Small Health Care Provider Quality Improvement Program

2022–2026 Grantee Directory

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

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Introduction

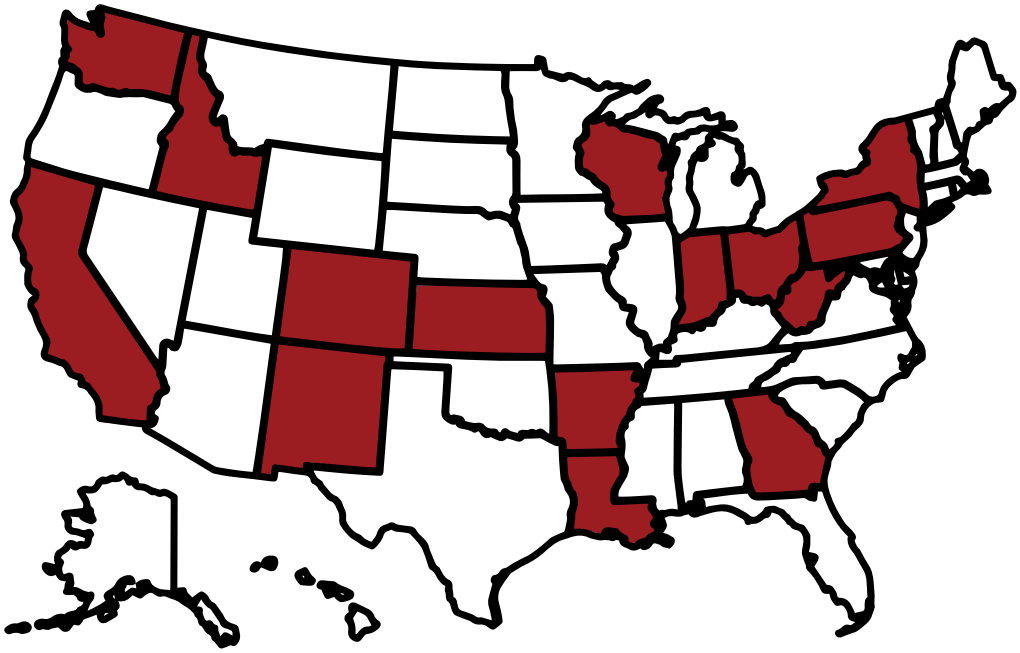
Authorized by Title III, Public Health Service Act, Section 330A(g) (42 U.S.C. 254c(g)), as amended by Section 201, P.L. 107-251, and Section 4, P.L. 110-355, the purpose of the Small Health Care Provider Quality Improvement Grant Program is to support planning and implementation of quality improvement activities for rural primary care providers, or providers of health care services, such as a Critical Access Hospital or a rural health clinic, serving rural residents. These activities include providing clinical health services to residents of rural areas by funding projects that coordinate, expand access to, contain the costs of, and improve the quality of essential health care services.

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

This directory provides contact information and a brief overview of each of the 21 initiatives funded under the Small Health Care Provider Quality Improvement Grant Program's 2022-26 funding cycle.

Grantees by State

This cohort has funded grantees in the following 15 states: Arkansas, California, Colorado, Georgia, Idaho, Indiana, Kansas, Louisiana, New Mexico, New York, Ohio, Pennsylvania, Washington, Wisconsin, and West Virginia.



Grantees by Primary Focus Area

Grantees may choose to address more than one issue within their organizations and communities to improve the delivery of health care services, engage patients in care, and better manage disease and disability. The following chart shows the primary focus area for each grantee in the cohort.

Grantee Name	Aging	Behavioral/Mental Health Services	Cancer	Cardiovascular Disease	Care Coordination	Chronic Obstructive Pulmonary Disease	Diabetes	Patient-Centered Medical Home	Pharmacy Assistance/ Medication Management
Cascade Medical Center	•								
Dublin City Schools		•							

Grantee Name	Aging	Behavioral/Mental Health Services	Cancer	Cardiovascular Disease	Care Coordination	Chronic Obstructive Pulmonary Disease	Diabetes	Patient-Centered Medical Home	Pharmacy Assistance/ Medication Management
El Centro Family Health				•					
El Dorado County Community Health Center				•					
Five Rivers Medical Center Inc.					•				
Holzer Health System					•				
Innis Community Health Center Inc.									•
Klickitat County Public Hospital District 2					•				
Logan-Mingo Area Mental Health Inc.				•					
Mainline Health Systems Inc.					•				
Margaretville Memorial Hospital						•			
Mendocino Coast Clinics Inc.		•							
Mountain Valleys Health Centers					•				
Neighborhood Health Center Inc.					•				
Sheridan County								•	
Teche Action Board Inc.					•				
ThedaCare Medical Center - Waupaca Inc.		•							
Tri-County Health Network					•				
UPMC Kane						•			
Westchester-Ellenville Hospital Inc.			•						
White River Health System Inc.		•							

Grantees Profiles

The following section contains contact information and brief descriptions of the 21 Small Health Care Provider Quality Improvement Grant Program grantees funded during the 2022-26 grant period. They are arranged alphabetically by organization name. These profiles include a description of the target population, project focus areas, evidence-based models, health information technology, project goals and objectives, project description, and expected outcomes.

Cascade Medical Center

Primary Focus Area:
Aging

Other Focus Area(s):
Community Health Workers, Disabled and Transportation-Limited Residents, Hospital or Emergency Department Reduction or Prevention, Social Determinants of Health

Organization type:
Critical Access Hospital

Grantee Contact Information

Organization	Cascade Medical Center
Address	402 Lake Cascade Pkwy #1330
City/State/Zip	Cascade, ID 83611
Website	www.cmchd.org
Project Director	Tom Reinhardt
Telephone No.	208-382-4242
Email	treinhardt@cmchd.org

Target Populations

The target population for this project is the service area of Cascade Medical Center (CMC) Hospital District in Valley County, Idaho. The population fluctuates seasonally from 4,000 residents in the winter to a multiple of that in the summer. Within the total population, more specific targets are the elderly, disabled, and other transportation-challenged residents. Seniors make up about 30% of the 4,000 full-time resident hospital district population, which is double Idaho's senior population rate (U.S. Census 2018 data).

Project Description

CMC and partners in the Healthy Aging Planning Network (HAPN) will address this issue of aging in place and transportation barriers to create better access to care and improve senior health outcomes through the Cascade Connects program. This program integrates a community health worker model with patient transport to medical appointments. Cascade Connects will send community health workers (called community health advocates in this

program) out into the community to patients' homes to address social determinants of health that adversely affect health, identify health issues early, and connect these patients to services. To ensure that patients get the care that they need, Cascade Connects will include a van transportation service to bring patients to medical appointments.

Health Information Technology Used

The health information technology that will be utilized for this project is the Athena electronic medical record, remote patient monitoring strategies, and the Zoom telehealth platform for video visits.

Evidence-based or Promising Practice

The Cascade Connects project will utilize the Chronic Care Model and community health workers to meet the needs of low-income seniors in the target service area. These models have been effective in similar rural and frontier communities addressing social determinants of health. In a similar community in Montana, use of this model proved effective to address the needs of chronically ill, underengaged, and underserved patients with comorbidities and few resources.

Project Goals

The goal of the Cascade Connects program is to improve health outcomes and access to care for 100 seniors per year and 100 other individuals who are transportation-challenged, including those who are disabled, unable to drive, or do not have access to a reliable vehicle.

Expected Outcomes

1. Improved health outcomes: Decline in Medicare hospitalization for clients participating in this program for at least a full year. At least two-thirds of participants will report that the program taught them about their health conditions, and more than 85% percent will report that the program improved their lives.
2. Expanded capacity for essential health care services:
   - Increased access to health services for 200 area senior citizens and other patients.
3. Increased financial sustainability:
   - Creation of sustainable transportation and community health advocate model resulting in the ability of seniors to remain in their personal residence longer.

Dublin City Schools

Organization type:
School District

Primary Focus Area:
Behavioral/Mental Health Services

Grantee Contact Information

Organization	Dublin City Schools
Address	205 Shamrock Drive
City/State/Zip	Dublin, GA 30263
Website	www.dcsirish.com
Project Director	Tonia Spaulding
Telephone No.	478-290-5711
Email	Tonia.spaulding@dcsirish.com

Target Populations

The target population for the project is all 2,336 students, prekindergarten through 12th grade, enrolled in the Dublin City School System and their parents or guardians.

Project Description

The purpose of the Dublin City School Health Network Quality Improvement Initiative is to plan and implement quality improvement activities for the school system's Behavioral Health Services Department, working closely with the school health clinics, serving all 2,336 students, prekindergarten through 12th grade, in the Dublin City School System. This includes enhancing our current mental/behavioral services through the use of telehealth technology and connectivity, continuing to integrate and expand mental/behavioral health offered through our school system's Behavioral Health Services Department (in-person and virtual), promoting effective communication and coordination of care, working with the community to promote wide use of best practices to enable healthy living, and developing the necessary capacity and ability to obtain funding from other sources.

Health Information Technology Used

This project will enhance current mental and behavioral services through the use of telehealth technology and connectivity. This includes investigating potential telehealth options and identifying necessary infrastructure, upgrading equipment as necessary, and receiving additional training and ongoing technical assistance support as needed. Grant performance data will be routinely tracked on grant-specific electronic spreadsheets.

Evidence-based or Promising Practice

Our selected quality improvement model involves integrating comprehensive mental/behavioral health services into the school-based setting.

Project Goals

Goals:

1. Promote the development of cost-effective, coordinated, culturally appropriate, and equitable health care services in schools with a focus on integrating mental/behavioral services.
2. Improve health outcomes for students and parents.
3. Increase financial sustainability.

Expected Outcomes

Outcome objectives (improved health outcomes):

Health Care Access:

1.1: Increase the number of students receiving on-site mental/behavioral services from a licensed mental health counselor by an additional 150 students per year by the 2025-26 school year.

1.2: Increase the number of students receiving mental/behavioral services using the telehealth model from zero students during the 2021-22 school year to 25 students per year during the 2025-26 school year.

Mental/Behavioral Services:

1.3: Decrease the percentage of students in grades 6-12 who state that they have been bullied or threatened in the past 30 days from 19.5% during the 2019-20 school year to 10% during the 2025-26 school year.

1.4: Decrease the percentage of students who have been in a fight at school from 13.3% during the 2019-20 school year to 9% during the 2025-26 school year.

1.5: Decrease the percentage of students who have seriously considered attempting suicide from 10.8% during the 2019-20 school year to 5% during the 2025-26 school year.

1.6: Decrease the percentage of students who have attempted suicide from 7.4% during the 2019-20 school year to 3.5% during the 2025-26 school year.

Process Objectives (expanded capacity for essential health care services and increased financial sustainability):

1.1: Enhance current mental/behavioral health services through the use of telehealth technology and connectivity.

1.2: Continue to integrate and expand mental/behavioral health services offered through the school system's Behavioral Health Services Department (in-person and virtual).

1.3: Promote effective communication and coordination of care.

1.4: Work with the community to promote wide use of best practices to enable healthy living.

1.5: Develop the necessary capacity and ability to obtain funding from other sources.

New Mexico

El Centro Family Health

Primary Focus Area:
Diabetes

Organization type:
Nonprofit

Other Focus Area(s):
Cardiovascular Disease

Grantee Contact Information

Organization	El Centro Family Health
Address	538 N. Paseo de Onate
City/State/Zip	Espanola, NM 87532
Website	www.ECFH.org
Project Director	Lore Pease
Telephone No.	505-753-7218
Email	Lore.pease@ecfh.org

Target Populations

The proposed project's target population is patients in northern New Mexico with a diabetes and hypertension diagnosis.

Project Description

The Semillas de Esperanza consortium members have identified that chronic care management/health education is especially important and critically timely in realizing population health improvements among the most vulnerable patients in this rural service area that have had limited or no access to primary care in the past two years. In addition, the lack of chronic care management strategies is one of the largest challenges for all the major health care institutions in transitioning toward value-based payments and patient-centered medical home models and the missing link for realizing fewer unnecessary hospitalizations and improved communication and data sharing among hospitals and primary care providers. The Semillas de Esperanza partners have designed a chronic care management/health education model that will be piloted in Rio Arriba County and Taos County, N.M., to provide targeted outreach to chronic care patients with a dual diagnosis of diabetes and hypertension who are established patients at El Centro's six primary care clinics in these counties. In addition, El Centro will prioritize these chronic care patients who have not been seen in the clinic for the past

12 months or have not received a hemoglobin A1c test in the last six months. Based on a recent eClinicalWorks report, there are 1,263 patients who meet these criteria and will be the focus of this chronic care management/health education initiative.

Health Information Technology Used

The project will collect patient demographic information using NextGen, the electronic health record system (EHR) that will be utilized throughout the grant period. The Semillas de Esperanza consortium has developed a comprehensive process and outcomes measurement plan that will collect data depicting project success and allow for regular tracking and assessment toward meeting expected outcomes. El Centro has well-established systems in place for data collection to collect, analyze, and track data to measure site-specific progress, impact, and outcomes with different cultural groups (race, ethnicity, and language) and be able to utilize the data to inform program development and service delivery.

Evidence-based or Promising Practice

The following evidenced-based models and promising practices will be used in the project:

- Chronic Care Model
- Motivational interviewing
- American Heart Association — Remote patient monitoring
- Patient Health Engagement Model

Project Goals

Goal 1: Reengage patients, reduce treatment anxiety, and improve health education/care coordination for patients with chronic health conditions through the dedicated support of chronic care health educators (CCHEs) to improve clinical quality measures and health outcomes in a rural northern New Mexico service area.

Goal 2: Provide evidence-based practice trainings and skills enhancement to the CCHE team to support effective patient engagement and chronic condition health care coordination, as well as building a skilled workforce.

Goal 3: Expand remote monitoring/device distribution and improved glucose monitoring to support the reengagement of patients with diabetes and hypertension, improve clinical quality measures, and improve patient health outcomes.

Goal 4: To support ongoing financial sustainability, chronic care management efforts will include billing to Medicare/Medicaid, accessing quality improvement–based incentives as available, and preparing for the overall health care system transition to value-based health care payment models.

Goal 5: Ensure a successful project through clinical, project, and Performance Improvement Measurement System (PIMS) measure tracking and evaluation; quality improvement analysis and continuous quality improvement cycles; collaboration with hospital partner; and grant plan/assessment development.

Expected Outcomes

- Improved clinical measures for controlling diabetes: Hemoglobin A1c poor control (42% improvement) and controlling high blood pressure with Uniform Data System (UDS) measures (40% improvement) by end of Year 4 (EHR/UDS)
- Patients working with CCHEs will see a 25% reduction in annual emergency department visits and hospitalizations by the end of Year 4.
- Fifty percent of targeted patients served by CCHEs in El Centro Family Health North and West hubs have a care plan developed by the end of Year 4.
- Patients provided with CCHE support increase their chronic condition knowledge by 50% between initial and one-year follow-up survey administrations.
- Patients provided with CCHE support increase their knowledge about remote monitoring device by 50% between initial and one-year follow-up survey administrations.
- Fifty percent of patients who have a remote monitoring device are sending in an electronic reading recorded in the electronic medical record by end of Year 4.
- El Centro Family Health able to bill for majority of CCHE activities through Medicare and New Mexico Medicaid by the end of Year 4.
- Sustainability plan completed in Year 4.

El Dorado County Community Health Center

Organization type:
Federally Qualified Health Center

Primary Focus Area:
Cardiovascular Disease

Other Focus Area(s):
Clinical Quality, Health Equity, Health/Wellness Coaching, Social Determinants of Health, Tobacco Use

Grantee Contact Information

Organization	El Dorado County Community Health Center
Address	4212 Missouri Flat Road
City/State/Zip	Placerville, CA 95667
Website	www.edcchc.org
Project Director	Alicia Kelley
Telephone No.	530-621-7700
Email	akelley@edchc.org

Target Populations

The target population for the project is 3,500 low-income adults living in rural areas of El Dorado County, Calif., who are at risk for heart disease and stroke and patients of El Dorado County Community Health Center (EDCCHC).

Project Description

The El Dorado Million Hearts Project will implement locally the national Million Hearts initiative to reduce heart disease and stroke among low-income adults living in rural areas. Working with Access El Dorado (ACCEL), an existing rural community collaborative, the project will build healthy communities through reductions in tobacco use, physical inactivity, and particle pollution exposure. The project will focus on optimizing care for patients at risk for heart disease and stroke by implementing the ABCSs of cardiovascular disease prevention, which are (1) appropriate aspirin and anti-coagulant use, (2) blood pressure control, (3) cholesterol management, and (4) smoking cessation. The project will also focus on health equity by implementing policies and practices that will ensure equal access to health care services and resources through social determinants of health screening and referrals to community hubs.

Health Information Technology Used

Systems that will be used to track and manage program data will include eClinicalWorks (eCW), EDCCHC's electronic health record, and Tableau and Relevant, which are data analytics and data reporting visualization tools. eCW will be used to track PRAPARE survey results, referrals, and follow-up for the target population. These systems will allow EDCCHC to create provider dashboards and reports that will allow for tracking performance in key project activities. Other systems essential to successful implementation of project activities include written workflows and referral processes and the use of Excel spreadsheets for tracking project activities outside of eCW.

Evidence-based or Promising Practice

The El Dorado Million Hearts Project will use two evidenced-based quality improvement models during project implementation. These models are the Model for Improvement and Plan-Do-Study-Act (PDSA).

Project Goals

The goal of the El Dorado Million Hearts Project is to reduce heart disease and stroke among 3,500 low-income adults living in rural designated areas of El Dorado County.

Expected Outcomes

Project expected outcomes align with those of the national Million Hearts initiative. Outcomes are categorized by three impact areas:

1. Improved health outcomes. The project will improve health outcomes among participants through 20% reductions in tobacco use, physical inactivity, and exposure to particulate pollution and a 20% improvement in the ABCSs of cardiovascular disease prevention. Seventy percent of project participants will receive cardiac rehabilitation and referral for social determinants of health issues.
2. Expanded capacity for essential health care services. Essential health care will be expanded by improved interagency referral practices, integration of the ABCSs of cardiovascular disease prevention, and more tobacco cessation and education classes.
3. Increased financial sustainability. Financial sustainability will be increased through an experienced ACCEL collaborative capable of securing funding, increased patient visits, and improvement in health plan–incentivized measures.

Five Rivers Medical Center Inc.

Organization type:
Rural Health Clinic

Primary Focus Area:
Care Coordination

Other Focus Area(s):
Cardiovascular Disease, Diabetes, Obesity

Grantee Contact Information

Organization	Five Rivers Medical Center Inc.
Address	2801 Medical Center Drive
City/State/Zip	Pocahontas, AR 72455
Website	www.stbernards.info/five-rivers
Project Director	Candi Kelly
Telephone No.	870-892-6000
Email	ckelly@frmcar.com

Target Populations

The model created by this grant will serve the citizens of Randolph County, Ark. Randolph County is a rural county in Northeast Arkansas with a population of 18,571 individuals, according to the 2020 U.S. Census. The target population for this grant includes anyone in the service area chronically suffering from diabetes or hypertension; this program will specifically target the historically underserved populations of Marshallese, Hispanics, and African Americans in Randolph County.

Project Description

“Know your numbers” is the campaign slogan St. Bernards Five Rivers Clinic (SBFRC) will utilize to empower and prepare patients to manage their health using self-management strategies. This project will allow staff at SBFRC clinic to align the organizational structure to support coordinated care and population health emphasis. SBFRC will engage in a multitude of teachings, such as diabetes education, stroke prevention, and safe blood pressure. SBFRC will be able to expand enhanced relationships among service providers that support care coordination, such as other primary care providers, dentists, optometrists, pharmacists, outpatient dialysis providers, the health department, and home health and social service agencies. This project will allow the care team to measure and track patients’ blood pressure, blood glucose, weight, and lab values. SBFRC will be able to develop care plans with patients and allow extra time for teaching services to help patients reach their goals.

Health Information Technology Used

SBFRC will utilize Athena medical software. Athena will allow our care coordinator, in conjunction with the advanced practice registered nurse, to produce care plans, adjust care plans for positive and negative changes, and archive completed care plans. Athena also allows internal reports to be created and pulled into an Excel spreadsheet. Athena report builder will enable SBFRC to track data accurately.

Evidence-based or Promising Practice

The project resulting from this grant will follow the evidence-based Wagner Chronic Care Model (CCM) and the Model for Improvement. The CCM includes six facets of care that lead to the objective of a prepared team of health care workers and an informed, activated patient, with the goal of improved outcomes in patient health. The Model for Improvement framework is a tool that helps to accelerate improvement in projects by asking a list of questions.

Project Goals

Goal 1: Increase care coordination around diabetes and heart disease (blood glucose, weight, blood pressure, cholesterol)

Goal 2: Increase chronic disease management protocols and embed evidence-based guidelines into clinical practice

Goal 3: Improve health outcomes

Goal 4: Quality improvement

Expected Outcomes

1. Improved health outcomes
2. Expanded capacity for essential health care services
3. Increased financial sustainability
4. Positive impact on individuals
5. Positive impact on the community
6. Positive impact on the health care system

Holzer Health System

Organization type:
Hospital Health System

Primary Focus Area:
Care Coordination

Other Focus Area(s):
Chronic Disease Management, Social Determinants of Health, Value-Based Care, Workforce Development/Training

Grantee Contact Information

Organization	Holzer Health System
Address	100 Jackson Pike
City/State/Zip	Gallipolis, OH 45631
Website	www.holzer.org
Project Director	Laurie Collins
Telephone No.	740-446-5152
Email	lcollins@holzer.org

Target Populations

This project will reach a target population of adults 60 and older throughout the Holzer Health System and partners' service area of eight rural, Appalachian counties, which include six counties in Ohio and two counties in West Virginia.

Project Description

The partners of the Appalachian Communication Consortium (ACC) will create a sustainable quality improvement infrastructure to test and replicate methods for decreasing hospital admissions and improving care transitions for the older adult patient population. This infrastructure builds on the ACC's foundation of multidisciplinary care and care management. To strengthen care transitions for identified older adult patients, multidisciplinary teams will apply quality improvement techniques to enhance communication throughout all levels of care. This would include care systems between health care and community providers, between teams and patients, within electronic health records, and any other systems requiring attention through our quality improvement process. To meaningfully address health disparities

in the population, meaningful post-hospitalization support for older adult patients, showcasing the Hospital2Home program and other models of community support will be built. To advance sustainability, the consortium will gain increased knowledge of innovative payment programs, improve relationships with Medicare and payers, and prepare to test new payment strategies. This Communications Improvement Project (CIP) will deliver and grow most of its service capacity through care management. As care management services are enhanced for older adults throughout the consortium systems, technical assistance will be sought to determine eligibility to bill for these services. To do this work in a coordinated, cross-system fashion, Holzer Health System will formally partner with Ohio Valley Physicians (OVP) and the Area Agency on Aging District 7 (AAA7). This partnership will commission and train multidisciplinary quality improvement teams to extend a suite of services to defined sets of adult patients 60 and older.

Health Information Technology Used

Three electronic medical record (EMR) systems will be used for the project (Paragon, AthenaHealth, and PointClickCare). Paragon is the acute care system EMR, AthenaHealth is the ambulatory EMR, and PointClickCare is the post-acute EMR.

Evidence-based or Promising Practice

There will be a combination of three evidence-based/promising practices used to implement the project:

- TeamSTEPPS
- Teach Back at Care Transitions
- Hospital2Home

TeamSTEPPS was selected as the communications quality improvement model. This program was developed by the Agency for Healthcare Research and Quality and the Department of Defense to improve collaboration and communication. Teach Back will serve as the health literacy mechanism, and Hospital2Home as the model for care and follow-up with older adult patients after hospitalization. These were chosen as they all play an essential role in building communication and practice change across all goal areas.

Project Goals

Goal 1: Communications quality improvement — Staffing and data infrastructure. Form multidisciplinary teams to establish a communications quality improvement infrastructure for testing and improving transitions of care for adults 60 and older and decreasing hospital admissions and readmissions for pneumonia, congestive heart failure, and sepsis in years 1-2 and chronic obstructive pulmonary disease (COPD) and urinary tract infection (UTI) by years 3-4 by 10% each year.

Goal 2: Communications quality improvement — Training infrastructure. Establish a communications improvement training infrastructure and continuing education infrastructure to sustain quality and communications practice and culture change across consortium systems.

Goal 3: Communications quality improvement — Testing care management practice changes. Multidisciplinary teams will conduct communications and quality practice changes to improve care management and hospitalization outcomes for adults aged 60 and older.

Goal 4: Health equity and access. Implement AAA Hospital2Home and other social service referrals and extend social supports for and among older adult patients, building off the Hospital2Home and other models of community support. Goal 5: Institutional capacity for innovative payment and sustainability infrastructure. Increase partner institutional capacity and readiness to test and adopt financial sustainability models, such as new methods of reimbursing for care management services, creating cost-savings, and exploring value-based care.

Expected Outcomes

Goal 1 outcomes: (1) Memorialized data sharing agreements between health systems, (2) documented identified sustainability funding sources for new hires, (3) documented team composition and staff time to activities, and (4) documented progress on setting social determinants of health (SDOH) screening methods.

Goal 2 outcomes: (1) Increased knowledge, skills, and abilities in TeamSTEPPS communications quality improvement tools; (2) increased knowledge, skills, and use of Teach Back methods; and (3) increased knowledge of the Hospital2Home program.

Goal 3 outcomes: (1) Increased utilization of TeamSTEPPS tools, (2) increased use of standardized SDOH data collection across teams, (3) increased numbers of patients served, (4) documented use of patient feedback in care, (5) decreased admission/readmissions for pneumonia, congestive heart failure per 1,000 patient admissions by Year 2, and (6) decreased admissions/readmissions for COPD, sepsis, and UTI by Year 4.

Goal 4 outcomes: (1) Increased referrals to Hospital2Home; (2) increased Hospital2Home services; and (3) increased referrals to Supplemental Nutrition Assistance Program, Medicare transportation, and nutrition or smoking programs.

Goal 5 outcomes: (1) Initiated meetings with Medicare office; (2) increased knowledge about steps toward value-based care and accountable care organizations; and (3) increased knowledge about and readiness for chronic care management or transitional care management.

Innis Community Health Center Inc.

Organization type:
Federally Qualified Health Center

Primary Focus Area:
Pharmacy Assistance/ Medication Management

Other Focus Area(s):
Diabetes,
Obesity,
Telehealth/Telemedicine

Grantee Contact Information

Organization	Innis Community Health Center Inc.
Address	6450 LA Highway 1
City/State/Zip	Batchelor, LA 70747
Website	www.arborfamilyhealth.org
Project Director	Linda Matessino
Telephone No.	225-492-3775
Email	linda@arborfamilyhealth.org

Target Populations

The service area for this project is Pointe Coupee parish, a rural parish with farming as a major industry. The target population focus of this initiative is patients of the Arbor clinics (four locations) who are existing adult patients as well as new adult patients who have a diagnosis of diabetes, prediabetes, or morbid obesity. Based on 2021 data the target population includes 1,085 patients. The socioeconomic demographics of this population indicate a poverty rate of 20%, uninsured rate of 9%, and racial breakdown of 60% Caucasian and 40% African American. These high-risk patients will be recruited to join this new program called Intersect: A Collaborative Team-Based Model of Care Delivery. The goal is to serve 70% of this population (759 patients) throughout the grant period.

Project Description

The project will utilize a quality planning process based on quality improvement principles to design and implement an infrastructure that integrates the role of a clinical pharmacist into a rural primary care setting with limited resources. In addition, the project will refine and expand the current chronic disease management model using the certified health coach model of practice with patients.

An intersecting partnership of clinical pharmacists, clinical providers, health coaches, and the patient will be developed and become critical to achieving improved clinical outcomes and optimizing a team-based care delivery system for Innis Community Health Center (d/b/a Arbor Family Health) clinics.

The introduction and practice of a clinical pharmacy in the primary care setting will offer a unique approach embracing the philosophy of pharmaceutical care, which is a blending of a caring orientation with specialized drug therapy knowledge, experience, and judgment for the purpose of ensuring optimal patient outcomes in patients with complex chronic conditions. Through the Intersect project, the clinical pharmacist services will be performed through collaborative practice agreements with providers to enable a more individualized and coordinated drug therapy regimen.

Health Information Technology Used

The electronic medical record (EMR) system used by Arbor Family Health is eClinicalWorks. Telehealth visits are also available to patients using the webcam platform Doxy.me as well as the Pexip-Prime-Cloud Suite Cart System. The Collaborating partner, Xavier University School of Pharmacy, will be an approved user of Arbor Family Health's EMR system eClinicalWorks. In addition, they will be an approved user of the webcam technology for telehealth visits with patients.

Evidence-based or Promising Practice

The following evidence-based/promising practice models are being employed in this program:

- **Integration of clinical pharmacists** into the primary care team has been shown to be effective in improving clinical and behavioral health indicators as well as improving treatment quality by increasing patient knowledge and adherence to medication regimens. Innovative care delivery models like these have shown improvement in the patient experience as they interact with the health care delivery system in rural areas where resources are limited.
- **Chronic care management model**
- **Health coaching** with chronic disease patients — a collaborative model vs. directive model of care delivery.
- **Continuous quality improvement** methods utilized in planning — A systematic method of improvement has been adopted guiding staff through stages of quality improvement. The Plan-Do-Study-Act model is the method adopted by the organization. These steps lead to a cycle that is used to test and implement process improvement strategies and action plans. This cycle is continuous and will be ongoing throughout the grant period. The model also incorporates evidence-based guidelines and population management and embeds them into an organization's system to support improvement efforts.

Project Goals

1. Establish the infrastructure for the integration of the clinical pharmacist role into a rural primary care setting delivery model focusing on high-risk populations.
2. Formalize the ongoing partnership with Xavier University actualizing the clinical e-consult and telemedicine patient visits systems.
3. Demonstrate through specific data monitoring elements the improvements of clinical and behavioral indicators for patients enrolled in the Intersect program.

4. Refine and expand the clinical health coaching model used in Arbor Family Health's chronic care management program to include the clinical pharmacist role optimizing an Intersect team–based care delivery in collaborative drug management therapy.
5. Develop a final sustainability plan for the continuation of the Intersect model of care delivery.
6. Complete four years of annual grant reporting to include financial reports, Performance Improvement Measurement System (PIMS) data reports, and other deliverables as required by the funder.

Expected Outcomes

The Intersect program will track the following clinical outcome measures in addition to the required PIMS measures:

1. Improved health outcomes (measures knowledge and clinical test changes)
    b. Percentage of medication reconciliations performed annually indicating improvement trends
    c. Percentage of positive changes in HbA1c (clinical diabetes more than 9%) and positive changes (HbA1c greater than 7% and less than 9%)
    d. Percentage of Intersect patients completing preknowledge testing (disease plus medication action) comparing changes in knowledge annually
    e. Number of e-clinical pharmacist consults completed annually
    f. Percentage of Intersect patients completing an e-consult visit with a pharmacist documenting medication assessment and plan of care annually
    g. Percentage of patients enrolled in Intersect program and retention rate after one year
    h. Measured changes in provider knowledge and value of clinical pharmacist services to patients
    i. Percentage of patients completing annual achievement of annual preventive screenings as indicated in report card performance

Klickitat County Public Hospital District 2

Organization type:
Critical Access Hospital

Primary Focus Area:
Care Coordination

Other Focus Area(s):
Health/Wellness Coaching, Traditional Care

Grantee Contact Information

Organization	Klickitat County Public Hospital District 2
Address	211 Skyline Drive
City/State/Zip	White Salmon, WA 98672
Website	myskylinehealth.org
Project Director	Heidi Hedlund
Telephone No.	509-637-2801
Email	hhedlund@myskylinehealth.org

Target Populations

The target population for the proposed project is Medicare beneficiaries 65 years of age and older living within the seven fully rural counties (Pacific, Wahkiakum, Skamania, Klickitat, Ferry, Stevens, and Lincoln) of Washington state.

Project Description

This project will provide support to rural primary care providers, such as a Critical Access Hospitals (CAHs), a Rural Health Clinic, or a network of rural health providers, for the planning and implementation of quality improvement activities providing services to residents of rural areas. The proposed project will bring together the Rural Collaborative, Allevant Solutions, CAHs (four), and their affiliated primary care clinics to expand access to, coordination of, and quality of essential health care services across seven fully rural counties of Washington state (Pacific, Wahkiakum, Skamania, Klickitat, Ferry, Stevens, and Lincoln). The network will launch hospital-based post-acute transitional care, an evidence-informed model, to meet the growing post-recovery needs of medically complex patients within the rural setting. In addition, the project will implement the promising practice model, hospital-based transitional care, including MENDS® health, wellness, and prevention interventions, a model created for CAHs by Allevant Solutions, LLC, and developed by Mayo Clinic and Select Medical.

Health Information Technology Used

There are multiple electronic health records used across partners to include:

1. Klickitat County Public Hospital District No. 2 — Cerner CommunityWorks
2. Ferry County Public Hospital District — MEDITECH
3. Lincoln Hospital District No. 3 — Epic
4. Willapa Harbor Hospital — CPSI (migrating to Epic soon).

Allevant will train all CAH project teams on the use of Allevant tools (including software, databases, and spreadsheets) to ensure the timely and accurate tracking of services provided. Patient-level data will be entered into Allevant's Vantage database by local CAH team members. Data will be available via dashboards or individual reports at any time.

Evidence-based or Promising Practice

The proposed project will utilize the promising practice model CAH-based transitional care with MENDS®, created and implemented by Allevant Solutions, LLC, and developed by Mayo Clinic and Select Medical. Designed to comprehensively meet the complex post–acute care needs of Medicare beneficiaries (aged 65 and older) and increase options for high-quality recovery while also supporting and enhancing rural health care services and viability, this promising practice model uses existing CAH capacity and infrastructure through Medicare swing bed reimbursement.

Project Goals

Goal 1: Develop a strong regional network to meet the demonstrated needs of target rural communities through expanded access, coordination, and quality of essential health care services across seven rural counties of Washington state by 2026.

Goal 2: Throughout the period of performance, expand and enhance the delivery of health care services in seven rural counties of Washington state by implementing hospital-based post-acute transitional care (an evidence-informed model) at four CAH partners.

Goal 3: Beginning in Year 2, strategically support rural primary care provider teams within at least four CAH-affiliated primary care clinics within the seven-county rural service area to enhance the quality and delivery of locally available wellness support for rural patients recently discharged from post-acute transitional care.

Expected Outcomes

Anticipated outcomes of the project include, but are not limited to, the following: Short-term outcomes of developing and enhancing CAH-based transitional care programs with the MENDS® model include (1) increase in admissions/bed days from internal and external acute care sources; (2) optimal post-acute discharge disposition, fewer discharges from CAH back to acute care, more patients discharged from CAH to home, and shorter post-acute stays; (3) satisfied patients

and care teams; (4) increase in family participation in discharge and wellness planning; (5) increase in CAH staff and patients with identified personal wellness interventions and healthy behaviors; and (6) increased CAH revenue long-term outcomes. Long-term outcomes of developing and enhancing CAH-based transitional care programs with the MENDS® model include (1) sustained increase in internal and external admissions/bed days compared to baseline; (2) sustained, more consistent revenue with lower Medicare cost per patient per day and increased ability to make investments in CAH staff, equipment, and facilities with benefits beyond just post-acute care; (3) satisfied staff, a culture of safety, and a work environment focused on learning and improving; (4) reduction in urban CAH long stays and more efficient use and increased availability of secondary and tertiary acute care resources; (5) optimal discharge disposition — fewer back to acute, more to home, and shorter post-acute stays; (6) satisfied patients; (7) improved staff and patient wellness; and (8) incorporation of evidence-based process improvement methods into local CAH culture.

Logan-Mingo Area Mental Health Inc.

Organization type:
Federally Qualified Health Center

Primary Focus Area:
Cardiovascular Disease

Other Focus Area(s):
Behavioral/Mental Health Services,
Diabetes,
Pharmacy Assistance/Medication Management

Grantee Contact Information

Organization	Logan-Mingo Area Mental Health Inc.
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Website	www.lmamh.org
Project Director	Jill Click
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Email	jclick@lmamh.org

Target Populations

The target population is at-risk patients suffering from heart disease, unintentional injury by substance use, and diabetes in the rural counties of Logan (population 32,567) and Mingo (population of 23,568 in the 2020 Census). In addition, this project will target diabetes, as it has also been identified as a leading cause of chronic illness in West Virginia.

Project Description

The health center sought support to launch its own pharmacy as part of a broader shift toward integrated care and comprehensive medication management. The focus of this grant will be improved health outcomes for patients with heart disease, diabetes, and substance use disorder. It will allow the organization to increase medication adherence, improve data collection and analysis to better identify at-risk patients, and overcome obstacles to providing essential health care services. It will increase financial sustainability by allowing for reimbursements from the 340B drug pricing program and expanding overall utilization of services.

Health Information Technology Used

The project will use AthenaOne, a robust electronic health record (EHR) system that fully meets internal and external financial, analysis, and data requirements. During the implementation phase of the project, the health center intends to contract with a health information technology provider for pharmacy services and integrate this system with the current EHR for seamless data collection of services delivered to target populations and identify at-risk patients.

Evidence-based or Promising Practice

Comprehensive medication management (CMM) is a service that encompasses the patient's condition, clinical history, interventions tried and failed, problem list, and clinical notes from the health center's EHR. CMM is considered comprehensive because it looks at each patient's overall condition. The health center providing pharmacy services to patients will provide a unique opportunity in which the pharmacist will function as part of the health center's care team. CMM offers a much more coordinated level of care with focus on integrated treatment of the patient, with the goal of optimizing outcomes, not just particular conditions.

Project Goals

The overarching goal of this project is to move toward an integrated health care approach and achieve comprehensive medication management, which will increase treatment adherence through the launch of an in-house pharmacy and related interventions through the following:

1. Improving access to health care and services
2. Strengthening the organization's program management and operations
3. Reducing health disparities
4. Enhancing the value and impact the health center has within the service area

Project-specific goals include:

1. Increase in number of patients served
2. Increase in access to care
3. Increased financial sustainability
4. Increase in number of patients with controlled hypertension
5. Decrease in number of patients with poor HbA1c
6. Increase in number of patients with substance use disorders served

Expected Outcomes

The organization intends to improve health outcomes for patients with hypertension, diabetes, and substance use disorders through proposed project activities. To expand capacity for essential health care services, the health center will drive up usage of in-house pharmacy and related services. In efforts to increase financial sustainability, the health center will utilize 340B pricing to increase revenue and decrease costs for patients.

Mainline Health Systems Inc.

Organization type:
Federally Qualified Health Center

Primary Focus Area:
Care Coordination

Other Focus Area(s):
Cardiovascular Disease, Chronic Disease Management, Diabetes

Grantee Contact Information

Organization	Mainline Health Systems Inc.
Address	583 W Gaines Street
City/State/Zip	Monticello, AR 71655
Website	www.mainlinehealth.net
Project Director	Amanda Gilbert
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Email	agilbert@mainlinehealth.net

Target Populations

Mainline Health Systems Inc.'s (MHSI's) Chronic Care Management (CCM) program will serve 1,949 patients 65 or older, the target population is older (72% are 75 years or older) with two or more chronic conditions throughout six counties in Southeast Arkansas.

Project Description

The integrated CCM and transitional care management (TCM) project will support MHSI's own senior patient population residing within the defined service area. With a current estimate of 1,949 patients who would be eligible for the program, the target population is older (72% are 75 years or older), with the majority being treated for health conditions related to the Small Health Care Provider Quality Improvement Program's five leading causes of avoidable death, including heart-related disorders, cancer, diabetes, chronic lower respiratory disorders, and substance abuse. While MHSI has not established a formal partnership to deliver TCM/CCM services, it will work closely with four organizations — Aledade, the Arkansas Rural Health Partnership, the State Health Alliance for Records Exchange (SHARE), and Boston Mountain Rural Health Center — to enhance programs and services.

Health Information Technology Used

MHSI currently utilizes eClinicalWorks (eCW) electronic medical record. MHSI will continue to utilize eCW with the addition of the chronic care management (CCM) module for the CCM program. The module was designed specifically to manage CCM programs. The program includes care plan templates, time recording, and automated billing claims creation. The CCM module identifies eligible patients with preconfigured diagnosis and insurance criteria and provides dashboards, reminders, and other monitoring and outreach tools.

Evidence-based or Promising Practice

MHSI is proposing a project based on two evidence-based quality improvement models: the Chronic Care Model and the transitional care model. MHSI will implement a chronic care management project based on the Chronic Care Model and will implement a transitional care management project based on the Transitional Care Model.

Project Goals

Project Goals

1. Improve health outcomes for patients enrolled in the CCM and TCM programs.
2. Expand capacity and increase access to care for all Medicare patients.
3. Develop a financial sustainable delivery model to maintain program capacity and service levels after the project period.

Expected Outcomes

Of enrolled patients with hypertension or cardiovascular disease, 80% have controlled blood pressure by the end of the project period. Of enrolled patients with diabetes, 80% have controlled diabetes with an A1c less than 9 by the end of the project period. By the end of the project period, 55% of all enrolled patients, have had colorectal cancer screening within the required period. By the end of the project period, 70% of all enrolled patients have had breast cancer screening (mammogram) within the required/recommended period. By the end of the project period, 50% of all enrolled patients are influenza-immunized within the required/recommended period. By the end of the project period, 50% of all enrolled patients have received pneumococcal immunization within the required/recommended period. The 30-day hospital readmission for Medicare patients discharged from an approved inpatient facility will decrease by 10% over the project period. By the end of the project period, 75% of the patients enrolled in the CCM program with an identified social determinants of health issue will be referred to a case manager for services or directly referred to a community provider. By the end of the project period, 85% of Medicare patients discharged from an approved inpatient facility will receive a post-hospitalization provider visit from the CCM manager.

Margaretville Memorial Hospital

Primary Focus Area:
Chronic Obstructive Pulmonary Disease

Organization type:
Critical Access Hospital

Other Focus Area(s):
Chronic Lower Respiratory Disease

Grantee Contact Information

Organization	Margaretville Memorial Hospital
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Project Director	Edward McNamara
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Target Populations

The service area comprises a rapidly aging population (65 and older), reflecting a disproportionately older population challenged with significant health inequities, health care disparities, and health illiteracy. Ten percent (about 5,000 individuals) of the population in the service area suffers from chronic lower respiratory disease (CLRD). The target population is estimated to be 300 CLRD adult patients residing in Delaware, northwestern Ulster, and western Greene counties.

Project Description

The goal of this project is to fulfill an unmet CLRD service gap for adult patients by providing pulmonary function screening, care coordination, and chronic disease self-management training over a four-year period. The project will focus on strategies to connect people to a primary care provider, promote healthy behaviors, and create safe environments, which are key to reducing hospital visits. Other strategies to reduce emergency department visits for chronic obstructive pulmonary disease (COPD) include reducing smoking and exposure to air pollution, teaching people with COPD how to manage it, and promoting tests that can detect disease diagnosis earlier. As much of the target population is aging and living in rural areas, strategies to reduce health inequalities for this vulnerable population are

built into the project's goal and objectives. The project considers three areas of health equity to address: health care access, health care utilization, and health outcomes. Equal access is achieved through conducting extensive community outreach and providing workforce training to ensure all eligible patients across internal and external networks have the same opportunity to join the program. Once joined, baselines for social determinants of health needs and CLRD risk/disease stage will be established, along with the provision of appropriate care coordination services. Therefore, the project will create an equal health care utilization model for patients to connect with services to meet their clinical and social determinants of health needs. Finally, the project will provide community workshops to promote healthful behaviors and prevent illnesses for the community at large. The project also offers targeted, customizable training programs to patients to better self-manage their conditions, achieve equitable health outcomes, and reduce preventable deaths.

Health Information Technology Used

Patients will be identified using bidirectional electronic referrals internally from the Margaretville Hospital emergency department, inpatient health records, and the Mountainside Residential Care Center nursing home, as well as patients from Advanced Physician Services, an outpatient medical group practice. Trained nursing staff will review the electronic health record, Paragon, to identify eligible patients.

Evidence-based or Promising Practice

The evidence-based, quality improvement models for chronic disease management to be used are the Chronic Care Model (CCM) and Plan-Do-Study-Act. Margaretville Hospital will use the CCM as its selected quality improvement framework. CCM identifies the essential elements of a health care system that encourage high-quality chronic disease care. The model uses evidence-based change concepts and has been applied to various health care settings to guide improvement in care for myriad chronic illnesses and target populations. Margaretville Hospital's project will incorporate all six domains of CCM.

Project Goals

The overarching goal of this project is to improve respiratory health for 300 rural CLRD adult patients, with a 25% reduction of COPD exacerbation by Year 4, through the application of evidence-based quality improvement models including CCM and Plan-Do-Study-Act.

Expected Outcomes

The project will show continued progress in achieving four primary objectives over the four-year period of performance, and will, by July 31, 2026:

1. Identify, track, and provide pulmonary screening and care coordination to 300 CLRD patients;
2. Develop and expand a six-member collaborative provider network with key multisectoral community organizations;
3. Provide education and training to CLRD patients to increase their knowledge in self-managing CLRD conditions; and
4. Provide training to 30 nursing and provider staff members, including future staff, to generate a well-informed and confident provider workforce.

Mendocino Coast Clinics Inc.

Primary Focus Area:
Behavioral/Mental Health Services

Organization type:
Federally Qualified Health Center

Grantee Contact Information

Organization	Mendocino Coast Clinics Inc.
Address	205 South St
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Project Director	Jeremie Foley and Tracy Legris
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Target Populations

The target population to be served is youth aged 12-18 who live in the service area and will be reached through network partner Fort Bragg Unified School District middle, alternative, and high schools, as well as through Mendocino Coast Clinic's (MCC) primary care clinics. The potential target population served is close to 1,000 adolescents, with approximately 46% of students enrolled in the Fort Bragg Middle School and Fort Bragg High School identifying as Hispanic/Latinx. MCC will also conduct targeted outreach and support to youth identifying as LGBTQ+ and adolescents experiencing homelessness.

Project Description

Students at local partner schools will receive direct outreach from community health workers (CHWs), who will be hired as part of the project and dedicated to supporting these efforts. The CHWs will visit classrooms to discuss MCC's new confidential, behavioral health care service offerings as well as collect PHQ-2 screenings using a software application. CHWs will also reach out to student youth groups as another method of outreach. For students who test positive on the patient health questionnaire-2 (PHQ-2) screen, direct follow-up will be provided by CHWs to schedule a behavioral health appointment (either at the MCC Blue Door Clinic at the JD Center or through a telehealth visit based at a school district location). Student outreach will be tracked using a behavioral health software application that the students use

to submit their PHQ screen and then integrated into MCC's electronic health record (EHR). Many students are expected to already be in the EHR as they are likely existing MCC patients for primary health care services. As CHWs reach out to schedule appointments, MCC will be able to document each student who receives follow-up outreach. As students utilize the expanded MCC student behavioral health care services through walk-in hours at the clinic located across from the high school and through scheduled telehealth visits, a PHQ-9 screen will be administered during the initial behavioral health care visit. MCC will then be able to document a wide range of data relevant to the proposed quality improvement project, to include the number of patients aged 12-18 who received a clinical depression screening using the Uniform Data System (UDS) Screening for Clinical Depression and Follow-Up Plan measure and by the number of youth aged 12-18 who submit a 12-month PHQ-9 screen in order to track UDS Depression Remission for those who received an initial behavioral health visit. CHWs will use EHR and i2i Population Health (a data analysis platform) reports to follow up with students who may have missed their appointment and to inform participating youth about behavioral health–focused groups availability.

Health Information Technology Used

The project will use the following electronic medical record systems:

- NextGen EMR and I2I Population Health

Evidence-based or Promising Practice

1. Direct services include outreach to students in their classroom and to student groups to collect patient health questionnaire (PHQ, PHQ-2, and PHQ-9) behavioral health screening, to include discrete follow-up to students who score positively on their PHQ to schedule a confidential appointment.
2. Expansion of behavioral health service offerings to students to include expanded walk-in hours and appointments available at the MCC Blue Door Clinic at the JD Center (located conveniently across from the Fort Bragg High School and the three Fort Bragg alternative schools).
3. Expansion of behavioral health offerings using telehealth, with private locations set up at the MCC Blue Door Clinic at the JD Center and at the Fort Bragg Middle School.
4. Launch of behavioral health–focused groups to support students who are participating in behavioral health counseling.

Project Goals

Key project goals include improved patient health outcomes for targeted patients. Improved health outcomes include an expectation that 95% of patients aged 12-18 will have received a clinical depression screening using the UDS Screening for Clinical Depression and Follow-Up Plan measure by the end of the grant. The second is a goal that 60% of youth aged 12-18 will submit a 12-month PHQ-9 screen to track UDS Depression Remission for those who received an initial behavioral health visit. The proposed project also aims to expand capacity to provide essential behavioral health care services at Fort Bragg Unified School District middle and high schools, as well as expand universal behavioral health screening for adolescents aged 12-18.

Expected Outcomes

1. Improved depression screening
2. Improved PHQ-9 screen and initial behavioral health visits
3. Increased CHW follow-up and number of adolescents receiving behavioral health care (in-person and telehealth)
4. Increased CHW reimbursement, alternative payment model, and CalAim value-based payments. By the end of the grant, 95% of patients aged 12-18 will have received a clinical depression screening using the UDS Screening for Clinical Depression and Follow-Up Plan measure, and by the end of Year 4, 60% of youth aged 12-18 will submit a 12-month PHQ-9 screen in order to track UDS Depression Remission for those who received an initial behavioral health visit.

Mountain Valleys Health Centers

Organization type:
Federally Qualified Health Center

Primary Focus Area:
Care Coordination

Other Focus Area(s):
Patient-Centered Medical Home, Telehealth/Telemedicine, Value-Based Care

Grantee Contact Information

Organization	Mountain Valleys Health Centers
Address	554-850 Medical Center Dr
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Project Director	Sarah Albaugh
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Target Populations

The target population for the project includes all residents (27,444) in the designated service area of Mountain Valley Health Centers (MVHC), a Federally Qualified Health Center located in northeastern California, contiguous to the Oregon and Nevada state borders. The service area includes portions of four rural California counties: Lassen, Modoc, Shasta, and Siskiyou. The target population is primarily low-income and aging, with 52% of residents aged 45 and older. All residents reside in a federally designated Health Professional Shortage Area (HPSA) and most reside in a federally designated Medically Underserved Area (MUA).

Project Description

This project is three-pronged in its approach, focusing on the following strategies:

1. Improving health outcomes through early detection of breast, cervical, and colorectal cancers; prevention of heart disease and stroke through weight assessments and follow-up; and better health outcomes for seniors with regular and timely annual wellness visits.

2. Expanding capacity for essential health care services through design and implementation of a standardized electronic specialty referral system, expanding access to telehealth for specialty services.
3. Improving financial sustainability through patient-centered medical home (PCMH) certification, implementation of the patient-centered care model, increased reimbursement through alternative payment models based on quality-based incentives, enrollment in California Medicaid alternative payment model, implementation of chronic care management model for Medicare patients, and participation in an Accountable Care Organization, which can increase potential incentive payments for meeting quality metrics.

Health Information Technology Used

The health information technology used as part of this grant will be Greenway Intergy Electronic Health Record

Evidence-based or Promising Practice

The evidence-based model used for the project will be the Model for Improvement, an evidence-based, effective quality improvement model developed by Associates in Process Improvement. This model has been used successfully by health care organizations to improve many different health care processes and outcomes. It is process- and outcomes-focused with testing for interventions or change grounded in science. This will be combined with the Plan-Do-Study-Act (PDSA) cycle to test changes and determine whether a change is an improvement.

Project Goals

1. Increase the screening percentage for breast, cervical, and colorectal cancers to ensure early detection and treatment of cancers and improve health outcomes.
2. Increase the percentage of patients receiving weight assessment for children, adolescents, and adults to address issues of obesity and potential weight-related conditions leading to heart disease and stroke.
3. Increase the percentage of Medicare patients receiving annual wellness visits to improve health outcomes for senior patients.
4. Design and implement a standardized, electronic specialty referral system utilized across all sites to ensure access to specialty services and “close the loop” on referrals.
5. Expand access to telehealth specialty services to increase the availability of care and completion of referrals.
6. Achieve PCMH certification for seven primary care sites to implement a patient-centered model of care and position the organization for alternative payment models based on quality-based incentives. Prepare for value-based reimbursement models and enroll in the California Medicaid alternative payment model to expand reimbursement beyond the FQHC Prospective Payment System (PPS) rate.
7. Utilize Medicare chronic care management for additional Medicare reimbursement.
8. Prepare for membership in an Accountable Care Organization to take advantage of risk-sharing arrangements and potential incentive payments for meeting quality care metrics.

Expected Outcomes

- **Improved patient health outcomes.** Increase compliance with breast cancer screening to 64%, cervical cancer screening to 66%, colorectal cancer screening to 50%, weight assessment for children and adolescents to 42%, and body mass index screening and follow-up plan for adults to 50% and provide at least 100 annual wellness visits to Medicare beneficiaries.
- **Expanded capacity of essential rural health care services.** Add at least three additional telehealth specialty care referral providers and increase completed patient specialty care referrals by 20%.
- **Increased financial sustainability.** Complete PCMH certification of all MVHC clinical sites, enroll in CalAIM (Medicaid) program for all MVHC sites, participate in the Medicare chronic care management program, and join an Accountable Care Organization.

Neighborhood Health Center Inc.

Organization type:
Federally Qualified Health Center

Primary Focus Area:
Care Coordination

Other Focus Area(s):
Community Health Workers, Social Determinants of Health, Telehealth/Telemedicine

Grantee Contact Information

Organization	Neighborhood Health Center Inc.
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Target Populations

This project will target patients served by Neighborhood Health Center Inc.'s (NHC's) Union County clinic. Union County is a rural community with high poverty and transportation challenges. Forty-four percent of the service area population lives at or below 200% the federal poverty level (FPL), about 22% lives at or below 100% FPL, and nearly 10% lives at or below 50% FPL.

The service area has high rates of obesity, diabetes, and tobacco use. NHC's care coordination program is providing care for the most at-risk patients. These patients live with at least one chronic condition and have enhanced risk factors.

Project Description

NHC will support improved health care outcomes, expanded capacity, and financial sustainability through the integration of remote patient monitoring and community health workers to support health care improvements and care coordination. NHC has identified the need to enhance chronic care management services to address wellness gaps and promote health and well-being. NHC has identified opportunity to expand the organization's reach by growing its newly implemented remote patient monitoring program while enhancing care coordination with community providers and integrating community health workers into daily workflows.

To address health care concerns specifically identified within the rural population, NHC is proposing the enhancement of data tracking and monitoring focused on the social determinants of health. By monitoring and tracking these factors identified above, NHC can support patients in making a care plan, alongside behavioral and lifestyle changes, that support addressing their health care needs. NHC community health worker and care coordination teams will create care plans where patients can self-manage their chronic disease to determine the best approach for care. Patients can monitor their health at home while having full access to the services NHC can provide and additional, more enhanced services, within the community. NHC will address social determinant of health factors, including socioeconomic status and transportation, to limit barriers in seeking and accessing health care services for all patients served through remote patient monitoring and care coordination.

Health Information Technology Used

NHC utilizes the OCHIN Epic electronic health record (EHR) system. OCHIN offers a robust care coordination system, social determinants of health screening, and community health worker documentation capabilities. It is formatted to provide enhanced communication and coordination between various key members of our care team. NHC will utilize:

- Compass Rose through OCHIN to manage population health and improve clarity to social determinants of health. Compass Rose will help improve care quality and equity by combining key health and social insights into a more patient-centered, comprehensive record. The advanced program structure includes robust metadata that facilities high-touch, whole-person care.
- PRAPARE tool and data to better understand and act on individuals' social determinants of health to continue to improve our equity of care for the communities we serve.

NHC utilizes MyVitalz for remote patient monitoring kits that allow patients to take their blood pressure, blood oxygen level, weight, temperature, and blood glucose. Those results are sent to the NHC care team through a cellular connection allowing providers to care for these patients in their homes.

Evidence-based or Promising Practice

NHC will utilize the following quality improvement models based on their evidence-based nature and proven outcomes:

- Lean Six Sigma for Quality Improvement
- Plan-Do-Study-Act (PDSA) Cycle
- Motivational Interviewing
- Living Well with Hypertension Curriculum
- Smoking Cessation-Quit Now Indiana
- Harvest Your Health, a prescriptive produce program that allows diabetic patients to receive vouchers redeemable for fresh fruits and vegetables every month.

Project Goals

The goal of NHC's grant project is to improve health care outcomes and access to care through interoperability of community health workers, remote patient monitoring, care coordination, and chronic disease management services, while also tracking and monitoring social determinant of health factors to improve overall health.

Project goal 1: At the end of Project Year 4, at least 75% of patients who need support and care for a chronic disease will be provided remote patient monitoring equipment to manage their care at home, focusing on improving healthy behavior and behavior choices.

Project goal 2: At the end of Project Year 4, NHC will have provided 100% of diabetic patients with at-home tools and equipment to assess and monitor their diabetes.

Project goal 3: At the end of Project Year 4, NHC will have aligned patients with a community health worker to discuss a care plan to eliminate smoking prevalence and support a positive behavior change for their health.

Project goal 4: At the end of Project Year 4, at least 80% of patients with hypertension and blood pressure concerns will have access to the tools they need to monitor their care at home and will have met with a community health worker to discuss their care plan and tools for reducing their hypertension and blood pressure counts (to be monitored throughout the project period).

Project goal 5: At the end of Project Year 4, 100% of patients seeking care at NHC will have been assessed for social determinant of health factors that impact care to create a care coordination plan.

Expected Outcomes

- **Access to care** (number of unique patients served, type of direct service provided): This data will be tracked through the patient's electronic health record. The goal is to increase patients served by 10% annually.
- **Population demographics** (number of people served by ethnicity, race, sex, sexual orientation, gender identity, age, and insurance status, etc.): These population demographics and social determinant of health data will be tracked via each patient encounter and inputted into the patient EHR. The goal is to increase minority patients served by 10% annually.
- **Sustainability** (sources of sustainability, program revenue, etc.): This data will be tracked through the financial team to ensure all revenues are tracked and feasibility of sustainability down the road for the program. The goal is to increase chronic care management and remote patient monitoring billing by 10% annually.
- **Network** (types and number of nonprofit organizations in the network): NHC will continue to track and keep a list of community partners that collaborate to provide primary care and behavioral health care services, as well as transportation, translation, and specialty health care services. The goal is to add two community partners or programs annually.
- **Quality improvement implementation strategies** (provider performance, quality improvement methodology): NHC will track patient and provider satisfaction surveys and integration of quality improvement models on overall implementation and success of quality improvement programs. The goal is to achieve a 4.5 score on a five-point scale annually for providers.
- **Utilization** (emergency department visits and 30-day hospital readmission rates): NHC will track emergency department utilization in partnership with local organizations and hospitals and through each patient's EHR. The goal is to reduce emergency department visits for chronic care management patients by 5% annually.
- **Clinical measures** (screening, follow-up care for primary and behavioral health care services): This data will be monitored and tracked through assessments and remote patient monitoring and tracked though the patient's EHR. The goal is hemoglobin A1c poor control at less than 35% and controlling high blood pressure for greater than 70% of patients.
- **Community health workers**: Increase the number of community health workers annually over the grant period.
- **Staff satisfaction**: Track staff satisfaction surveys, ease of use, and integration of the program. The goal is to achieve 4.5 out of 5 annually for staff.

Sheridan County

Organization type:
Federally Qualified Health Center

Primary Focus Area:
Patient-Centered Medical Home

Other Focus Area(s):
Cardiovascular Disease, Chronic Care Management, Diabetes, Patient Engagement

Grantee Contact Information

Organization	Sheridan County
Address	826 18th Street, Suite A
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Target Populations

The target patient population for this program includes all medical patients served by Hoxie Medical Center (HMC).

Project Description

The project will improve health outcomes for over- or underweight patients; those with hypertension or diabetes; and those who use tobacco, have depression, or have heart disease. Project staff will create checklists to streamline workflows and ensure all team members are up to date. Morning huddles will facilitate communication and use Azara and NextGen for tracking and reporting. The patient-centered medical home (PCMH) coordinator/communicator will serve as the project's care manager. The care manager will meet with the referred patients to provide them with health promotion and other care management services.

In addition to health improvement, HMC seeks to reduce hospital readmissions and the percentage of chronic care management patients with a return visit to the hospital emergency department. The transitional care management

nurse will assist the care manager in identifying repeat visits within 72 hours, providing education to the community and patients, and improving handoff communication with the hospital. The transitional care management nurse will complete an assessment of social determinants of health to help identify patient needs and will refer to community resources, following up to ensure the patient received the service.

HMC will increase the number of patients enrolled in care management, those with a comprehensive care plan documented, and the percentage of managed care patients to complete an assessment of social determinants of health. HMC will increase the percentage of patients with completed referrals within three months by order date and encourage referral to the in-house care management team by clinicians and social services. The care manager will monitor referral notes and educate patients on the importance of sending the consult notes to their primary care provider. The care manager will provide education to expand the knowledge about services, work with patients to remove financial and other barriers, and maintain contact with the patient for 30 days. HMC will increase the percentage of patients aged 65 and older to have advance directives documented. The care management team will dialog with the patient about end-of-life decisions, providing education on the importance of the documentation before the patient becomes elderly.

An essential part of the proposed program is educating patients, family members, and the general public about the benefits of care management. HMC will network with community partners to plan an outreach event, expand the use of technology to provide an alternative to in-person education, and survey the community on topics of interest. The care management team will help HMC to attain PCMH Recognition throughout the project period by learning the requirements, educating health center staff, and helping apply the concepts and criteria to the practice.

Health Information Technology Used

HMC utilizes NextGen Enterprise as its electronic health record (EHR) and for billing. The hospital uses CPSI Evident EHR, and the clinic accesses lab and radiology orders and results through an interface with the hospital. Proposed program funding includes purchasing the Azara Care Management module, designed to leverage the full set of clinical, claims, health information exchange, and practice-management data in Azara DRVS, a population health registry and quality improvement tool that HMC already utilizes. HMC uses the NextGen UDSx Module, a patient registry within the EHR that tracks quality measures for Uniform Data System reporting, the NextGen HQM portal, which focuses on measures available for Merit-based Incentive Payment System (MIPS) reporting, and the NextGen PCMH module.

Evidence-based or Promising Practice

Care management is a team-based, patient-centered approach designed to meet the needs and complexity of care in an outpatient setting and is a vital tool for managing population health. The three strategies of care management are identifying populations with modifiable risk, aligning care management services to population needs, and identifying and training personnel. In addition to the care management evidence-based practice, HMC utilizes an effective quality improvement model called the PACEe QI to manage quality and performance improvement efforts. PACEe stands for plan, act, check, enhance, and efficiency. The model's focus is growing performance to keep pace with an ever-changing environment. It creates the type of language that allows it to fit into discussions and makes it easier to avoid the frequent confusion when people do not intuitively know the difference between doing and acting in Plan-Do-Study-Act or Plan-Do-Check-Act.

Project Goals

The goal of the proposed project is to establish an integrated, coordinated system for the prevention and management of chronic diseases, with productive interactions among patients, families, communities, and health care organizations/ providers. Project objectives relate to the treatment of heart disease.

Expected Outcomes

Impact area — improved health outcomes:

- HMC will reduce hospital readmission rates from 12% to 10% by the end of the project period.
- HMC will decrease the percentage of chronic care management patients to have a return visit to the hospital emergency department from 7% to 5% or less by the end of the project period.
- HMC will increase the percentage of patients aged 65 and older to have advance directives documented from 3% to 50% by the end of the project period.
- HMC will increase the number of participants in community education classes from an average of four per class to 10 per class by the end of the project period.
- HMC will increase the number of patients enrolled in care management from 38 to 100 by the end of the project period.
- HMC will increase the percentage of managed care patients to complete an assessment of social determinants of health from 2% to 16% by the end of the project period.
- HMC will increase the percentage of adults with a documented body mass index and follow-up plan documented if outside parameters from 85% to 90% by the end of the project period (excluding pregnant and terminally ill patients or those who refuse height and weight measurement).
- HMC will increase the percentage of patients diagnosed with hypertension to have controlled blood pressure from 64.2% to 68% by the end of the project period.
- HMC will decrease the percentage of patients diagnosed with diabetes with an HbA1c greater than 9% from 28% to 11.6% by the end of the project period.
- HMC will increase the percentage of adult patients assessed for tobacco use with counseling and/or pharmacotherapy if identified as users from 83.1% to 91% by the end of the project period.
- HMC will increase the percentage of patients aged 12 and older screened for depression with a follow-up plan documented if the screen is positive from 92.5% to 95% by the end of the project period.
- HMC will increase the percentage of patients at risk of cardiovascular events prescribed or already on statin therapy from 77% to 82% during the project period.

Impact area — expanded capacity for essential health care services:

- HMC will increase the percentage of patients enrolled in chronic care management services to have a comprehensive care plan documented and updated annually from 46% to 90% by the end of the project period.

Impact area — increased financial sustainability:

- HMC will increase the percentage of patients with completed referrals with three months by order date from 66% to 87% by the end of the project year.
- HMC will maintain National Committee for Quality Assurance PCMH Recognition throughout the project period.

Teche Action Board Inc.

Primary Focus Area:
Care Coordination

Organization type:
Federally Qualified Health Center

Other Focus Area(s):
Chronic Disease Management

Grantee Contact Information

Organization	Teche Action Board Inc.
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Project Director	Jennifer Fabre
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Target Populations

The target population for this project is Medicare recipients with two or more chronic diseases treated at one of the seven clinics located in five rural parishes (total population of 340,215) with approximately 47,291 individuals 65 years of age and older. Nineteen percent of individuals in the service area live below 100% of the federal poverty level (FPL) and 42% live below 200% of the FPL. Demographics of the service area consists of 34% Black, 62% white, 3% Native American, 4% Hispanic, and 1% all other races.

Project Description

Guided by the Chronic Care Model (CCM), individualized electronic patient care plans will be developed and implemented with non–face-to-face care coordination services outside of the regular office visit. To drive the project forward, roles will be established for the chronic care manager, chronic care management coordinator, and care team. The team will finalize program design using the CCM Toolkit, conduct training of staff, apply risk stratification to identify target patients, and implementing patient engagement and coordinated CCM services. They will ensure the capacity for billing Medicare for CCM-eligible services as a basis for sustainability by ensuring all staff receive appropriate training on documentation and recording time. The Chronic Care Management Platform in eClinicalWorks' (eCW's) electronic health record system will be used for all data collection, tracking, reporting, and billing related to chronic care management services. The project team will work with eCW to develop electronic reports that track chronic disease management activities, capture time spent each month with enrolled patients, and generate invoices for billing and reimbursement of services to increase revenue-generated income and financial sustainability.

Health Information Technology Used

The Chronic Care Management Platform in eCW's electronic health record system will be used for all data collection, tracking, reporting, and billing related to chronic care management services. eCW will be utilized to run reports quarterly or as needed to report to the Quality Assurance Performance Improvement (QAPI) committee on a quarterly basis.

Evidence-based or Promising Practice

This program is guided by the CCM and the Care Coordination Model. The CCM identifies six elements of a health care system that promote high-quality care for chronic diseases. They include the community, the health system, self-management support, delivery system design, decision support and clinical information systems. The premise is for patients to have active participation in their care, thus obtaining a goal of healthier patients, satisfied providers, and reduction in health care costs. Utilization of the Plan-Do-Study-Act (PDSA) cycles will assist the interdisciplinary team to focus on the changes that need to be made. PDSA cycles will also help the team to determine which changes were successful and which changes were not.

Project Goals

Project goals — Expanded capacity for essential health care services, improved health outcomes, and increased financial sustainability by:

1. Selecting a chronic care management implementation design
2. Developing a chronic care manager job and care team roles
3. Developing training for chronic care management implementation and maintenance
4. Patient identification and risk stratification
5. Provider and office staff engagement
6. Patient engagement and enrollment
7. Increasing financial sustainability for program services

Expected Outcomes

- Organizationwide implementation of the CCM program
- Strengthened infrastructure and improved efficiency
- Capacity to build electronic care plans and reports to capture data necessary to improve health outcomes and clinical quality measures
- Ability to meet mandatory reporting requirements and increased referral completion rates
- Increased rate of annual wellness, preventive, and disease-specific screenings
- Decreased gaps in care
- Improved National Quality Forum, Healthcare Effectiveness Data and Information Scores, Clinical Quality Measure, and Uniform Data System scores
- Improved internal integration of primary, dental, and behavioral health care services and increased revenues and financial sustainability

ThedaCare Medical Center – Waupaca Inc.

Primary Focus Area:
Behavioral/Mental Health Services

Organization type:
Critical Access Hospital

Grantee Contact Information

Organization	ThedaCare Medical Center – Waupaca Inc.
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Project Director	Tina Pelishek
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Target Populations

Target population: adults (18 and older) seen in primary care with a diagnosis of anxiety, depression, or substance use disorder. The communities served by grant activities are in rural East-Central Wisconsin. Except for the Ripon clinic, all serve counties with a population density of less than 71 people per square mile. (The Ripon clinic is a HRSA-designated rural area in Fond du Lac County, which has a population density of 141 people per square mile.)

Project Description

ThedaCare Behavioral Health (TCBH) will expand capacity to deliver BHCC — an evidence-based model of care shown to improve health outcomes, expand system capacity, and increase financial stability — at 14 primary care clinics in 12 Wisconsin communities. This project will involve hiring and training six full-time behavioral health collaboration managers, two part-time consulting psychiatrists, one part-time data and evaluation specialist, and one full-time project director. These individuals will form a BHCC team that will implement, deliver, and track performance of BHCC in targeted communities.

Health Information Technology Used

ThedaCare uses an electronic health record (specifically Epic) that contains a patient registry of all patients enrolled in collaborative care.

TCBH has been utilizing telehealth to provide services to patients in rural areas since 2013. In response to the COVID-19 public health emergency, TCBH converted most services to video or phone and have continued to use telehealth as a primary source of care since that time. TCBH continues to leverage telehealth services to make receiving treatment more accessible by removing barriers.

Collaborative Care is built around access, and it has been successfully integrated into telehealth services in other clinics and settings. Collaborative Care can be integrated seamlessly into existing telehealth services without adding cost, transportation, or stigma barriers for patients. Behavioral Health Collaborative Care (BHCC) will be available via telehealth as long as payers and regulations allow for it.

Evidence-based or Promising Practice

Collaborative Care was developed by the University of Washington in the 1990s and is now supported by the school's Advancing Integrated Mental Health Solutions (AIMS) Center. The approach has been piloted, implemented, and researched extensively since. Randomized control trials and meta-analyses consistently return evidence in support of its effectiveness in caring for patients with depression, anxiety, and other behavioral health conditions. In clinics and health care settings using this model of care, patients diagnosed with depression and anxiety saw significantly better outcomes than those receiving usual care. It has been shown to be effective in addressing acute and chronic depression and anxiety and for treating mental and behavioral health disorders alongside physical health issues. Collaborative Care is an integrated care model that treats common but often difficult-to-treat mental and behavioral health conditions such as depression and anxiety.

The model is based on five core principles:

1. **Patient-centered team care**, where primary care and behavioral health providers collaborate on patient goals and care plans.
2. **Population-based care**, where a defined group of patients is shared by the care team, steps are taken to support patients who are not improving, and mental health specialists provide caseload-focused consultation.
3. **Measurement-based treatment to target**, so each patient's treatment plan has specific and clear personal goals and clinical outcomes to be achieved. In addition, progress is monitored, measured, and adjusted until the patients' treatment goals are achieved.
4. **Evidence-based care**, in which patients are treated using approaches that have strong evidence for efficacy for their specific needs. This includes evidence-based psychotherapies proven to work in primary care, such as problem-solving treatment, behavioral activation, and cognitive behavior therapy, as well as medications and medication-assisted treatment for substance use disorders.
5. **Accountable care**, where providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

Project Goals

The goals of BHCC expansion are fourfold:

1. More people in targeted rural Wisconsin communities can access behavioral health care within primary care using the Collaborative Care model by 2027.
2. Fewer people in targeted rural Wisconsin communities are at risk of preventable death from heart disease, preventable cancers, unintentional injury, substance use disorder/overdose, chronic lower respiratory disease, and stroke by 2027.
3. Targeted ThedaCare Primary Care clinics serving rural Wisconsin can more effectively and efficiently support patient health by 2027.
4. Collaborative Care in targeted ThedaCare Primary Care clinics will serve as an effective model for replication throughout rural Wisconsin by 2027.

Expected Outcomes

Implementing BHCC across ThedaCare's network of rural clinics in Wisconsin will result in improved health outcomes for patients, expanded capacity to deliver essential health care services, and increased financial stability for these clinics. In addition, by addressing upstream mental and behavioral health barriers to physical health, BHCC will help to reduce patient risk of death from the five leading causes of avoidable death (heart disease, cancer, unintentional injury/substance use, chronic lower respiratory disease, and stroke).

Tri-County Health Network

Organization type:
Nonprofit

Primary Focus Area:
Care Coordination

Other Focus Area(s):
Cancer,
Cardiovascular Disease,
Social Determinants of Health

Grantee Contact Information

Organization	Tri-County Health Network
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City/State/Zip	Telluride, CO 81435
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Project Director	Lynn Borup
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Email	lynn@telluridefoundation.org

Target Populations

The program will serve patients from these clinics located in San Miguel, Colo., and the West End of Montrose County, Colo., with a chronic disease (heart disease, cancer, stroke, diabetes, mental health disorder, respiratory disease, and/or substance use disorder) and social determinant of health (SDOH) need. The program will prioritize clinical patients who are most at risk of poor health outcomes due to health inequities. It is anticipated that the program will serve 575 people over the grant period.

Project Description

Tri-County Health Network (TCHNetwork) and its clinical partners will adapt the evidence-based Pathways HUB Care Coordination model for use in the region. The three clinical partners will identify patients with chronic disease and screen patients for SDOH needs, focusing on those most at-risk of poor health outcomes due to health inequities. Clinics will refer patients to community health workers using the Community Resource Network (CRN), a system connected to the region's health information exchange that allows for bidirectional communication among clinics and community-based organizations providing services to an individual. Once community health workers receive a referral, they will connect with the client, assess the person's needs and priorities, and assign the client to different Pathways to address each need (e.g., Behavioral Health Pathway, Housing Pathway, Health Insurance Pathway). Each pathway will have a reason for initiation, action steps, and a completion step.

TCHNetwork will also convene a Clinical Subcommittee comprised of the medical directors from the network's member clinics. The subcommittee meets quarterly to discuss program outcomes and identify best practices to implement across the region to improve the health of the population. The Clinical Subcommittee members will play a key role in building the 20 pathways for the care coordination services that are the most relevant for chronic disease patients in the rural region. The three core clinical partners will enter biometric health information into their chronic disease registry for patients with chronic disease who seek care at their clinic.

Health Information Technology Used

The three core clinical partners will enter biometric health information into a chronic disease registry to help partners identify potential patients to refer for the project and monitor health outcomes over time. TCHNetwork and its three clinical partners will also utilize the CRN to build a care team for clients. Clinics will refer patients to TCHNetwork using CRN, and CRN will communicate outcomes of care coordination back to clinics.

Evidence-based or Promising Practice

Throughout the grant period, TCHNetwork and its partners will incorporate quality improvement activities using the evidence-based Model for Improvement to ensure the project is operating efficiently, effectively, and equitably. No adaptations will be made to the model.

Project Goals

The goals of the project are to:

1. Build health equity, improve health outcomes for chronic disease patients in the region, and expand capacity for essential health care services by offering an adaptation of the evidence-based Pathways HUB Care Coordination model to 575 clients over the four-year grant period in this rural, underserved area
2. Develop a culture of continuous quality improvement among TCHNetwork members

Expected Outcomes

Expected outcomes include:

- Building health equity and improving the health of chronic disease patients in the region by providing care coordination for up to 575 clients through 20 pathways throughout the four-year grant period
- Increased client connection to supportive services that will help to reduce barriers to care and address SDOH needs
- Reduced risk of mortality from the five leading causes of avoidable deaths
- Improved quality of care at local health clinics
- Improved relationships among health care providers in the rural region
- Increased bidirectional communication between clinics and community-based services providers through CRN

UPMC Kane

Primary Focus Area:
Chronic Obstructive Pulmonary Disease

Organization type:
Hospital

Other Focus Area(s):
Cardiovascular Disease, Hospital or Emergency Department Reduction or Prevention, Patient Engagement

Grantee Contact Information

Organization	UPMC Kane
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Project Director	Lisa Keck
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Target Populations

Target population is 3,000 at-risk individuals with chronic illness (chronic obstructive pulmonary disease, lung disease, heart disease, and substance abuse/misuse) in a three-county rural area (McKean, Elk, and Warren counties) of Pennsylvania.

Project Description

The quality improvement program will improve access through a planned approach to fill health care gaps in a collaborative arrangement. Resources that are available to community-based agencies can strengthen individuals' access to preventive care and provide linkages to services offered through the consortium. The quality improvement project will provide an action plan with network collaborators to address equity of the target population and subpopulations that have had poorer health outcomes. The group will analyze workforce, infrastructure, information technology, telemedicine, health care information exchanges, and other operational support to identify efficiencies in services and develop a network business model to improve access, eliminate barriers to treatment, and provide care and supports for improved community health. Evidence-based programs and disease management services will be shared and

strengthened across providers and agencies, as well as primary care and behavioral health integrated programs, to build a sustainable and equitable redesigned health care delivery system. The current service environment is largely led by UPMC Kane, but community providers, including the Lutheran Home at Kane and UPMC Kane Home Health Care, are important providers for therapy and ongoing care after an acute care episode and for maintaining health. Preventive care is also a challenge when access to care is compounded by socioeconomic barriers. The Kane Senior Center will provide health care screenings, a preventive program, and wellness activities and hosts a food bank for the community. Project partners will ensure that underrepresented populations have a voice in the planning and system redesign.

Health Information Technology Used

The current electronic health record (EHR) is Centriq, owned by Evident. The system plans to adopt a new EHR in latter 2023. Most IT functions for this grant will be supported by the EHR, along with the telemedicine infrastructure. EHR tracked will include diagnosis-related group (DRG) codes, case notes, and other aspects of evidence-based patient care.

Evidence-based or Promising Practice

Proposed models: Project ECHO® — Extension for Community Healthcare Outcomes and Chronic Disease Self-Management Program were adapted for the quality improvement initiative. Adaptations include utilizing primary care providers, emergency room staff, network staff, and community centers to link at-risk target individuals to prevention, with referrals to screenings, primary care, education, chronic disease management models, and services. Pathways will be enhanced for connecting specific services based on screening tools. The Chronic Disease Self-Management Program will link nontraditional agencies with services, education, screenings, and prevention programs and improve ways to manage chronic illnesses.

Project Goals

Goals and activities include (1) improved health outcomes for heart and lung disease and reduced substance abuse (reduce potentially avoidable utilization or acute care admissions through enhanced delivery of cost-effective, coordinated, and culturally and linguistically appropriate and equitable health care services); (2) expanded capacity for essential health care services for targeted chronic illnesses through care coordination, greater access to enhanced chronic disease management, provision of clinical health services for rural residents through telehealth, and screening programs and community health and prevention efforts; (3) increased financial sustainability in the rural health model by reducing chronic disease costs, reducing hospital readmissions, and improving efficiency through greater access to clinical management of services with care coordination strategies.

Expected Outcomes

Expected outcomes: Improved health of individuals with chronic illnesses, reduced hospital readmissions, increased patient-focused prevention, increased utilization of community-based, self-directed prevention programs, and greater access to pain management and reduced substance abuse in target population.

Westchester-Ellenville Hospital Inc.

Organization type:
Critical Access Hospital

Primary Focus Area:
Cancer

Other Focus Area(s):
Care Coordination, Community Health Workers, Social Determinants of Health

Grantee Contact Information

Organization	Westchester-Ellenville Hospital Inc.
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Project Director	Brandon Bogert
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Target Populations

The project will serve adults over the age of 21 who are recommended for preventive cancer screenings (i.e., breast, cervical, colorectal, or lung) based on the U.S. Preventive Services Task Force (USPSTF) guidelines and who live within the rural Wawarsing Region. This region includes 10 ZIP codes that are covered almost entirely by three towns, Wawarsing, Mamakating, and Crawford, throughout three counties, Orange, Sullivan, and Ulster, N.Y.

Project Description

The purpose of this project is to increase adherence to preventive screening recommendations among those who are eligible in the service area in an effort to reduce disease burden and improve health outcomes. The prevention services specialist (PSS) from Ellenville Regional Rural Health Network (ERRHN) will work with existing clients to remind them when mammography, colonoscopy, low-dose computed tomography (LDCT), and cervical cancer screening appointments are due; assist with scheduling those appointments; and help with overcoming barriers to ensure that clients are completing or rescheduling appointments in a timely manner. The care navigator from the Institute for Family Health will identify Ellenville Family Health Center (EFHC) patients who are due or out-of-date for mammography, colonoscopy, LDCT, and cervical cancer screenings, and work with the PSS to schedule appointments and ensure they get completed. Both positions will then follow-up with clients after completion of screening appointments to verify results. For clients who test positive on their screenings, the PSS and care navigator will encourage diagnostic testing. The PSS and care

navigator will also provide clients with individualized and group support for tobacco cessation as well as basic health coaching and assistance with goal setting related to physical activity or mental wellness, which includes making referrals to the ERRHN nutritionist, who can work with clients to create individualized dietary improvement plans.

Health Information Technology Used

Health information technology to be used includes the electronic health record software Athena.

Evidence-based or Promising Practice

The project will utilize three quality improvement models, including the Chronic Care Model, the Model for Improvement, rapid cycle Plan-Do-Study-Act process, and the Lean/Toyota Production Systems model in addition to the evidence-based Community Health Worker — Health Educator Model.

Project Goals

1. Expand the RHN Wellness Workgroup to include the implementation of the Cancer Prevention Services Program.
2. Increase the number of mammograms completed at Ellenville Regional Hospital (ERH) by a least 10% from baseline in Year 1, then work to achieve the Healthy People 2030 goal of 80.5% of eligible patients receiving their screening by the end of the grant.
3. Increase the number of colonoscopies completed at ERH by a least 10% from baseline in Year 1, then work to achieve the Healthy People 2030 goal of 74.4% of eligible patients receiving their screening by the end of the grant.
4. Increase the number of LDCT completed as cancer screening at ERH by a least 10% from baseline in Year 1, then work to achieve the Healthy People 2030 goal of 7.5% of eligible patients receiving their screening by the end of the grant.
5. Increase the number of cervical cancer screenings completed at ERH by a least 10% from baseline in Year 1, then work to achieve the Healthy People 2030 goal of 84.3% of eligible patients receiving their screening by the end of the grant.
6. A minimum of 50 individuals per year and a total of 100 unduplicated individuals over the four-year period will receive nutrition counseling from the nutritionist.
7. Increase the number of patients with a positive screening who achieve complete diagnostic evaluation within 90 days for breast, lung, cervical, and colorectal cancer.
8. Decrease current tobacco use in adults (screened) to the NYS Prevention Agenda 2024 target of 11% by Year 2 of the grant period by implementing free and accessible tobacco cessation interventions. Further reduce this rate to 9% of screened participants by Year 4.

Expected Outcomes

It is expected that there will be an increase in preventive screenings for breast, cervical, colorectal, and lung cancer over the four-year course of the grant, as well as an increase in diagnostic evaluation for appropriate patients. It is expected that this may lead to more cancer diagnoses, but eventually an earlier average stage of diagnosis for our service area. In addition, it is expected there will be an increase in people meeting with the nutritionist and receiving tobacco cessation counseling, in turn leading to an increase in patients reporting feeling healthy and well and in control of their own health.

White River Health System Inc.

Organization type:
Hospital

Primary Focus Area:
Behavioral/Mental Health Services

Other Focus Area(s):
Cancer,
Care Coordination,
Community Health Workers,
Social Determinants of Health

Grantee Contact Information

Organization	White River Health System Inc.
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City/State/Zip	Batesville, AR 72501
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Project Director	Molly Jones
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Target Populations

The target population for this grant includes uninsured and underinsured residents of three rural, primary care clinics serving six north-central Arkansas rural counties with total population of 114,116 residents who need accessible and affordable mental and substance abuse treatment services and screening and prevention services for selected cancers, chronic diseases, and social determinants of health (SDOH) issues. These counties have an 18% or higher poverty rate. The Hispanic population is small except for in Independence County, which has 6.6%. The Black population is small except for in Jackson County, with 17.4%. The population transportation barriers include not having a driver's license, not having a working vehicle, not being able to afford gasoline, or having a disability.

All counties are designated Medically Underserved Areas, Primary Care Health Professional Shortage Areas, and Mental Health Professional Shortage Areas. Fourteen percent of adults have diabetes, and 35% have prediabetes. The obesity rate for four the counties ranges from 40% to 46.6%, and 30% suffer from anxiety or depression, with 10% considering suicide. There is also a high opiate use disorder/substance use disorder (OUD/SUD) rate. Sixty-six percent to 70% have had no recent mammogram, 15.2% to 28.5% had no Pap test, 52.1% to 71.3% had no prostate-specific antigen screening, and 38% to 59.2% no colorectal exam.

Project Description

White River Health System (WRHS) plans to:

- Integrate into primary care provider (PCP) clinics mental/behavioral health care and OUD/SUD treatment via telehealth.
- Provide timely PCP screening for mental health status, SDOH, and health literacy.
- Provide timely PCP screening and referrals for breast, uterine, prostate, and colorectal cancers.
- Provide timely PCP body mass index and diabetes screening; provide diabetes and nutrition education.
- Use a community health worker (CHW) to help address SDOH to improve care plan compliance and care coordination; build capacity in the clinic and community to address health issues.
- Use evidence-based quality models to plan, develop, study, adopt, and evaluate the project's success — which are easily implemented, patient-centered, outcome-based, and value-based.
- Expand primary clinic capacity, leverage new billing codes, and improve sustainability.

Health Information Technology Used

WRHS Information Systems Department will make sure the electronic medical record (EMR) system will support grant goals, as well as provide the data needed for analysis and reporting. WRHS hospital has Meditech as its EMR, and the clinics use Athena, Greenway, and Meditech among them. It is planned that all clinics will convert to Meditech. WRHS plans to utilize the University of Washington AIMS Center Care Management Tracking System, which is a full-featured and customizable web application, for behavioral health integrated-care settings. Pinnacle Data Strategies will serve as a third-party evaluator to consolidate WRHS EMR patient data for cancer, diabetes, and obesity, along with identified social determinants of health, into Performance Improvement Measurement System reporting data and reports to help the grant team members evaluate performance and take corrective action to improve processes.

Evidence-based or Promising Practice

The grant project will use three evidence-based quality improvement models to plan, develop, study, adopt, and evaluate the project's success: (1) Plan-Do-Study-Act QI Model, (2) Collaborative Care Model, and (3) Value-Based Care Model. All of these can be easily implemented and are patient-centered, outcome-based, and value-based.

Project Goals

1. Improved health outcomes for breast, cervical, prostate, and colorectal cancer, as well as for diabetes, prediabetes, obesity, and those negatively affected by the SDOH.
2. Expand capacity by integration of mental/behavioral health care and OUD/SUD treatment via telehealth, placement of a CHW to help address SDOH and work with the community to address health issues, reduction of the medical transportation barrier for patients receiving cancer screenings, and integration of quality improvement into clinic culture.
3. Increased sustainability with additional income from screenings and tele–mental health care, value-added payments, increased patient satisfaction, and better community relations.

Expected Outcomes

Project-specific measures will be used to evaluate how well the project is meeting goals and objectives for:

- Increasing the number of screenings for diabetes, body mass index, cancer (breast, cervical, colon, and prostate), anxiety, and depression
- Increasing the referrals and compliance for specialist cancer screenings, using gas cards to overcome transportation barriers
- Patient progress and outcome of alcohol and drug dependence treatment and mental/behavioral health treatment, reduction of the time for patients receiving medication-assisted treatment and anxiety and depression medication
- The project's economic impact using the Economic Impact Analysis Tool (EIA) to track program dollars as they flow through the local community and impact population well-being.

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