorder (OUD) and substance use disorder (SUD) within the Project HOME Network services area.
2. Develop a multidisciplinary, integrated, comprehensive, evidence-based model of treating OUD and SUD.
3. Develop a comprehensive integrated recovery community within the Project HOME Network.
4. Develop a comprehensive electronic overdose-tracking and interagency communication program to support evaluation and program sustainability.

Expected Outcomes

Implement outreach-specific strategies that allow for the proactive engagement of patients with SUD or OUD. To highlight a few of the expected outcomes by the end of the project implementation:

1. Ninety percent of emergency department patients referred for opioid overdose and SUD will be offered a Naloxone kit and/or resource material at discharge.
2. At least 500 community members will receive SUD or OUD education.
3. Ninety percent of patients who screen positive on the Screening, Brief Intervention, and Referral to Treatment tool in the ED will be referred to a behavioral health consultant, clinical drug and alcohol consultant, and/or peer support specialist.

Michigan Center for Rural Health

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Non-profit Organization	517-884-8641	www.MCRH.msu.edu	
Street Address	**City**	**State**	**Email**
909 Wilson Road	East Lansing	MI	jeff.nagy@affiliate.msu.edu

Primary Consortium Partners

Name	State	Organization Type
Baraga County Memorial Hospital	Michigan	Critical Access Hospital (CAH)
Kalkaska Memorial Health Center	Michigan	Critical Access Hospital (CAH)
Munising Memorial Hospital	Michigan	Critical Access Hospital (CAH)
Munson Charlevoix Hospital	Michigan	Critical Access Hospital (CAH)
Schoolcraft Memorial Hospital	Michigan	Critical Access Hospital (CAH)
UP Health System Bell	Michigan	Critical Access Hospital (CAH)
Munson Medical Center	Michigan	Hospital (non-CAH)
UP Health System Marquette	Michigan	Hospital (non-CAH)
Allevant Solutions, LLC	Pennsylvania	Health Care Consultant
Michigan Center for Rural Health	Michigan	Non-profit Organization

Focus Areas

Care Coordination	Mental Health
Chronic Disease Management	Population Health
Health Equity	Health Screenings

Target Population

The target population for the proposed project is Medicare beneficiaries 65 years of age and older living within the 10 fully rural counties of the Upper Peninsula and Northern Michigan (Alger, Antrim, Baraga, Charlevoix, Delta, Grand Traverse, Houghton, Kalaska, Marquette, and Schoolcraft counties).

Evidence-based/Promising Practice

The project will implement the promising practice model Hospital-Based Transitional Care, including MENDS health, wellness and prevention interventions, a model created for Critical Access Hospitals (CAHs) by Allevant Solutions, LLC., developed by Mayo Clinic and Select Medical.

Project Description

The project has brought together local, state, and national nonprofit and for-profit health care partners and formed a consortium in order to expand and enhance the delivery of hospital-based post-acute transitional care services in 10 fully rural (and remote) counties located in the Upper Peninsula and North Lower Peninsula of Michigan.

The project is providing critical infrastructure and capacity to support the rural health care delivery system in the region to improve the health and wellness resources and outcomes of aging residents. The project leverages the federal FORHP/HRSA Rural Health Care Services Outreach Program funds to support six CAHs to launch hospital-based, post-acute transitional care services (an evidence-informed model) in order to meet the growing post-recovery needs of medically complex patients within the rural setting. The incorporation of a health and wellness program (MENDS) into the “golden moment” of post-acute recovery in participating CAHs, a novel approach, will provide additional value and reduce disparities in resources and outcomes. Through the collaborative efforts of consortium members, the project will also strive to influence state rules and regulations that currently limit the utilization of swing beds within the CAH setting.

Project Goals

1. Develop a strong regional consortium to meet the demonstrated needs of target rural communities through the expansion of clinical and service capacity across 10 rural counties of the Upper Peninsula and North Lower Peninsula of Michigan by 2025.

2. Throughout the period of performance, enhance care delivery, support, and enabling services in the Upper Peninsula and North Lower Peninsula of Michigan by implementing hospital-based, post-acute transitional care (an evidence-informed model) at six CAH partners.
3. By 2025, enhance the utilization of hospital-based, post-acute Transitional Care services across the region and state of Michigan through collaboration and education efforts.

Expected Outcomes

Outcomes of the project include, but are not limited to:

1. Increase in rural CAH post-acute recovery (admissions and bed days);
2. Improved post-acute outcomes (length of stay, quality of care);
3. Increase in patient and staff wellness;
4. Satisfied patients and staff;
5. Increased CAH and acute care Prospective Payment Systems hospital collaboration; and
6. Increased CAH revenue and stability of rural facilities.

Michigan Rural EMS Network

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Non-profit Organization	989-284-5345	www.mirems.org	
Street Address	**City**	**State**	**Email**
3270 Wilson Street	Marlette	MI	info@mirems.org, leslie@mirems.org

Primary Consortium Partners

Name	State	Organization Type
Alpena Fire/Alpena County EMS	Michigan	Municipality
Frederic Fire Department	Michigan	Municipality
Bay Ambulance	Michigan	Non-profit Organization
Pickford Fire and EMS	Michigan	Municipality

Focus Areas

Care Coordination	Substance Use
Mental Health	Health Equity
Population Health	Emergency Medical Services

Target Population

Michigan Rural EMS Network (MiREMS) has monitored needs of more than 6,000 rural first responders over 10 years to guide projects and initiatives. This project focuses on agencies and professionals that provide emergency medical services in the 57 rural counties of Michigan. The project will impact 1.8 million rural residents of Michigan who face a number of health disparities and social determinants of health risks.

Evidence-based/Promising Practice

The project follows three frameworks: EMS Agenda 2050 for system strategies, Mobilizing Action through Partnerships and Planning (MAPP) for needs assessment and planning, and the state of Nebraska Regional EMS Promising Practice Model for regional field offices and coaching/Technical Assistance services. Initial evidence-based interventions have been selected based on existing data from needs assessments: Critical Stress Incident Management (CISM), Stress First Aid, and National EMS Education Standards.

Project Description

Without adequate support for the rural prehospital system, the health care system and patient outcomes are jeopardized. Loss of life, disability, and quality of life after a medical emergency often hinge upon the response time, scope and quality of service, system protocols, and stability of the EMS first responder system. This project will strengthen the rural prehospital system and fill an important gap in resources for first response agencies. The project provides a cohesive approach to meeting the needs of the 6,000 rural first responders and 300 departments within the service area. The consortium will establish the structure and provide education programs and training for first responders to ensure positive patient outcomes and support for responders' mental health needs.

Project Goals

Program Goal: Provide targeted support to rural first responders through a network of seven regional rural EMS field offices throughout Michigan.

1. Increase stability and capacity of rural first responder departments.
2. Increase the level of support for first responders to adequately process and cope with the stress and trauma related to their emergency response role.
3. Increase access to targeted training programs for rural first responders.
4. Establish regional processes to monitor and address the evolving needs of first responders.
5. Build resources and connections to sustain field office operations.

Expected Outcomes

This project will increase effectiveness of Michigan's rural prehospital response, thereby reducing loss of life and improving patient outcomes related to medical and behavioral health emergency calls. As a result of the program, we will establish seven MiREMS field offices, increase support for stress and trauma related to first responder roles, increase access to skills training, and establish regional processes to monitor and address evolving needs of first responders.

Miners' Colfax Medical Center

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Hospital	575-445-3661	www.minershosp.com	
Street Address	**City**	**State**	**Email**
203 Hospital Drive	Raton	NM	kdozal@minershosp.com

Primary Consortium Partners

Name	State	Organization Type
University of New Mexico (UNM)	New Mexico	University
Northwest Community Action Program (NOWCAP)	New Mexico	Non-profit Organization

Focus Areas

Chronic Lower Respiratory Disease	Health Screenings
Telehealth/Telemedicine	

Target Population

Current and former miners in Utah and Wyoming constitute the target population, with a comparison group of New Mexico miners, the latter group served by a separate HRSA-funded grant. The target population has disparities related to race and ethnicity, socioeconomic status, rurality, and language, placing them at risk of poorer health outcomes.

Evidence-based/Promising Practice

This project innovatively combines multiple tailored evidence-based and promising practice models that have been shown to be effective in addressing needs in a community setting and improving the health status of participants, an approach that has never been used in miners before (Evans, Lerch et al. 2016). These models are as follows:

1. Evidence-based screening and comprehensive care of miners;
2. Promising practice use of mobile units;
3. Promising practice use of telemedicine and telementoring; and
4. Promising practice use of a mobile Department of Labor Black Lung Impairment Examination (m-DoLBE).

Project Description

This project seeks to improve access to comprehensive health services for rural underserved miners using innovative models of health care delivery. The following key strategies will be implemented: (1) expand New Mexico-based comprehensive Black Lung services to Utah and Wyoming in partnership with HRSA-funded Northwest Community Action Program (NOWCAP) serving miners in these states, (2) augment existing screening services by providing m-DoLBE to Utah and Wyoming miners, and (3) expand existing programs by providing telemedicine and telementoring services to Utah and Wyoming miners and providers respectively, the latter helping to build local health care capacity. It is anticipated that the project over the four-year grant period will conduct 16 mobile screening clinics with 15 telemedicine sessions, six m-DoLBE screening clinics, and 15 telementoring sessions for local providers in Wyoming and/or Utah.

Project Goals

The goals of the project are to improve access to comprehensive health services for currently underserved miners using innovative models of health care delivery for chronic conditions. The project's objectives are threefold:

1. To examine the portability of the New Mexico-based mobile health care delivery model supplemented by telemedicine to outside New Mexico by comparing miner outcomes between New Mexico and other states (Utah and Wyoming), thus establishing the mobile intervention's generalizability to other parts of the country;
2. To compare the effectiveness of m-DoLBE in New Mexico, Utah, and Wyoming to fixed-clinic DoLBE in New Mexico, thus establishing the evidence basis for using m-DoLBE in extremely rural mining communities; and
3. To examine telementoring-related improvement in Utah and Wyoming provider competencies in the care of miners.

Expected Outcomes

There are two levels of grant-project–specific project outcomes: the patient level and the provider level. For patients, the project-specific measures are the index of new chronic conditions detected and patient satisfaction measures. For providers, the project-specific measures are measures of satisfaction, self-efficacy, and competency related to telementoring services. The following are some of the expected short-term and intermediate-term outcomes expected by this project:

1. Equivalent number of new chronic conditions screened in non–New Mexico miners vs. New Mexico miners;
2. Equivalent miner satisfaction in non–New Mexico miners vs. New Mexico miners;
3. Fifty percent greater miner satisfaction in telemedicine clinics; and
4. Fifty percent greater provider satisfaction, self-efficacy, and competency using telementoring.

North Dakota State University

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Area Health Education Center (AHEC)	701-231-6279	https://www.ndsu.edu/centers/american_indian_health/	
Street Address	**City**	**State**	**Email**
640 Aldevron Tower	Fargo	ND	vanessa.tibbitts@ndsu.edu

Primary Consortium Partners

Name	State	Organization Type
North Dakota Indian Affairs Commission	North Dakota	Non-profit Organization
North Dakota Department of Health	North Dakota	Health Department
Quentin Burdick Memorial Hospital	North Dakota	Critical Access Hospital (CAH)
Elbowoods Memorial Health Center	North Dakota	Rural Health Clinic
Quentin Burdick Memorial Hospital	North Dakota	Non-profit Organization
North Dakota State University	North Dakota	Area Health Education Center (AHEC)

Focus Areas

Maternal and Child Health	Population Health
Telehealth/Telemedicine	

Target Population

American Indian (AI) women and infants living in tribal nations residing in North Dakota are the target population of this project. The five tribal nations residing in the state of North Dakota are Mandan, Hidatsa, Arikara Nation on the Fort Berthold Reservation (Mountrail, McKenzie, Dunn, Mclean, and Mercer counties); Sisseton Wahpeton Oyaté on the Lake Traverse Reservation (Richland, Sargent, Roberts, Marshall, Day, Grant, and Codington counties); Spirit Lake Nation on the Spirit Lake Dakota Reservation (Ramsey, Benson, and Eddy counties); Standing Rock Sioux Tribe on the Standing Rock Indian Reservation (Sioux, Corson, Campbell, and Walworth counties); and Turtle Mountain Band of Chippewa on the Turtle Mountain Indian Reservation in Belcourt, N.D. (Rolette County).

Evidence-based/Promising Practice

The first evidence-based practices that will be applied in this project include community-based surveillance and case management for suicide prevention. This surveillance and case management system will be applied to identify trends in maternal and infant deaths to inform community-based development, implementation, and evaluation of strategies to reduce the risk of death of pregnant women, women who have recently had a live birth delivery, and living infants. Telehealth services are an evidence-based practice that will be applied to this project. Telehealth services offer the opportunity to increase access to obstetric and pediatric care, while addressing the barriers of transportation and workforce shortages. Community health representatives are an evidence-based practice that will be applied to this project, as well as the HealthyPeople 2030 Tools for Action.

Project Description

The title of our project is Reducing Maternal and Infant Mortality Through Collaborative Engagement of Tribal Health Care Services. The American Indian Public Health Resource Center (AIPHRC) is proposing to expand access to maternal and infant health services in rural North Dakota tribal communities. The goal of this project is to reduce American Indian maternal and infant morbidity in rural tribal nations residing in North Dakota. The objectives of this project are to utilize community health representatives to the top of their scope of work in addressing maternal and infant care; increase the utilization of telehealth maternal and infant services; develop and engage a consortium of community members and service providers in community action planning; engage tribal communities in developing culturally responsive, community-based models for delivering maternal and infant care; and build tribal momentum for sustainability in continued improvement in maternal and infant health outcomes.

This project seeks to enhance and expand existing health care systems' and providers' abilities to improve maternal and infant health through data-driven resources targeting programs and services, ensuring all health care workers with maternal and infant health in their scope of work are providing all services their credentials permit and addressing telehealth end user issues. A

deliverable of the project is an asset map for each participating tribal nation. The purpose is to identify all services available and assist in avoiding duplication of services in the maternal and infant health improvement plan.

Consortium members in this project will be actively engaged in the planning and delivery of services, utilize community engagement and evidence-based or innovative evidence-informed models in the delivery of health care services, improve population health, and demonstrate health outcomes and sustainability. Member roles include providing strategic direction to consortia, identifying staff to represent their organization in the consortium, and assisting in procuring data related to maternal and child health.

Project Goals

The goal of this project is to reduce American Indian maternal and infant morbidity in rural tribal nations residing in North Dakota from 16.3 in 1,000 to 12 in 1,000 by April 2025. Our project's goal of reducing American Indian maternal and infant deaths in rural tribal nations residing in North Dakota aligns with Healthy People 2030 Maternal, Infant and Child Health Measures (MICH):

1. MICH-01. Reduce the rate of fetal deaths at 20 or more weeks of gestation.
2. MICH-02. Reduce the rate of infant deaths within 1 year of age.
3. MICH-04. Reduce maternal deaths.

Our project's overarching goals are to:

1. Expand access to maternal and infant health services in rural North Dakota tribal communities;
2. Utilize community health representatives to the top of their scope of work in addressing maternal and infant care;
3. Increase utilization of telehealth maternal and infant health services in rural North Dakota tribal communities;
4. Develop and engage a consortium of community members and service providers in community action planning;
5. Engage tribal communities in developing culturally responsive, community-based models for delivering maternal and infant care;
6. Build tribal capacity for sustainability in continued improvement in maternal and infant health outcomes; and
7. Utilize data to inform action planning and sustainability.

Expected Outcomes

Outcomes expected during the four years of the project include development of a data-driven, interagency mindset and approach aimed at a reduction in the number of preventable maternal and infant deaths in tribal nations residing in North Dakota. The development of community health representative and parent skills to navigate racism and lateral oppression, reduce Adverse Childhood Experiences (ACEs), and apply ACE resiliency factors through professional and community education and a reduction in end user hardware barriers to accessing telehealth services. A final outcome is the completion of a maternal and infant health needs assessment and development and implementation of community maternal and infant health improvement plan for each tribal nation residing in North Dakota.

Northwest Iowa Mental Health Center

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Non-profit Organization	712-262-2922	www.seasonscenter.org	
Street Address	**City**	**State**	**Email**
201 E. 11th Street	Spencer	IA	info@seasonscenter.org

Primary Consortium Partners

Name	State	Organization Type
Department of Human Services – Western SA	Iowa	Department of Human Services – State Agency
Juvenile Court Services – 3rd District	Iowa	Juvenile Court Services - State Agency

Focus Areas

Care Coordination	Mental Health

Target Population

The Family Support Center Services project will serve foster and adoptive youth and their families, with a focus on the subpopulation of infants and young children, across a nine-county service area (Buena Vista, Clay, Dickinson, Emmet, Lyon, O'Brien, Osceola, Palo Alto, and Sioux) in rural Northwest Iowa.

Evidence-based/Promising Practice

1. Evidence-based therapies: Dialectical Behavior Therapy, Parent Child Interaction Therapy, Trauma-Focused Cognitive.
2. Behavioral Therapy and Eye Movement Desensitization and Reprocessing Therapy.
3. Evidence-based practices: National Adoption Competency, Thera play, Seeking Safety, W.I.S.E UP!

Project Description

The purpose of the Family Support Center Services project is to enhance partnerships in rural northwest Iowa with local child-serving agencies to increase access to specialized, trauma-informed mental health services for foster and adoptive children and their families, with an emphasis on infant and early childhood mental health. The project seeks to create foster- and adoption-competent mental health clinicians, programs, and services; promote awareness of the need for foster- and adoption-competent services; and integrate strategies among child welfare, fostering and adoption programs, early childhood, and other child- and family-serving systems to create sustained practice change for providing high-quality services across systems.

Key activities include formation of a high-quality regional partnership, including Department of Human Services and Juvenile Court Services; external and internal implementation teams to identify and address barriers and challenges as well as celebrate successes; provision of mental health therapy to foster and adoptive youth and their families; development of specialized care services such as care coordination and support groups; provision and promotion of evidence-based trainings and education and support services to families, professionals, and community members; and offering respite and other family-friendly events and outreach opportunities.

Project Goals

1. Demonstrate the organizational capacity to lead and champion a high-quality regional partnership to effectively deliver and sustain trauma-informed, culturally responsive, and evidence-based practices in foster and adoptive child- and family-serving systems during and beyond the grant.
2. Increase the number of foster and adoptive children and families served through the use of developmentally and trauma-informed evidence-based programs and services to nine counties in northwest Iowa.
3. Continue to enhance partnerships within local communities to promote program services and awareness, need, and understanding of the significance for fostering and adoption competency, early brain research, trauma-informed care, adverse childhood experiences, cultural competency, and resiliency to mobilize local services to support families and create practice change in how services are delivered.

Expected Outcomes

1. Increased access to specialized services.
2. Improved mental and behavioral health and well-being.
3. Increased access to prevention and early intervention services.

4. Enhanced access to community services and supports.
5. Improved consortium and organizational capacity.
6. Sustained project and practice change.

Oklahoma Foundation for Medical Quality, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Non-profit Organization	405-840-2891	https://www.ofmq.com/	
Street Address	**City**	**State**	**Email**
515 Central Park Drive, Suite 101	Oklahoma City	OK	Grants@ofmq.com

Primary Consortium Partners

Name	State	Organization Type
Oklahoma Nutrition Information and Education Project	Oklahoma	Non-profit Organization
SWOSU College of Pharmacy – Rural Health Center	Oklahoma	Non-profit Organization
Cordell Memorial Hospital	Oklahoma	Critical Access Hospital (CAH)
Elkview General Hospital	Oklahoma	Critical Access Hospital (CAH)
Great Plains Regional Medical Center	Oklahoma	Hospital (non-CAH)
Roger Mills Memorial Hospital	Oklahoma	Critical Access Hospital (CAH)
Buster Rural Health Clinic	Oklahoma	Rural Health Clinic
Elkview Physicians Group	Oklahoma	Rural Health Clinic
Family Medical Clinic of Western Oklahoma	Oklahoma	Rural Health Clinic
Family Practice of Elk City	Oklahoma	Rural Health Clinic

Focus Areas

Diabetes	Chronic Disease Management
Health Education/Promotion and Disease Prevention	Health Information Technology
Telehealth/Telemedicine	

Target Population

The Western Oklahoma Wellness consortium has targeted a five-county rural area in Western Oklahoma, including Beckham, Greer, Kiowa, Roger Mills, and Washita counties. All five counties have higher than national rates of diabetes prevalence. Adult community members are at high risk for diabetes and other poor health outcomes due to high rates of smoking, obesity, physical inactivity, high blood pressure, and poor nutrition. The service region is also home to many Native Americans, so focus and support will also be directed to include this population.

Evidence-based/Promising Practice

Our consortium utilized a hybrid approach including multiple evidence-based practice models to meet the needs of the target population. The models utilized include:

1. Combined diet and physical activity promotion programs;
2. The Clinical Partnerships Model; and
3. The telehealth model. Our primary evidence-based practice implemented through the program will be CDC-recognized lifestyle change programs through the National Diabetes Prevention Program (DPP), a major multicenter clinical research study.

Project Description

The Western Oklahoma Wellness (WOW) consortium will implement and expand prevention programs to address diabetes and other related chronic conditions within rural Oklahoma communities. The main focus areas for the program include community engagement, education, health promotion programs, and technical support. The WOW consortium, through support from the Oklahoma Nutrition Information and Education Project (ONIE), will host rotating Weeks of Wellness across the five counties that are created specifically for the target communities through needs assessment and evaluation. These events will provide education and outreach within the rural communities and host a variety of events from cooking demonstrations, to 5 K fun walk/runs, or establishing

new farmers markets and other healthy living resources. Weeks of Wellness will be designed around existing community events to promote program sustainability.

Through the outreach program WOW will develop and train lifestyle coaches to implement the CDC Lifestyle Change program within the service area. Southwestern Oklahoma State University College of Pharmacy, through their nationally recognized DPP program, will provide technical support to coaches and organizations that want to implement their own Lifestyle Change program. Additionally, Oklahoma Foundation for Medical Quality (OFMQ) will provide technical assistance to rural clinicians and hospitals with electronic health record processes including care coordination, clinical quality reporting, and population health management. Telehealth technology will be utilized and expanded through the program for various education and patient engagement opportunities.

Project Goals

Project goals include these:

1. Improve health outcomes by increasing access to education and recommended preventive health services to reduce the onset of diabetes and related chronic conditions.
2. Advance rural health care systems using health information technology (HIT) for population health management.

Project objectives include:

1. Develop a diverse consortium to enhance the delivery of preventive health care services and implement sustainable programs covering Beckham, Greer, Kiowa, Roger Mills, and Washita counties.
2. Increase the number of health care providers utilizing HIT for patient engagement, population health management, and health information exchange to improve health care cost and access to care.
3. Improve rural health outcomes through the development of a regional diabetes prevention program and increased access to healthy living programs.
4. Provide continuing education and training opportunities to advance the knowledge of the rural health care workforce and improve care quality.

Expected Outcomes

Expected outcomes for the WOW program include these:

1. Reduce the proportion of adults who don't know they have prediabetes within the target population by 5% by the end of the WOW outreach program;
2. Establish at least one certified Lifestyle Change program coach within each of the five target counties;
3. Weight loss of 5% of their bodyweight for lifestyle change program participants; and
4. Improve community awareness about local preventive services and resources.

Oneida Health Systems, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Hospital (non-CAH)	315-363-6000	www.oneidahealthcare.org	
Street Address	**City**	**State**	**Email**
321 Genesee Street	Oneida	NY	mmosack@oneidahealthcare.org

Primary Consortium Partners

Name	State	Organization Type
Oneida Health Systems	New York	Hospital (non-CAH)
Oneida Medical Practice	New York	Rural Health Clinic
Oneida Medical Practice	New York	Rural Health Clinic
Madison County Mental Health	New York	Health Department
Family Counseling Services of Cortland County Inc.	New York	Mental Health Provider
BRiDGES	New York	Non-profit Organization

Focus Areas

Care Coordination	Mental Health
Population Health	Primary Care

Target Population

Adults (18 years and older) in rural Madison and western Oneida County who are in need of behavioral health care services.

Evidence-based/Promising Practice

1. Standard Framework for Levels of Integrated Healthcare.
2. Stepped Model of Integrated Behavioral Health Care.

Project Description

The outreach program is a community-based grant program aimed toward promoting rural health care services by enhancing health care delivery to rural underserved populations in the local community. Oneida Health and its partners are coordinating efforts to develop a network of local health care providers, public health entities, and community nonprofit organizations to enhance the delivery of behavioral health care services to rural and underserved populations in Central New York. The partners are developing strategies to enhance care team skills to integrate behavioral health screenings into primary and emergency care settings, creating data-sharing capability to promote communication of individual treatment plans, and implementing a close looped referral system to track individual compliance with care.

Project Goals

Improve behavioral health outcomes in our rural area by:

1. Integrating behavioral health care services in a primary care setting; and
2. Increasing the access to behavioral health care for the target population.

Expected Outcomes

1. Increase the number of primary care providers who are trained to identify, assess, and treat mild to moderate presentations of anxiety and depression and refer patients for appropriate behavioral and mental health treatment.
2. Increase the number of patients screened and referred, as appropriate, for behavioral health care services from primary care providers.
3. Increase the number of patients attending transition of care visits within seven days of a behavioral health visit in the emergency department.
4. Decrease emergency department utilization for behavioral health that can be managed in outpatient settings.
5. Increase the number of patients who are adhering to outpatient treatment plans for behavioral health such as medication management, attending counseling, substance abuse treatment, etc.
6. Develop a network sustainability plan.

Oswego County Opportunities, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Non-profit Organization	315-598-4717	www.oco.org	
Street Address	**City**	**State**	**Email**
239 Oneida Street	Fulton	NY	Bcoleman@oco.org

Primary Consortium Partners

Name	State	Organization Type
Farnham Family Services	New York	Non-profit Organization
Northern Oswego County Health Services Inc.	New York	Federally Qualified Health Center (FQHC)
Catholic Charities of Oswego County	New York	Non-profit Organization
Oswego Health	New York	Hospital (non-CAH)
St. Luke Health Services	New York	Non-profit Organization

Focus Areas

Care Coordination	Chronic Disease Management
Health Equity	Heart Disease
Population Health	

Target Population

The target population of our project is the low-income population across Oswego County in the HRSA rural-designated areas of the county. The program will serve 350 individuals with complex medical and behavioral health comorbidities. In Year 1 the focus will be the low-income population with cardiovascular disease or those at risk of cardiovascular disease. In years 2-4, the consortium will expand the project to include other disease states such as diabetes.

Evidence-based/Promising Practice

1. Chronic Care Model — Developed by the MacColl Center for Healthcare Innovation at Group Health Research Institute. The model identifies the essential elements of a health care system that encourage high-quality chronic disease care, which include community, the health system, self-management support, delivery system design, decision support, and clinical information systems.
2. Population Health Model — Developed by the National Committee for Quality Assurance (NCQA). The primary focus of this model is a shift from a disease-centered approach of care delivery to one that considers the needs of the whole person. Surrounding the person/population are components critical to implementing the program, including population identification, data integration, stratification, measurement, care delivery systems, health plans and payers, and community resources.

Project Description

The Oswego County Integrated Delivery Network (OCIDN) Clinical Care Management and Care Coordination program will target individuals with complex medical and behavioral health comorbidities. There will be two phases of patient population identification. In Year 1 the target population will be individuals aged 22-85 with or at risk of cardiovascular disease. In Year 2, the target population will expand to include patients 22-85 with comorbidities and additional disease states with conditions that would benefit from care coordination and those who will require more advanced clinical care management. Each individual will be assessed using a health assessment to determine the areas of risk and need for the patient. The patients will then be risk-stratified and engaged as appropriate. At the hospital level, patients will be engaged at bedside during initial inpatient visits and in the ED while admitted. In primary care, registered nurse care managers will conduct proactive outreach to patients who meet criteria for the system and offer further support following ED visits or inpatient stays at the hospital. OCIDN community partners will engage patients through coordination with primary care and the OCIDN registered nurse care managers to engage patients in services to support their needs and enroll in the program. Care managers will work with the patient to develop a person-centered care plan based on assessment results that respond to their physical, social, and behavioral health needs, and referrals to services will be completed for clinical services as well as behavioral health services and substance use disorder treatment, social care needs, emergency services, and other social determinant of health needs. Care plans and all patient interaction will be captured in the Care Coordination Tool, a custom tool built by OCIDN partners for clinical partners to work together in the same space that allows for reporting on program

data. The Care Coordination Tool will allow for reporting that will enable OCIDN to analyze the effectiveness of the program and the impact on patient health.

Project Goals

The overarching goal of the OCIDN Clinical Care Management and Care Coordination project is to implement and demonstrate the effectiveness of a sustainable clinical care management and care coordination system for 350 individuals in the target population. This will be accomplished by providing the right care at the right time according to the patient's needs, not the provider's. The system will be designed to deliver whole-person care that responds to the person's medical, social, and behavioral health needs to improve specific health outcomes among individuals with complex medical and behavioral health comorbidities. By delivering care in this way the project aims to decrease costs associated with avoidable inpatient and ED utilization. Additionally, the project will provide an opportunity for OCIDN to engage payers in value-based payment arrangements that will sustain the project into the future.

Expected Outcomes

The expected outcomes of the OCIDN Clinical Care Management and Care Coordination program are as follows:

1. Patients will experience improved access to care, health outcomes, and engagement in the health and human services systems. This will include changes in morbidity and mortality related to chronic conditions, mitigation of access to care barriers, and maintenance of desired behavior.
2. Costs associated with avoidable ED utilization will decrease, which will provide a basis for shared savings in value-based payment contracts.
3. Rural areas of the county will have an increased capacity for identifying, engaging, and serving patients to achieve the Triple Aim of better care, better outcomes, and lower costs.

Otto Kaiser Memorial Hospital Foundation

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Non-profit Organization	830-583-3401	www.okmh.org	
Street Address	**City**	**State**	**Email**
3349 S. Highway 181	Kenedy	TX	barbara.james@okmh.org

Primary Consortium Partners

Name	State	Organization Type
The Office of Joel Saldana, MD	Texas	Rural Health Clinic
The Office of Roberto Ramires, MD	Texas	Rural Health Clinic
Otto Kaiser Memorial Hospital	Texas	Federally Qualified Health Center (FQHC)
Otto Kaiser Memorial Hospital	Texas	Rural Health Clinic
Kenedy Independent School District	Texas	School District
Karnes City Independent School District	Texas	School District
Department of State Health Services	Texas	Health Department
Methodist Ministries	Texas	Non-profit Organization

Focus Areas

Diabetes	Health Education/Promotion and Disease Prevention
Telehealth/Telemedicine	

Target Population

The project's target population is children and adults who are identified as at risk for diabetes or with diabetes and/or who are obese. Of the target population 21% are living in poverty, 26% children are living in poverty, 66% of the population are either Black/African American, Hispanic/Latin, or Native American, and 25% of the population did not complete high school.

Evidence-based/Promising Practice

The project has selected multiple evidence-based models to best serve the rural population of Karnes County. This will include the Clinical Partnership Model, the Rural Diabetes Prevention and Management Toolkit, and the Stanford Diabetes Self-Management Program as an evidence-based approach designed to improve diabetes self-management practices and delivered by certified educators. Each of these evidence-based models will be offered via the telehealth model as needed or based on pandemic restrictions in the future. Additionally, the project will utilize the community health worker model in the final two years to ensure sustainability and increased access to educators.

Project Description

The project's target population are children and adults who are identified as at risk for diabetes or with diabetes and/or who are obese. To meet the needs of this population, services will be provided individually as needed or via online access. Every patient referred for project services will be met with by the certified diabetes educator to develop a plan for education that meets their needs. This is also the case due to the geographic area of Karnes County. For some in the most rural areas of the county with no online access, the project will partner with schools, community businesses, and faith-based communities to provide space for education. Further, as needed services will be available at the patient's home. The project realizes that the pandemic is ongoing and status changes may occur that force new precautions and increase online communication in a community where greater than 30% of houses do not have internet. The schools have developed multiple hotspots for students who do not have access to attend online classes. The consortium will be able to access these resources to expand access into homes, when possible, in the worst-case scenario. However, normal precautions allow for distancing in small groups to meet, in-home visits, and outdoor gatherings. Regardless of the ongoing pandemic the project is committing to finding the solution to provide services to the targeted population.

Project Goals

The project has established the following goals:

1. Provide evidence-based diabetes education to reduce the prevalence of diabetes in Karnes County.
2. Provide evidence-based diabetes management education in Karnes County.

3. Establish and expand a consortium between primary care physicians and Otto Kaiser Memorial Hospital to increase access to sustainable diabetes prevention and diabetes management education by a certified diabetes educator.

Expected Outcomes

The project has targeted the following outcomes:

1. Increased knowledge of diabetes awareness among participants (as measured by pre- and post-surveys).
2. Increased competence in self-management knowledge and ability (as measured by pre- and post-surveys).
3. Improved physical health of participants including improved body mass index, weight loss, and increased activity levels.
4. Decreased rates in obesity levels.

Pennyroyal Healthcare Service, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Federally Qualified Health Center (FQHC)	270-365-0227	www.communitymedicalclinic.org www.4Heartssake.com	
Street Address	**City**	**State**	**Email**
310 Hawthorne Street	Princeton	KY	kfulcher@communitymedicalclinic.org

Primary Consortium Partners

Name	State	Organization Type
Christian County Health Department (CCHD)	Kentucky	Health Department
Pennyroyal District Health Department (PDHD)	Kentucky	Health Department
Pennyroyal Center Regional Prevention Center	Kentucky	Non-profit Organization
American Cancer Society-Northcentral Region (ACS)	Kentucky	Non-profit Organization
Kentucky Cancer Program (KCP)	Kentucky	Non-profit Organization
American Heart Association (AHA)	Kentucky	Non-profit Organization

Focus Areas

Care Coordination	Chronic Disease Management
Health Education/Promotion and Disease Prevention	Health Equity
Population Health	Primary Care

Target Population

The project targets rural residents of Lyon, Caldwell, and Christian counties in the Pennyroyal region of southwestern Kentucky who are at risk for cardiovascular disease, to include adults, African Americans, Caucasians, preschool children, pregnant women, school-age children (elementary and teens), elderly, infants, Latins, Native Americans, Pacific Islanders, and uninsured.

Evidence-based/Promising Practice

Hub's Community Health Gateway. The partners are adapting the model to account for inclusion of telemonitoring, additional screenings, and a broader set of outreach strategies. Outreach and education activities will be conducted at community events rather than the workplace, and program staff will offer the CDC Heart Age calculator screening tool. Finally, approximately 125 patients will be provided remote patient monitoring equipment, and telehealth service options will be offered to rural patients who are unable to travel to provider sites. The Chronic Care Model is another best practice Pennyroyal Health Service's (PHS's) Community Health Centers integrate into their programming.

Project Description

The project targets rural residents of Lyon, Caldwell, and Christian counties in the Pennyroyal region of southwestern Kentucky who are at risk for cardiovascular disease. These rural communities are characterized as "economically distressed." In keeping with the Rural Health Care Services Outreach Program goals, PHS and its consortium partners execute a comprehensive, coordinated project to enhance access to and delivery of prevention, screening, and treatment services that will improve the target community's cardiovascular health. The project, 4HeartsSake, addresses obesity, diabetes, physical activity and nutrition, and cancer screening, with a special emphasis on tobacco use prevention and cessation. PHS and the consortium partners will offer coordinated services and outreach and will implement a marketing campaign to advertise services and influence the target population's health-related attitudes and behaviors. The project will offer screening, direct services via primary care treatment, a seamless referral network, and enabling assistance to promote accessibility and empower patients to take charge of their health.

PHS will use a network of partners to share the process and outcome evaluation findings. Regional and statewide partners include the Kentucky Health Center Network for Federally Qualified Health Centers and the Kentucky Department of Public Health's Cabinet for Health and Family Services, which manages public health departments across the state. The American Cancer Society and American Heart Association partners are also part of larger statewide and national networks.

Project Goals

1. Expand the delivery of health care services to include new and enhanced services, including remote patient monitoring and other telehealth options, exclusively in rural communities in Lyon, Caldwell, and Christian counties.

2. Deliver health care services through a strong consortium in which every consortium member organization is actively involved and engaged in the planning and delivery of services.
3. Improve population health by demonstrating health outcomes that show changes to cardiovascular risk as a result of the activities supported by the outreach program and by ensuring sustainability.
4. Build knowledge regarding effective strategies for improving rural health.

Expected Outcomes

The outcomes include systemic changes as well as shifts that will occur for the target population. They are organized by short-term (within the project period), long-term (beyond the project period within approximately three to five years), and broad-scale impacts that will result within five to 10 years of sustained efforts. The consortium set three major impact goals to complete as a result of the project:

1. The rate of smoking is lowered from 27% to 19%, moving the service area into the top 10% of Kentucky counties with the lowest rates of tobacco use.
2. As evidence of the change in attitudes and awareness of risk factors for cardiovascular disease, cities and counties within the service area enact two to three new healthy policies such as no-smoking ordinances, new public green spaces that promote recreation and exercise, and expanded access to affordable public transportation.
3. The service area has lower rates of hypertension, obese adults, lung and oral cancers, and diabetes and higher rates of people who seek and receive treatment for health factors related to cardiovascular disease than state and national averages.

Randolph County Caring Community, Inc.

Lead Organization Information			
Lead Applicant Organization Type	**Phone**	**Organization Website**	
Non-profit Organization	660-263-7173	www.randolphcaringcommunity.org	
Street Address	**City**	**State**	**Email**
101 West Coates Street, Suite 201	Moberly	MO	caringcomm@rcccpmo.org

Primary Consortium Partners		
Name	**State**	**Organization Type**
Moberly Regional Medical Center	Missouri	Critical Access Hospital (CAH)
Randolph County Health Department	Missouri	Health Department
Big Tree Medical	Missouri	Rural Health Clinic
Monroe County Health Department	Missouri	Health Department
Compass Health	Missouri	Federally Qualified Health Center (FQHC)
MU Health Care	Missouri	Critical Access Hospital (CAH)
Lighthouse Counseling Services	Missouri	Mental Health Provider
Oak Hills Behavioral Health Services	Missouri	Mental Health Provider
Crossroads Counseling Services	Missouri	Mental Health Provider
Authentically Becoming	Missouri	Mental Health Provider
Burrell Behavioral Health	Missouri	Mental Health Provider
Sam's Health Mart (Pharmacy)	Missouri	Mental Health Provider
Timberlake Christian Counseling	Missouri	Mental Health Provider
University of Missouri Health Management	Missouri	School District
Moberly Area Community College	Missouri	School District

Focus Areas	
Care Coordination	Health Education/Promotion and Disease Prevention
Health Equity	Mental Health
Primary Care	Telehealth/Telemedicine

Target Population

The target area population is rural Northeast Missouri residents who face challenges of coordinated access to collaborative primary care, mental health, behavioral health, and coordinated social services. These populations include elderly and seniors; isolated, high-risk homebound residents; and homeless and transient individuals who are low-income, uninsured, and lack adequate social supports and reside in the rural counties of Randolph, Monroe, Chariton, and Howard, which are considered as the "core four" service area.

Evidence-based/Promising Practice

The Accountable Health Community (AHC) model is an ongoing health initiative of the Center for Medicare and Medicaid Innovation to accelerate the development and testing of new payment and service delivery models. AHC is designed to address the gap between clinical care and community services in the current health care delivery system by testing how systematically identifying and addressing the health-related social needs of individuals might impact total health care costs while improving health. This project's AHC model has been adapted to be inclusive of the Community Health Worker Care Coordination and Collaborative Care Models.

Project Description

The Innovative Communities project is a collaborative effort of diverse sectors, including primary care, mental health, behavioral health, and social service providers designed to engage in the enhancement of an existing AHC model to provide coordinated and collaborative services to socially and economically disadvantaged populations located within rural Northeast Missouri. The project is the expansion of an existing AHC model being implemented in Randolph County into additional counties that are served by

members of the Rural Mental Health Network convened by Randolph County Caring Community. Through the Innovative Communities project, this project will provide coordinated care services through a team of credentialed community health workers who will assist clients in navigating health care and social service systems. In addition, this project will provide collaborative care for clients demonstrating the need for coordinated clinical care services offered by diverse clinical providers led by a collaborative care team manager. Innovative Communities will utilize a Community Connections MO (CCMO) web-based information-sharing and health record system to provide innovative telehealth services to address access to care created by rural isolation and other barriers.

Project Goals

1. To utilize a collaborative approach to coordinate and deliver health care services through a diverse network of partners.
2. To develop and strengthen a highly skilled care coordination workforce to respond to vulnerable populations' unmet needs within the targeted rural communities.
3. To expand access and improve quality of care, service delivery, and health outcomes through the implementation of innovative telehealth strategies and activities.
4. To develop and strengthen care coordination financial sustainability by establishing effective revenue sources

Expected Outcomes

1. Strengthened rural health care system through integration and innovation.
2. Improved mental health outcomes for the targeted populations.
3. Improved access and quality of care through coordinated services and technology utilization.
4. Value-based care that changes the focus of health care from volume to value (quality/cost) of care.
5. Healthy communities that collaboratively address health inequities and disparities.

Regents of the University of Idaho

Lead Organization Information			
Lead Applicant Organization Type	**Phone**	**Organization Website**	
Academic Institution	208-364-4640	https://www.uidaho.edu/academics/wwami/echo	
Street Address	**City**	**State**	**Email**
875 Perimeter Drive, MS 3020	Moscow	ID	LWINTERSJUEL@uidaho.edu

Primary Consortium Partners		
Name	**State**	**Organization Type**
Coire Weathers, MD PLLC	Idaho	Mental Health Provider
Gritman Medical Center	Idaho	Critical Access Hospital (CAH)

Focus Areas	
Mental Health	Primary Care
Telehealth/Telemedicine	

Target Population

Rural and frontier communities in Idaho's 10 northern-most counties (Boundary, Bonner, Kootenai, Benewah, Shoshone, Latah, Clearwater, Nez Perce, Lewis, and Idaho) including low-income individuals, adults, older adults, adolescents, pregnant women, Native Americans, and veterans.

Evidence-based/Promising Practice

The consortium will utilize Project Extension for Community Healthcare Outcomes (ECHO) to deliver psychiatric consultative services and behavioral health care training to professionals at identified facilities in the proposed rural service area.

Project Description

The purpose of the proposed North Idaho Outreach Network (NION) is to collaboratively expand the delivery of mental health care services in Idaho's 10 most northern rural counties. The NION consortium will increase access to care by connecting community providers with specialists in regularly scheduled telehealth trainings aimed at increasing local capacity to identify and treat common and complex behavioral health issues to improve the health outcomes of rural patients.

More specifically, this funding will support two ECHO Idaho series: (1) COVID-19 and (2) pediatric autism. The COVID-19 series will provide for ECHO telehealth trainings that explore topics such as updates to and interpretation of Idaho's COVID-19 and vaccination numbers, an opportunity to ask questions about diagnosis and treatment of coronavirus through a case review, and assistance identifying helpful resources statewide. The pediatric autism ECHO series will be used to train rural health care providers to develop enhanced autism spectrum disorder expertise to address unique health issues in their patients.

Project Goals

1. Enhance North Idaho's rural health care services through the NION consortium committed to improving outcomes, ensuring access, and transforming health care delivery through sustainable approaches and community input.
2. Leverage Project ECHO to expand the delivery of health care services in rural areas through 84 hours of curriculum offered to 200 primary care providers and behavioral health professionals.
3. Increase rural providers' capacity to improve and expand health care services by increasing behavioral health knowledge, competence, and clinical skills in rural communities.

Expected Outcomes

1. The NION consortium will have implemented consortium plans, outlined strategies and metrics, and identified sustainable solutions to support the successful implementation of outreach activities to meet the behavioral health needs in north Idaho for the duration of the project period and beyond.
2. NION members; the Washington, Wyoming, Alaska, Montana and Idaho Medical Education Program at the University of Idaho; and additional community partners will have created and implemented a robust plan to increase the use of telehealth and telementoring to improve access to behavioral health services.
3. At least 84 hours of curriculum will be offered to 200 primary care providers and behavioral health professionals in north Idaho to increase their behavioral health knowledge, competence, and clinical skills in rural communities.

Richland Medical Center, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Federally Qualified Health Center (FQHC)	573-765-5131	www.centralozarks.org	
Street Address	**City**	**State**	**Email**
304 W. Washington	Richland	MO	dschneider@centralozarks.org

Primary Consortium Partners

Name	State	Organization Type
Laclede County Health Department	Missouri	Health Department
Miller County Health Department	Missouri	Health Department
Pulaski County Health Department	Missouri	Health Department
Camden County Health Department	Missouri	Health Department

Focus Areas

Primary Care	Maternal and Child Health
Population Health	Diabetes

Target Population

The target population includes individuals throughout the rural communities of Richland Medical Center Inc. d/b/a Central Ozarks Medical Center's (COMC's) service area. Expanding access to comprehensive, coordinated, high-quality health care through utilization of the Mobile Medical Unit to individuals and families who face barriers getting to a community-based clinic. Another population of focus will be obstetrics patients and improving early entry in obstetric care.

Evidence-based/Promising Practice

1. Pregnancy Medical Home (PMH) model is relatively early in development in most parts of the United States; some early evidence exists of its positive impact on birth outcomes.
2. The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is a national effort to help health centers and other providers collect the data needed to better understand and act on their patient's social determinants of health.

Project Description

The proposed project uses evidence-based and promising practices to effect change at the individual and community level related to the delivery of community-based primary and prenatal care through mobile clinical services in coordination with local public health agencies and COMC. Project activities will include managing chronic health conditions for all population groups, providing wellness care for school staff, and providing pregnancy care for patients throughout the COMC service area to meet the goals of improving individual clinical outcomes, increasing access, and expanding partnerships. The project will lead to important communitywide changes and will allow the development of further interventions focused on improving access to health care in our communities.

The proposed project focuses on the development of a communitywide approach to improving access to primary care through mobile outreach services and community partnerships. The project will undertake a structured community-driven process to deploy a primary care team that includes a nurse practitioner; medical assistant, licensed practical nurse, or registered nurse; and a community health worker to expand COMC's school-based services to the broader community through mobile primary care, including prenatal and obstetrics.

Project Goals

The goals and objectives of the project are to improve the health outcomes of COMC patients by increasing access to care through mobile services, specifically addressing the needs of patients with diabetes and other chronic conditions and also for prenatal and obstetric care, as well as improving the National Quality Forum measures on all applicable COMC patients, including patients served through direct outreach in the mobile clinic setting. By improving (lowering or increasing, dependent on measure) these rates, the community benefits by ensuring patients receive less costly care from an outpatient facility verses inpatient care. Further, when patients' chronic health care needs are addressed, their health status will be better managed, and they will also be lined to supportive community services to address social issues such as food insecurity, housing support, and transportation assistance.

Project goals are as follows:

1. Increase access to comprehensive, coordinated, high-quality health care to the target population through a patient-centered health home model delivered via mobile outreach.
2. Improve health outcomes among the target population.
3. Increase the number of individuals facing health inequities who are connected to community-based services.
4. Ensure financial sustainability of network services.

Expected Outcomes

Outcomes will be achieved by meeting overarching goals for the outreach program, which include:

1. Expanding the delivery of health care services in COMC's rural communities through the use of mobile services.
2. Delivering services through the Ozark Rural Health and Human Services Network (ORHN), an established and engaged rural health network and Federally Qualified Health Center.
3. Utilizing an evidence-based and evidence-informed care delivery model.
4. Improving population and patient-specific health outcomes through sustainable services.

Samaritan Pacific Health Services, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Critical Access Hospital (CAH)	541-7574-4985	www.samhealth.org	
Street Address	**City**	**State**	**Email**
3043 NE 28th Street	Lincoln City	OR	sbaird@samhealth.org

Primary Consortium Partners

Name	State	Organization Type
Capitol Dental	Oregon	Critical Access Hospital (CAH)
Advantage Dental	Oregon	Critical Access Hospital (CAH)

Focus Areas

Health Education/Promotion and Disease Prevention	Oral Health
Primary Care	Substance Use

Target Population

Subpopulations who have historically suffered poorer health outcomes and health disparities in Lincoln County, Ore.: Hispanic/Latin, limited English speakers, people with disabilities, members of the Confederated Tribes of the Siletz Indians, underinsured and uninsured people, homeless residents, and pregnant women.

Evidence-based/Promising Practice

The project is based on the community dental health coordinator (CDHC) program implemented in a rural hospital in Little Falls, N.Y., and on the expanded practice dental hygienist (EPDH) colocation pilot project implemented in Samaritan Lebanon Community Hospital in rural Linn County, Ore. The Lincoln County project's modifications to the CDHC program include allowing the EPDH to screen hospital patients for oral health needs and expanding the EPDH's role in staff, patient, and community education.

Project Description

The EPDH will serve patients presenting at Samaritan North Lincoln Hospital (SNLH) emergency department and hospitalized patients based on referrals from hospital staff. Using portable equipment on a mobile workstation, the EPDH will provide basic dental hygiene services and will also provide an oral assessment, which will be uploaded into a cloud-based record for review by an off-site dentist. The dentist will make a diagnosis and create a treatment plan. The EPDH will use this information to create a patient-specific oral care program and provide oral health education and discharge instructions. The EPDH will also follow up post-discharge with patients needing enhanced navigation into a dental home. In the case that the patient has urgent oral health needs, the EPDH will ensure the patient is navigated into an office within 24-48 hours after discharge from SNLH.

The EPDH will act as the hospital oral health resource and provide education for providers individually on an as-needed basis, as well as provide education and training in group settings within the hospital. The EPDH will also conduct community outreach and provide education in the community.

Project Goals

Overarching goal: Improve the oral health of people living in Lincoln County.

1. Integrate oral health with physical health in two rural hospitals in Lincoln County.
2. Provide oral health services and connections to follow-up services for hospital patients.
3. Promote and demonstrate the link between oral health and physical health through the provision of provider, staff, patient, and community education across Lincoln County.

Expected Outcomes

We expect this project to result in three long-term improvements that will positively impact the health status of Lincoln County residents by improving oral health, increasing the number of people with access to a dental provider, and increasing the knowledge of the importance of oral health. In addition to the expected benefits to the target population, we anticipate implementation of this model will provide significant benefits to the medical providers and staff at the two participating CAH hospitals. With staff and provider education taking place on multiple fronts and an EPDH physically present on a daily basis, this project will bring oral health to the forefront within the hospital community, impacting individual providers as well as the general hospital culture. Supporting oral

health as part of a patient's overall health will become standard practice, and staff will be equipped with the knowledge and skills to do so.

Santa Fe Recovery Center, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Non-profit Organization	505-471-4395	www.sfrecovery.org	
Street Address	**City**	**State**	**Email**
5312 Jaguar Drive	Santa Fe	NM	sbarela@sfrecovery.org

Primary Consortium Partners

Name	State	Organization Type
Navajo Area Indian Health Services	New Mexico	Hospital (non-CAH)
Rehoboth McKinley Christian Health Care Services	New Mexico	Hospital (non-CAH)
New Mexico Human Services Department Behavioral Health Services Division	New Mexico	Health Department
Hozho Center for Personal Enhancement	New Mexico	Non-profit Organization

Focus Areas

Substance Use

Target Population

Residents of McKinley County, N.M., of which 80% are Native American and 14% are Hispanic, who have a history of, or are at risk for, substance use disorders (SUD).

Evidence-based/Promising Practice

American Society of Addiction Medicine (ASAM) Social Detoxification

1. ASAM medically monitored detoxification.
2. Harm reduction.
3. Peer support services.
4. Motivational interviewing.

Project Description

The Four Corners Rural Health Care Services Outreach consortium will develop health policies, best practices, and direct service programs to significantly improve health outcomes for predominantly Native American and Hispanic individuals living in the city of Gallup and throughout McKinley County. The project will also help reduce dire health disparities and delayed access to treatments related to substance use.

Project Goals

1. Expand the delivery of SUD-related health care services to include new and enhanced services.
2. Deliver health care services through a strong consortium.
3. Utilize community engagement and evidence-based or innovative models in the delivery of SUD-related health care services.
4. Improve population health and demonstrate health outcomes and sustainability.

Expected Outcomes

1. Reduce morbidity and mortality rates.
2. Reduce incidents of SUD and opioid use disorder (OUD) at the two local hospital emergency departments.
3. Create greater access to medically monitored social and harm-reduction detox services.
4. Increase the availability of peer support services.
5. Increase funding streams for SUD and OUD services.
6. Create legislation to serve individuals experiencing SUD or OUD.
7. Create more meaningful collaborative relationships and quality of care.
8. Increase the availability of SUD and OUD services.
9. Increase awareness regarding the effectiveness of culturally sensitive services.

Southcentral Foundation

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Federally Qualified Health Center (FQHC)	907-729-4955	https://www.southcentralfoundation.com/	
Street Address	**City**	**State**	**Email**
4441 Diplomacy Drive	Anchorage	AK	lkotelman@scf.cc

Primary Consortium Partners

Name	State	Organization Type
Chickaloon Native Village	Alaska	Tribal Partner
Nikolai Village	Alaska	Tribal Partner
Nondalton Village	Alaska	Tribal Partner
Village of Igiugig	Alaska	Tribal Partner
Village of Kokhanok	Alaska	Tribal Partner
Nikolai Village	Alaska	Tribal Partner
Takotna Tribal Council	Alaska	Tribal Partner
Native Village of Tyonek	Alaska	Tribal Partner
Port Alsworth Improvement Corp.	Alaska	Tribal Partner
Aleut Community of Saint Paul Island	Alaska	Tribal Partner
Village of Pedro Bay	Alaska	Tribal Partner
McGrath Native Village	Alaska	Tribal Partner
Village of Iliamna	Alaska	Tribal Partner

Healthy Rural Hometown Initiative (HRHI)

Substance Use	Unintentional Injury

Target Population

Residents in the service region of all ages who operate all-terrain vehicles (ATVs) and who reside in incorporated and unincorporated area of Southcentral Alaska; Upper Kuskokwim region of Interior Alaska; and St. Paul Island in Priboloff Islands.

Evidence-based/Promising Practice

Project resources are used to reduce injuries associated with the operation of ATVs by providing “hands-on,” evidence-based training in rural Alaska communities. The project will use the ATV safety training curriculum developed by the ATV Safety Institute. The institute is a manufacturer-sponsored organization with the mission of promoting safe use of these vehicles to eliminate injuries and mortalities associated with ATV operation. A second evidence-based practice will be distribution of helmets via a social marketing campaign.

Project Description

The Rural Anchorage Area Health Network with Southcentral Foundation (lead) partner will focus on the Healthy Rural Hometown Initiative (HRHI) track. The purpose of the grant is to address a major cause of morbidity and mortality in the network’s and other rural Alaska communities — unintentional injuries attributable to the operation of ATVs. Funding is focused on fostering the development of the network and its collective impact to address this and other health issues too complex or expensive for small communities to address on their own. A community assessment will identify the strengths, challenges, resources, opportunities for collective action, and readiness of the network and its members.

Project Goals

1. Promote wellness in the rural network communities by maximizing their collective impact to address shared health challenges with effective, efficient, and feasible solutions otherwise unattainable by small communities acting in isolation.
2. Eliminate morbidity and mortality associated with ATV operations in rural Alaskan communities by instituting community-level educational activities and the use of safety gear.

Expected Outcomes

Reduction in injuries, deaths, and medevacs attributable to ATV operations in rural Alaska. This project is expected to have a major impact on the target population by reducing major causes of injury in rural Alaska that often results in death or long-term disabilities. The priority placed on children and youth is commensurate with the greater risk these ages have of incurring an injury associated with ATV operations.

Tallahatchie General Hospital Medical Foundation

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Non-profit Organization	662-625-3040	www.jckwellness.com, www.mytgh.com	
Street Address	**City**	**State**	**Email**
188 Honeysuckle Drive	Charleston	MS	cmoring@mytgh.com

Primary Consortium Partners

Name	State	Organization Type
Tallahatchie General Hospital	Mississippi	Critical Access Hospital (CAH)
William Carey University College of Osteopathic Medicine	Mississippi	University School of Osteopathic Medicine
Fastring Evaluation and Consulting, LLC	Mississippi	Evaluation Services
James C. Kennedy Wellness Center	Mississippi	Community and Hospital Wellness Center

Focus Areas

Chronic Disease Management	Diabetes
Health Education/Promotion and Disease Prevention	Health Screenings
Telehealth/Telemedicine	

Target Population

The target population for Delta Thriving is people living with chronic health conditions, namely diabetes and other lifestyle-related conditions, within the service region in the Mississippi Delta. The primary service area is Grenada, Panola, Tallahatchie, and Yalobusha counties. The secondary service area is Coahoma, Leflore, Sunflower, and Quitman counties.

Evidence-based/Promising Practice

The evidence-based models are:

1. Diabetes Self-Management Education and Support Services (DSMES);
2. Diabetes Prevention Program (DPP);
3. Medical nutrition therapy (MNT); and
4. Chronic care management (CCM).

Project Description

Delta Thriving was developed to provide Diabetes Self-Management Education and Support Services (DSMES), Diabetes Prevention Program (DPP), as well as medical nutrition therapy (MNT) in a virtual format to patients living in the service area. Rural Mississippi has traditionally been underserved and lacks access to these important services. Less than 10% of people diagnosed with diabetes receive diabetes or nutrition education, and such services are associated with significant reductions in A1c and improvements in health outcomes and quality of life. Delta Thriving also provides chronic care management (CCM)-type services to non-Medicare beneficiaries for individuals who are not currently enrolled in such programs and can benefit from lifestyle and nutrition coaching services. Additionally, the program will provide health fairs and community screenings as well as encourage screenings for at-risk patients in the clinical setting to identify patients with underlying undiagnosed chronic health conditions (i.e., prediabetes, diabetes, hypertension). Delta Thriving includes the use of four evidence-based models. Delta Thriving will increase access to preventive health care services; provide CCM, DSMES, DPP, and MNT via telehealth; host health fairs and community screenings; and make appropriate referrals for care, including behavioral health care.

Project Goals

1. Provide access to DSMES, DPP, and MNT through the provision of telehealth and virtual content to participants in our eight-county service region.
2. Identify individuals with undiagnosed prediabetes, diabetes, and hypertension.
3. Reduce hemoglobin A1c below 6.5% in 50% of participants with type 2 diabetes.
4. Reduce hemoglobin A1c below 5.7% in at least 50% of participants with prediabetes.
5. For those participants who are overweight, a 5% weight loss will be achieved by Delta Thriving participants over one year.
6. For those participants who have obesity, a 10% weight loss will be achieved by Delta Thriving participants over one year.

7. Increase frequency of physical activity and exercise among participants; at least 50% of program participants will exercise at least 150 minutes per week.
8. Increase health literacy of program participants.
9. Improve dietary behavior and increase knowledge of nutrition concepts.
10. Establish a network of referring health care providers.

Expected Outcomes

1. Increased and expanded use of telehealth (Increased access to care).
2. Improved self-management of chronic conditions.
3. Reduction in chronic disease related complications (including emergency department visits).
4. Reduction in unnecessary health care spending.
5. Improved health outcomes.
6. Identification of undiagnosed chronic conditions and provision of follow-up care.
7. Improved quality of life.

Tattnall County Board of Education, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
School District	912-557-6026	www.tattnallschools.org	
Street Address	**City**	**State**	**Email**
146 W. Brazell Street	Reidsville	GA	banderson@tattnall.k12.ga.us

Primary Consortium Partners

Name	State	Organization Type
Tattnall County Family Connection Collaborative	Georgia	Non-profit Organization
Tattnall County Health Department	Georgia	Health Department
Tattnall County DFCS	Georgia	Social Services Provider
Tattnall County Sheriff's Department	Georgia	Law Enforcement
Action Pact	Georgia	Non-profit Organization
ESE Telehealth	Georgia	Telehealth Provider
Live Life Counseling, LLC	Georgia	Mental Health Provider

Focus Areas

Mental Health	School-based Health
Telehealth/Telemedicine	

Target Population

All 3,712 students, prekindergarten through 12th grade, enrolled in the Tattnall County School System and their parents/guardians. The service area is Tattnall County, Ga. This project anticipates serving all 3,712 students. Approximately 25% of the students are African American, 51% are White, 20% are Hispanic, and 4% are other.

Evidence-based/Promising Practice

School-based behavioral and mental health services. These services are provided through an on-site licensed counselor and telehealth services.

Project Description

This includes services for anxiety, depression, behavior problems, ADD/ADHD, or any other identified related problem. Also, to provide depression screening services for all of the students and follow-up behavioral and mental health services for all students with identified problems (as long as they have parental permission to receive these services). Additionally, the program aims to work with students' families to ensure that the students and their parents are communicating positively on an ongoing basis in order to promote healthy student- and family-friendly environments.

The eight partners are providing a variety of resources, support, and assistance for the project. This includes providing office space and phone and Internet services for the project staff; making referrals for mental/behavioral health issues to the project; accepting referrals from the project for identified social services needs; assisting with project-related student, parent, and school system staff educational programming; providing state-of-the-art equipment and the use of a telemedicine platform software; and providing billing and scheduling services. In addition, these partners will also serve actively on the consortium and work with other consortium members to secure long-term continuation funding for the project.

Project Goals

The goal is to enhance access to available mental/behavioral health services in each of the schools in Tattnall County. The six objectives include these:

1. Provide a depression screening assessment for 100% of the students enrolled in our school system during each year of the project.
2. A minimum of 200 students and their families, with an identified need, will receive mental or behavioral health services during each year of the project.
3. A minimum of 150 of their parents will participate in evidence-based mental health–related education during each year of the project.

4. A minimum of 100 of the parents will receive family support assistance in completing the necessary paperwork or online forms for local mental and behavioral health services.
5. One hundred percent of the teachers and other staff members will participate in evidence-based educational programming focused on their students' potential medical, mental health, and social needs during each year of the project.
6. Develop and implement an effective sustainability plan for sustaining initiative-related services by Jan. 1, 2023.

Expected Outcomes

The expected outcomes include, but are not limited to, providing a depression screening assessment for all students enrolled in our school systems, increasing the percentage of students with mental health problems who get treatment, decreasing the percentage of students who state they have felt sad or withdrawn during the past 30 days, decreasing the percentage of students who have current thoughts of self-injury, decreasing the proportion of students who receive disciplinary referrals, and decreasing the proportion of students who are absent 15 or more days from school each year.

Trustees of Indiana University

Lead Organization Information			
Lead Applicant Organization Type	**Phone**	**Organization Website**	
Academic institution	812-855-4789	https://publichealth.indiana.edu/	
Street Address	**City**	**State**	**Email**
1025 E. 7th Street	Bloomington	IN	prbarnes@indiana.edu

Primary Consortium Partners		
Name	**State**	**Organization Type**
REAL Recovery	Indiana	Non-profit Organization
Purdue Extension	Indiana	Non-profit Organization
Good Samaritan Hospital	Indiana	Hospital (non-CAH)
Daviess County Connections	Indiana	Non-profit Organization
Daviess County Community Corrections	Indiana	Local government
United Way of Daviess County	Indiana	Non-profit Organization
Central Christian Church – Recovery Centra	Indiana	Non-profit Organization
DRPERK INC/Serenity House	Indiana	Non-profit Organization
Daviess Community Hospital	Indiana	Hospital (non-CAH)
Samaritan Center	Indiana	Mental Health Provider
Daviess County Economic Development Corp.	Indiana	Non-profit Organization
Indiana Department of Health, Division of Chronic Disease, Primary Care and Rural Health	Indiana	State government
St. Vincent Evansville – Ascension	Indiana	Hospital

Focus Areas	
Care Coordination	Mental Health
Recovery	

Healthy Rural Hometown Initiative (HRHI)	
Substance Use/Unintentional Injury	

Target Population

Residents of Daviess County, Ind., living with an active addiction or individuals living in long-term recovery.

Evidence-based/Promising Practice

Traditional state and local hub-and-spoke models for opioid use disorders still fail to address the needs of rural communities like Daviess County. Though supported by robust research, health care clinics at the point of emergency department (ED) intake unintentionally further stigmatize individuals and deter them from seeking help. Also, individuals living with an active addiction and working toward long-term recovery need additional support that extends beyond the ED. For this initiative, we adapted this model by placing the recovery community organization as the core operating organization (as opposed to a health care entity) at the center of the network. This model implements coordinated care networks where clients seek medical, mental health, substance use, and recovery services through a collaborative network of providers that is facilitated by peer recovery specialists. This increases access to care while maintaining local relationships and ensuring no client falls through the cracks of an uncoordinated system.

Project Description

The objective of this project is to implement and test the efficacy of a coordinated peer recovery, rural-based care model in Daviess County. The goals of this project are to:

1. Implement a community health improvement process to set priorities and coordinate resources about substance use and associated determinants;
2. Mobilize community partnerships to maximize recovery-oriented resources and reduce duplication of services through the development of a recovery community organization; and

3. Improve the facilitation of access to recovery-oriented services through a recovery hub for individuals living with an active addiction and for individuals living in long-term recovery in Daviess County.

Project Goals

1. Implement a community health improvement process to set priorities and coordinate resources related to substance use and associated determinants from key stakeholders in Daviess County.
2. Mobilize community partnerships to maximize recovery-oriented resources and reduce duplication of services.
3. Improve the facilitation of access to recovery-oriented services for individuals living with an active addiction and for individuals living in long-term recovery in Daviess County.

Expected Outcomes

The primary objective of the project is to implement and test the efficacy of a coordinated peer recovery, rural-based care model in Daviess County, Ind. We expect the outcomes to include, but not to be limited to:

1. Increasing the number of individuals receiving peer support services;
2. Increasing the number of individuals receiving mental or behavioral health direct services; and
3. Reducing the number of ED admissions due to unintentional overdoses or other related substance use concerns.

University of Arkansas System

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Hospital (non-CAH)	870-403-2623	www.uams.edu	
Street Address	**City**	**State**	**Email**
4301 W. Markham Street	Little Rock	AR	EROneal@uams.edu

Primary Consortium Partners

Name	State	Organization Type
UAMS Union County	Arkansas	Rural Health Clinic
Medical Center of South Arkansas	Arkansas	Hospital (non-CAH)
Union County Health Department	Arkansas	Health Department
Murphy USA	Arkansas	Non-profit Organization
Dr. Stephen Smart	Arkansas	Hospital (non-CAH)
Arkansas Cancer Coalition	Arkansas	Non-profit Organization
Winthrop P. Rockefeller Cancer Institute	Arkansas	Hospital (non-CAH)
Arkansas Minority Health Commission	Arkansas	Non-profit Organization
ADH Office of Rural Health and Primary Care	Arkansas	Health Department

Focus Areas

Health Education/Promotion and Disease Prevention	Health Equity
Health Screenings	

Healthy Rural Hometown Initiative (HRHI)

Cancer	

Target Population

The overall target population is Union County. Total population 40,334. All of Union County is designated rural by HRSA.

Evidence-based/Promising Practice

The Union County CONNECT program will utilize the HRSA evidence-based model Sickness Prevention Achieved through Regional Collaboration (SPARC). The SPARC model has achieved the highest level of evidence-based rating and is determined to be "Effective" by HRSA, as cited on the Rural Health Information Hub.

Project Description

The purpose of Union County CONNECT is to promote rural health care through collaboratively enhancing cancer prevention and education, screening for early detection, navigation, treatment, and survivorship services in Union County, Ark. Union County CONNECT will address the underlying factors that are driving growing rural health disparities by identifying and bridging the gap between social determinants of health and other systemic issues to reduce cancer disparities. Union County CONNECT's program focuses on addressing cancer, one of the five leading causes of death in the rural United States. Union County CONNECT will expand the delivery of cancer services through a strong, active, and engaged consortium of local rural and statewide partners who are involved in every step of planning and implementation of strategies and objectives. The first year will focus on conducting a comprehensive community health assessment and refining our strategic work plan and four-year work plan. In years 2-4, we will use the assessment to implement innovative approaches to challenges related to cancer prevention, early detection, navigation, treatment, and survivorship.

Project Goals

1. Establish a strong consortium with local rural and statewide members to ensure the success of Union County CONNECT.
2. Implement an outreach and care model that will increase access to and utilization of cancer prevention and education, screening for early detection, navigation, treatment, and survivorship services. To achieve strategy/objective 2, we will strategy/objective 2.A. Conduct a comprehensive community health assessment in Union County related to cancer, using a community-based participatory approach and the Social Ecological Model.

3. Implement evidence-based practices in cancer prevention and education and screening for early detection for rural Union County residents with a focus on the leading cancers within Arkansas and Union County: lung cancer, colorectal cancer, breast cancer, and cervical cancer.
4. Implement a navigator program to mitigate economic and social barriers to cancer treatment.
5. Implement a rigorous process and outcome evaluation.
6. Ensure sustainable outcomes and the ability for replication.

Expected Outcomes

The long-term outcome is reduced cancer disparities in Union County as measured by morbidity and mortality. The measurable short- and mid-term outcomes are expanded cancer services provided to rural Union County and a sustainable partnership after grant funding ends. As well as higher utilization of cancer prevention and education, screening and early detection, navigation, treatment, and survivorship services.

Williamson Health & Wellness Center, Inc.

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Federally Qualified Health Center (FQHC)	304-235-3400	https://www.healthyinthehills.com/	
Street Address	**City**	**State**	**Email**
182 E. 2nd Avenue	Williamson	WV	jhudson@williamsonhealthwellness.com

Primary Consortium Partners

Name	State	Organization Type
Tug Valley Appalachian Regional Healthcare	West Virginia	Hospital (non-CAH)
Southern West Virginia Area Health Education Center	West Virginia	Area Health Education Center (AHEC)
Able Families	West Virginia	Non-profit Organization
Williamson Forward	West Virginia	Non-profit Organization
Williamson Housing Authority	West Virginia	Non-profit Organization

Focus Areas

Care Coordination	Chronic Disease Management
Diabetes	Heart Disease
Health Equity	

Target Population

Mingo County, W.Va., (population 25,150; area 423 square miles) has one of the highest rates of poverty among all 55 counties in West Virginia. According to recent data, 13.2% of adults in Mingo County are diagnosed with diabetes; 40% of adults in Mingo County are obese, compared to the national benchmark of 28%. The Mingo County population primarily comprises of Non-Hispanic White (96.1%), African American (2.8%), American Indian (0.4%), and Asian (0.1%). The network includes a community representative who is responsible for driving equity by asking, Who are we serving, and how can we reach all people with our outreach services.

Evidence-based/Promising Practice

The Quality Lives program employs four evidence-based practices: Chronic Care Model (CCM) plays an important role in the management of chronic disease and ensuring access to quality, team-based care. Care Transitions Intervention (CTI) is a person-centered intervention for patients with complex care needs as they transition across care settings after hospital discharge. Motivational interviewing is a conversational approach that care teams can employ to assist individuals to communicate their desire for change in their own words, understand their ambivalence about making changes, and plan for and begin the process of change. Text Messaging Interventions Among Patients with Chronic Diseases is an evidence-based practice to improve short-term rates of medication adherence. The project will engage patients by text messaging customized medication adherence and event reminders.

Project Description

The Quality Lives program drives healthy habits and strengthens social connections among individuals diagnosed with diabetes and heart disease. The project is led by organizations, residents, and health care partners who are members of the Healthy in the Hills Network. Clinical and neighborhood interventions encourage healthy eating, active living, social connections, and self-management of chronic conditions. Network partners play a role in care coordination with patients and in codesigning interventions with the community. Within a clinical and hospital setting, care teams grow capacity through enhanced training and improved understanding of health information technology to support patients along their journey. The team is committed to reducing health care costs and overutilization of services through collaboration.

Project Goals

1. Improve health outcomes and reduce complications among individuals with uncontrolled hypertension and diabetes.
2. Maximize value-based payments and reduce hospital readmission rates and penalties annually.
3. Enhance care coordination workforce with trainings on evidence-based practices, internal workflow, and health information technologies to improve quality of care delivery.
4. Promote heart health among patients and families through neighborhood events and text alerts.

Expected Outcomes
Patients will experience reduced complications from heart disease and diabetes: 70% of patients will have controlled high blood pressure; the number of patients with poor control of diabetes will decrease from 27% to 21%. Sustainable interventions will demonstrate financial viability: CCM and TCM billings increase, value-based payments increase 10% annually, and readmission penalty payments decrease. The network will build social cohesion around cardiac and diet-related health issues across rural neighborhoods.

Wirt County Health Services Association, Inc.

Lead Organization Information			
Lead Applicant Organization Type	**Phone**	**Organization Website**	
Federally Qualified Health Center (FQHC)	304-679-6680	www.coplinhealth.com	
Street Address	**City**	**State**	**Email**
483 Court Street	Elizabeth	WV	sbarton@wchsa.com

Primary Consortium Partners		
Name	**State**	**Organization Type**
Mid Ohio Valley Rural Health Alliance	West Virginia	Non-profit Organization
Minnie Hamilton Health System	West Virginia	Federally Qualified Health Center (FQHC)
Mid Ohio Valley Health Department	West Virginia	Health Department
Ritchie Regional Health Care	West Virginia	Federally Qualified Health Center (FQHC)
West Virginia University Extension Service	West Virginia	Area Health Education Center (AHEC)
WV Health Connection	West Virginia	Non-profit Organization
Mountaineer Foodbank	West Virginia	Non-profit Organization
Rural Action	Ohio	Non-profit Organization

Focus Areas	
Health Education/Promotion and Disease Prevention	Health Equity
Health Screenings	Population Health

Healthy Rural Hometown Initiative (HRHI)	
Cancer	Heart Disease
Stroke	

Target Population

Food Access through Rural, Medical And Community sYstem (FARMACY) will serve adults aged 20-65 who have not previously been diagnosed with hypertension, stroke, or cancer in nine West Virginia counties (Calhoun, Doddridge, Gilmer, Jackson, Pleasants, Ritchie, Roane, Wirt, and Wood). The project focuses on high-risk populations, including individuals living in rural communities, with income at 200% or below the federal poverty rate, racial minorities, or individuals with disabilities.

Evidence-based/Promising Practice

Wholesome Rx, an evidence-based prescription for food model, had been adapted for this project. The program will be modified to focus its education component on prevention of heart attack, stroke, and cancer through diet and nutrition modification, and will include evidence-based education and screenings related to heart attack, stroke, and cancer.

Project Description

Participants will be able to participate in a FARMACY program through the health care clinic in their region. Participants will receive a prescription for FARMACY, providing access to healthy food, training in an evidence-based nutrition intervention program, evidence-based cancer screening education, and information about other resources in their service area.

Through the FARMACY, our consortium will expand access to, coordinate, and improve the use of regional resources related to food access, community nutrition intervention, and cancer screening education and health care services. Additionally, the FARMACY will help the consortium implement policy, environmental, systemic, and community-clinical linkage changes that will address behaviors that can lead to death by hypertension, stroke, and cancer. The project will strengthen the rural health community and regional resources in creating efficiencies of service and improve overall health outcomes.

Project Goals

1. Expand access to, coordinate, and improve the use of regional resources between health care agencies, food distribution organizations, and community education programs to improve the health outcomes of rural at-risk patients to prevent hypertension, stroke, and cancer.
2. Develop, implement, and access a FARMACY program that can be duplicated to other rural medical sites based on the Wholesome Rx, a promising practice of prescription for healthy food program, to improve health by promoting healthy eating

and making nutritious foods available; educating about the impact of nutrition on hypertension, stroke, and cancer; and providing increased health screenings.

3. Achieve efficiencies through the development of a strong consortium of services between rural medical organizations, food banks and produce aggregators, community health educators, and state agencies by coordinating and increasing data collection, education, and use of food access programs in the FARMACY region.
4. Strengthen the rural health system and the participating communities as a whole to support the population in addressing and reducing risky behaviors that can result in hypertension, stroke, and cancer by strengthening the capacity, sustainability, and outcomes of FARMACY project members to support the needs of the community.

Expected Outcomes

Anticipated outcomes include:

1. Increased access to healthy nutrition-dense foods through clinical sites;
2. Improved screening rates and earlier intervention for hypertension, diabetes, abnormal body mass index, and cancer;
3. Increased education on heart disease, stroke, and cancer;
4. Decrease in deaths related to heart attack, stroke, and cancer; and
5. Improved efficiencies in the coordination of health care, foodbanks, and community education programs.

Worcester County

Lead Organization Information

Lead Applicant Organization Type	Phone	Organization Website	
Health Department	410-632-9915	www.worcesterhealth.org	
Street Address	**City**	**State**	**Email**
6040 Public Landing Rd.	Snow Hill	MD	traceya.age@maryland.gov

Primary Consortium Partners

Name	State	Organization Type
Atlantic General Hospital	Maryland	Hospital (non-CAH)
Berlin Volunteer Fire Company	Maryland	Fire/Emergency Medical Services
Bishopville Volunteer Fire Department	Maryland	Fire/Emergency Medical Services
Girdletree Volunteer Fire Company	Maryland	Fire/Emergency Medical Services
Newark Volunteer Fire Company	Maryland	Fire/Emergency Medical Services
Ocean City Fire Department	Maryland	Fire/Emergency Medical Services
Ocean Pines Volunteer Fire Department	Maryland	Fire/Emergency Medical Services
Pocomoke City Emergency Medical Services	Maryland	Fire/Emergency Medical Services
Pocomoke City Volunteer Fire Company	Maryland	Fire/Emergency Medical Services
Showell Volunteer Fire Department	Maryland	Fire/Emergency Medical Services
Snow Hill Volunteer Fire Company	Maryland	Fire/Emergency Medical Services
Stockton Volunteer Fire Company	Maryland	Fire/Emergency Medical Services

Focus Areas

Care Coordination	Health Equity

Target Population

Worcester County adults who are identified as high utilizers of emergency medical services (EMS) and emergency department (ED) services. These high-risk individuals are recipients of fragmented health care services, experience high rates of chronic disease, and are identified as needing preventive, primary care services.

Evidence-based/Promising Practice

The Worcester County Mobile Integrated Community Health (MICH) program design utilizes the evidence-based model of Mobile Integrated Health (MIH) care coordination services. The Worcester County MICH program has slightly adapted the MIH model with the addition of a community health worker. The core team of professionals is a paramedic, registered nurse, and community health outreach worker, who work in collaboration with a hospital pharmacist, social worker, and EMS medical director.

Project Description

Worcester County Health Department (WCHD), in collaboration with Atlantic General Hospital (AGH) and 11 Worcester County Fire/EMS agencies, has established a multidisciplinary MICH team focused on addressing the overutilization of EMS and ED services. Aligning the care coordination experience of WCHD, medical direction and pharmaceutical support from AGH, and early identification of high-risk individuals by Worcester County Fire/EMS providers gives an integrated team to address the overutilization of EMS and ED services. The close relationship of EMS with their rural communities provides an effective opportunity to engage high-risk individuals onto a path of improved health through a decrease of social determinant of health barriers, improved access to health care, and a better understanding of their own person-centered health care plan. MICH interventions include home visits, comprehensive health and safety assessments, medication reconciliation, chronic disease education, facilitated referral into primary care and specialty chronic disease care, social support resources, procurement of resources for medication assistance, as well as other resources for improved disease self-management and overall health.

Project Goals

The overall goal of this project is to establish a MICH care coordination program to improve health outcomes of Worcester County adults identified as high utilizers of EMS and ED services. This proposal has four specific goals identified to promote the delivery of health care services to the target population:

1. The provision of care coordination services to increase access to appropriate health care services and community resources for high utilizers of Worcester County EMS system and Atlantic General Hospital ED.
2. Build and maintain a consortium of agencies, engaged and committed to supporting a MICH program to address the health care needs and services gaps of Worcester County residents identified as inappropriate utilizers of EMS and high utilizers of ED services.
3. The Worcester County MICH team, utilizing a MIH evidence-based model, will have representation and engagement of Worcester County Fire and EMS paramedics who can relate and identify the diverse needs of their own rural communities throughout Worcester County.
4. Reduce health disparities of high-risk individuals by addressing social determinant of health barriers and develop a sustainability plan to achieve improved health outcomes of MICH participants while demonstrating value and partnering agency cost savings to sustain future MICH program activities.

Expected Outcomes

Reduction in Worcester County emergency medical service 9-1-1 (Priority 3) calls of enrolled MICH clients. Reduction in Atlantic General Hospital's ED visits of enrolled MICH clients. Reduction in Atlantic General Hospital's 30-day readmission rate of enrolled MICH clients. Increased utilization of primary care services of enrolled MICH clients. Improved self-management of chronic disease of enrolled MICH clients. Reduction in number of falls of enrolled MICH clients. Improved patient satisfaction of enrolled MICH clients in the health care delivery provided by the Worcester County MICH team.

APPENDIX A: Grantees by Focus Areas

Grant Organization Name	State	Track	Cancer	Care Coordination	Chronic Disease Management	Chronic Lower Respiratory Disease	Diabetes	Health Education/Promotion and Disease Prevention	Health Equity	Health Screenings	Heart Disease	Maternal and Child Health	Mental Health	Oral Health	Population Health	Primary Care	School-based Health	Stroke	Substance Use	Telehealth/Telemedicine	Unintentional Injury
Adagio Health, Inc.	PA	HRHI	●	●				●		●											
Arukah Institute of Healing, Inc.	IL	HRHI		●									●						●		●
Avera Health	SD	HRHI		●	●	●					●									●	
Bi-State Primary Care Association, Inc.	NH	HRHI		●	●						●					●					
Coastal Bend Wellness Foundation, Inc.	TX	HRHI		●				●											●		
Columbia County Hospital District	WA	HRHI			●	●															
Delta Health Alliance, Inc.	MS	HRHI																	●		●
Great Mines Health Center	MO	HRHI			●						●										
Health West, Inc.	ID	HRHI			●	●	●	●			●				●						
Intermountain Health Care, Inc.	UT	HRHI		●	●	●					●										
James Madison University	VA	HRHI																	●		●
Louisiana Rural Health Association	LA	HRHI					●				●										
Southcentral Foundation	AK	HRHI																	●		●
Trustees of Indiana University	IN	HRHI		●									●						●		
University of Arkansas System	AR	HRHI	●					●	●	●											
Wirt County Health Services Association, Inc.	WV	HRHI	●					●	●	●	●				●			●			
Access East Inc.	NC	Outreach		●	●										●						
AdvantagePoint Health Alliance – Great Lakes, LLC	TN	Outreach		●	●			●							●	●					
AdvantagePoint Health Alliance Blue Ridge, LLC	TN	Outreach		●	●			●							●	●					

Grant Organization Name	State	Track	Cancer	Care Coordination	Chronic Disease Management	Chronic Lower Respiratory Disease	Diabetes	Health Education/Promotion and Disease Prevention	Health Equity	Health Screenings	Heart Disease	Maternal and Child Health	Mental Health	Oral Health	Population Health	Primary Care	School-based Health	Stroke	Substance Use	Telehealth/Telemedicine	Unintentional Injury
Appling County	GA	Outreach					●				●										
Bighorn Valley Health Center, Inc.	MT	Outreach															●				
Canyonlands Community Health Care	AZ	Outreach		●			●	●	●						●						
Catholic Health Initiatives – Iowa, Corp.	IA	Outreach													●	●					
Cornerstone Care, Inc.	PA	Outreach		●			●	●													
Creek Valley Health Clinic	AZ	Outreach			●		●	●					●			●					●
Dublin City Schools	GA	Outreach						●						●			●				
Educational Service District 113	WA	Outreach						●					●	●		●	●			●	
Family Health Centers	WA	Outreach		●				●	●						●					●	
Family Health Council of Central Pennsylvania, Inc.	PA	Outreach		●										●							
Goshen Medical Center, Inc.	NC	Outreach									●			●		●			●		
Granville-Vance District Health Department	NC	Outreach											●						●		●
HealthIE Georgia Corp.	GA	Outreach		●								●	●			●			●		
Healthy Acadia	ME	Outreach										●							●		
Healthy Communities Coalition of Lyon and Storey Counties	NV	Outreach					●	●						●		●				●	
Heartland Rural Health Network, Inc.	FL	Outreach		●												●				●	
Horizon Behavioral Health	VA	Outreach											●						●		
Lake County Tribal Health Consortium, Inc.	CA	Outreach			●		●	●													
MaineHealth	ME	Outreach		●	●			●		●					●					●	
MaineHealth Care at Home	ME	Outreach		●	●	●		●													
Mainline Health Systems, Inc.	AR	Outreach													●						
Marysville Unified School District 364	KS	Outreach											●				●		●		
Mercy Health Cincinnati, LLC	KY	Outreach											●						●		

Grant Organization Name	State	Track	Cancer	Care Coordination	Chronic Disease Management	Chronic Lower Respiratory Disease	Diabetes	Health Education/Promotion and Disease Prevention	Health Equity	Health Screenings	Heart Disease	Maternal and Child Health	Mental Health	Oral Health	Population Health	Primary Care	School-based Health	Stroke	Substance Use	Telehealth/Telemedicine	Unintentional Injury
Michigan Center for Rural Health	MI	Outreach		●	●				●	●			●		●						
Michigan Rural EMS Network	MI	Outreach		●									●		●				●		
Miners' Colfax Medical Center	NM	Outreach				●				●										●	
North Dakota State University	ND	Outreach										●			●					●	
Northwest Iowa Mental Health Center	IA	Outreach		●									●								
Oklahoma Foundation for Medical Quality, Inc.	OK	Outreach			●		●	●												●	
Oneida Health Systems, Inc.	NY	Outreach		●									●		●	●					
Oswego County Opportunities, Inc.	NY	Outreach		●	●				●		●				●						
Otto Kaiser Memorial Hospital Foundation	TX	Outreach					●	●												●	
Pennyroyal Healthcare Service, Inc.	KY	Outreach		●	●			●	●						●	●					
Randolph County Caring Community, Inc.	MO	Outreach		●				●	●				●			●				●	
Regents of the University of Idaho	ID	Outreach											●			●				●	
Richland Medical Center, Inc.	MO	Outreach					●					●			●	●					
Samaritan Pacific Health Services, Inc.	OR	Outreach						●						●		●			●		
Santa Fe Recovery Center, Inc.	NM	Outreach																	●		
Tallahatchie General Hospital Medical Foundation	MS	Outreach			●		●	●		●										●	
Tattnall County Board of Education, Inc.	GA	Outreach											●				●			●	
Williamson Health & Wellness Center, Inc.	WV	Outreach		●	●		●		●		●										
Worcester County	MD	Outreach		●					●												
		Total	3	27	19	6	12	23	10	7	10	4	16	6	16	15	4		14	13	6

APPENDIX B: Grant Organizations by State

State	Grant Organization Name	Track
AK	Southcentral Foundation	HRHI
AR	Mainline Health Systems, Inc.	Outreach
AR	University of Arkansas System	HRHI
AZ	Canyonlands Community Health Care	Outreach
AZ	Creek Valley Health Clinic	Outreach
CA	Lake County Tribal Health Consortium, Inc.	Outreach
FL	Heartland Rural Health Network, Inc.	Outreach
GA	Appling County	Outreach
GA	Dublin City Schools	Outreach
GA	HealtHIE Georgia Corp.	Outreach
GA	Tattnall County Board of Education, Inc.	Outreach
IA	Catholic Health Initiatives – Iowa, Corp.	Outreach
IA	Northwest Iowa Mental Health Center	Outreach
ID	Health West, Inc.	HRHI
ID	Regents of the University of Idaho	Outreach
IL	Arukah Institute of Healing, Inc.	HRHI
IN	Trustees of Indiana University	HRHI
KS	Marysville Unified School District 364	Outreach
KY	Mercy Health Cincinnati, LLC	Outreach
KY	Pennyroyal Healthcare Service, Inc.	Outreach
LA	Louisiana Rural Health Association	HRHI
MD	Worcester County	Outreach
ME	Healthy Acadia	Outreach
ME	MaineHealth	Outreach
ME	MaineHealth Care at Home	Outreach
MI	Michigan Center for Rural Health	Outreach
MI	Michigan Rural EMS Network	Outreach
MO	Great Mines Health Center	HRHI
MO	Randolph County Caring Community, Inc.	Outreach
MO	Richland Medical Center, Inc.	Outreach
MS	Delta Health Alliance, Inc.	HRHI
MS	Tallahatchie General Hospital Medical Foundation	Outreach
MT	Bighorn Valley Health Center, Inc.	Outreach
NC	Access East, Inc.	Outreach
NC	Goshen Medical Center, Inc.	Outreach
NC	Granville-Vance District Health Department	Outreach
ND	North Dakota State University	Outreach
NH	Bi-State Primary Care Association, Inc.	HRHI
NM	Miners' Colfax Medical Center	Outreach
NM	Santa Fe Recovery Center, Inc.	Outreach

State	Grant Organization Name	Track
NV	Healthy Communities Coalition of Lyon and Storey Counties	Outreach
NY	Oneida Health Systems, Inc.	Outreach
NY	Oswego County Opportunities, Inc.	Outreach
OK	Oklahoma Foundation for Medical Quality, Inc.	Outreach
OR	Samaritan Pacific Health Services, Inc.	Outreach
PA	Adagio Health, Inc.	HRHI
PA	Cornerstone Care, Inc.	Outreach
PA	Family Health Council of Central Pennsylvania, Inc.	Outreach
SD	Avera Health	HRHI
TN	AdvantagePoint Health Alliance – Great Lakes, LLC	Outreach
TN	AdvantagePoint Health Alliance Blue Ridge, LLC	Outreach
TX	Coastal Bend Wellness Foundation, Inc.	HRHI
TX	Otto Kaiser Memorial Hospital Foundation	Outreach
UT	Intermountain Health Care, Inc.	HRHI
VA	Horizon Behavioral Health	Outreach
VA	James Madison University	HRHI
WA	Columbia County Hospital District	HRHI
WA	Educational Service District 113	Outreach
WA	Family Health Centers	Outreach
WV	Wirt County Health Services Association, Inc.	HRHI
WV	Williamson Health & Wellness Center, Inc.	Outreach

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