

Rural Health Care Coordination Program Directory

2023-2027



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Introduction

Over 60 million people live in geographically isolated rural and tribal communities in the United States. Residents of these areas often face barriers to accessing comprehensive and affordable health care services, including long travel distances, limited public transportation, lack of specialty care, higher rates of uninsurance, and the accelerating pace of hospital closures in rural communities. As a result, health care is often difficult to access for many rural residents.¹

Care coordination can be an effective strategy to promote rural health care services outreach by expanding delivery of health care services in those areas.² This work is important because when providers and health care workers can share information in timely, accurate, and effective ways, it can lead to better health outcomes in the community.

The Federal Office of Rural Health Policy (FORHP) of the Health Resources and Services Administration administers grant programs designed to build health care capacity and improve health outcomes for rural residents. Through its community-based programs, FORHP supports evidence-based and innovative programs that build care coordination strategies and efforts for those who need it the most.

The Rural Health Care Coordination Program is a four-year grant program that funds rural health networks to plan and implement creative community-based health solutions that expand access to and coordination of care within their respective service regions. The goals of the Rural Health Care Coordination Program are to:

1. Expand access to and quality of equitable health care services through care coordination strategies exclusively in rural areas;
2. Utilize an innovative evidence-based, promising practice, and/or value-based care model(s) that is known to, or demonstrates strong evidence to, improve patient health outcomes and the planning and delivery of patient-centered health care services;
3. Increase collaboration among multi-sector and multidisciplinary network partnerships to address the underlying factors related to social determinants of health; and
4. Develop and implement deliberate and sustainable strategies of care coordination into policies, procedures, staffing, services, and communication systems.

Awardees are required to focus on heart disease, cancer, chronic lower respiratory disease, stroke, maternal health, or a combination of the aforementioned.

This *Directory* provides an overview of the cohort, including profiles for each of the 10 rural health care coordination initiatives funded during the 2023-2027 project period. Awardee profiles include information on the project partners, project focus area(s), targeted populations for care coordination initiatives, and the evidence-based or promising practice(s) that guide the care coordination approach.

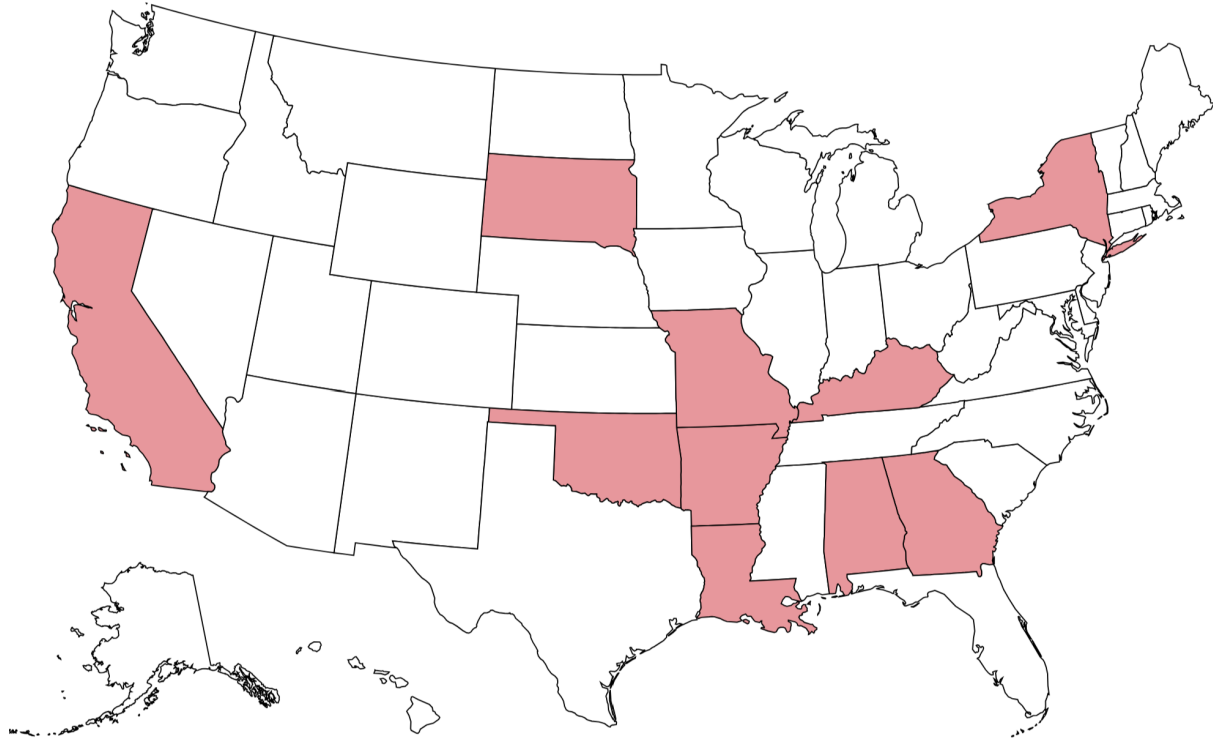
¹ Centers for Medicare & Medicaid Services. (2022). *CMS framework for advancing health care in rural, tribal, and geographically isolated communities*. Accessed at <https://www.cms.gov/files/document/cms-geographic-framework.pdf>

² Health Resources & Services Administration. (2023). *Rural Health Care Coordination Program*. Accessed at <https://www.hrsa.gov/grants/find-funding/HRSA-23-125>

Cohort Snapshot

With funding provided by the FORHP, 10 grantees in 10 states are planning and implementing rural health care coordination initiatives.

Grantee Location Map



Grantee By Organization Type

Lead organizations represent a range of health care providers and other health-related organizations.

Grantee Organization	501(c)(3) Collaborative	Critical Access Hospital	Health System	Nonprofit	Primary Care Association	Rural Health Clinic	State Rural Health Association	University
Adirondack Health Institute				•				
Avera Health			•					
Duncan Regional Hospital				•				
Georgia Center for Oncology Research and Education	•							
Kaweah Delta Health Care District						•		
Louisiana Rural Health Association							•	
Mercy Health – Marcum and Wallace Hospital		•						
Missouri Coalition for Primary Health Care					•			
SGOH Acquisition		•						
University of Alabama at Birmingham								•

Grantee By Primary Focus Area

Many funded organizations have identified a focus area around which they are conducting their care coordination efforts. The table below summarizes the primary focus areas identified by the grantees.

Grantee Organization	Cancer	Coordination of Care Services	Chronic Lower Respiratory Disease	Heart Disease	Pregnancy Continuum of Care
Adirondack Health Institute				•	
Avera Health			•		
Duncan Regional Hospital	•				
Georgia Center for Oncology Research and Education	•				
Kaweah Delta Health Care District					•
Louisiana Rural Health Association		•			
Mercy Health – Marcum and Wallace Hospital		•			
Missouri Coalition for Primary Health Care				•	
SGOH Acquisition		•			
University of Alabama at Birmingham			•		

The 2023 Rural Health Care Coordination Grantee Directory

This *Directory* provides a description of geographic coverage area and target population for the care coordination activities, goals for the planning year, and partners.

University of Alabama at Birmingham

University

D78RH50232

Primary Focus Area:
Chronic Lower Respiratory Disease

Secondary Focus Areas:
Access: Specialty Care,
Community Health Workers,
Coordination of Care Services,

Grantee Contact Information

Grantee Contact: Claudette Poole, M.D.

Title: Assistant Professor of Pediatrics, Division of Pediatric Infectious Diseases

Organization: University of Alabama at Birmingham

Address: 1720 University Blvd., Birmingham, AL 35294

Telephone Number: 205-934-4011

Website: www.uab.edu/home

Email: claudettepoole@uabmc.edu

Project Description

Initiative: To identify gaps and implement sustainable solutions to care coordination in a rural underserved region of the Alabama Black Belt by leveraging services provided by the Alabama Coordinated Health Network (ACHN), funded by Alabama Medicaid, and the community action agencies (CAAs), funded by the Community Services Block Grants, to address pediatric asthma as a model.

Key Activities:

1. Improve access to quality pediatric care for children in the west central region of the Alabama Black Belt, a rural underserved region with notable health disparities, focusing on asthma.
2. Leverage case management services offered through the ACHN, funded by Alabama Medicaid, to support evidence-based models known to improve pediatric asthma outcomes, which include establishing a medical home, scheduled disease maintenance visits, asthma educators for one-on-one coaching to identify barriers to adherence of asthma action plans, and community-level education via community health workers.
3. Increase collaboration among regional health providers, case management services offered through the ACHN, and social service programs offered through the CAAs, the local nonprofits that administer the Community Services Block Grant programs to address underlying factors related to social determinants of health.

4. Identify funding, staffing, and communication strategies required to establish a sustained program to support ongoing care coordination among existing network partners with the goal of expanding the model across the region.

Evidence-Based or Promising Practice Model Being Used or Adapted

The consortium seeks to adopt an integrated model of care to implement evidenced-based interventions that have demonstrated efficacy in improving pediatric asthma outcomes:

1. Ensure partnership between network health providers and the regional ACHN that provides care coordination to Medicaid recipients in the region. Work with care coordination specialists to identify local resources to overcome identified barriers to care.
2. Project Extension for Community Healthcare Outcomes (ECHO): Pediatric asthma specialists at Children's of Alabama will meet with rural health care teams as part of this network at regular intervals using the teleECHO platform established at University of Alabama at Birmingham to address topics related to pediatric asthma diagnosis and management.
3. Dedicated staff educated as asthma educators to provide patient and family-centered counseling and education.
4. Community health workers trained in pediatric asthma diagnosis and care to provide community outreach and education to increase parent and patient self-efficacy on asthma disease management.
5. Partnership with network providers and local schools to provide access to primary pediatric well visits and asthma maintenance visits through implementation of a mobile clinic that visits area schools.

The evidence-based care model for care coordination to improve pediatric asthma outcomes involves a collaborative effort among health providers, patients, and their families to ensure comprehensive and personalized care. Evidence-based guidelines serve as the foundation for decision-making and guiding health care professionals in the diagnosis and management of asthma symptoms, medication regimens, and environmental triggers.

Expected Outcomes

The desired disease-specific outcomes will include:

- Improving frontline providers' and primary care providers' knowledge of pediatric asthma diagnosis and management.
- Improving caregivers' knowledge of asthma and effective preventative strategies, including value of disease maintenance visits with primary providers.
- Ensuring children presenting in the emergency room with asthma exacerbations have a primary care medical home and a follow-up visit.
- Improving access for children with poorly controlled asthma to subspecialty care.
- Increasing use of asthma preventative medications and less reliance on rescue medications.
- Decreasing number of emergency room visits for children due to asthma exacerbations.
- Decreasing number of missed school days due to asthma exacerbations.
- Increasing utilization of available social service programs to address modifiable social determinants of health impacting childhood asthma.

Special Populations Served

- Black or African American
- Children/Adolescents

Area Served

- Dallas
- Marengo
- Perry
- Wilcox

Consortium Partners

Organization	County	State	Organization Type
Children’s Hospital of Alabama	Jefferson	AL	Hospital
Rural Health Medical Practices	Dallas, Marengo, Perry, Wilcox, Monroe	AL	Federally Qualified Health Center
Selma Pediatrics	Dallas	AL	Multi-physician pediatric practice
Whitfield Regional Hospital	Demopolis, Marengo	AL	Hospital

SGOH Acquisition

Critical Access Hospital

D78RH50231

Primary Focus Area:
Coordination of Care Services

Secondary Focus Areas:
Heart Disease,
Pharmacy Assistance,
Telehealth

Grantee Contact Information

Grantee Contact: Tressie Gilmore

Title: Clinic Administrator, Project Director

Organization: SGOH Acquisition, Inc.

Address: 1101 Jackson St, Gravette, AR 72736

Telephone Number: 479-787-5358

Website: www.ochonline.com

Email: tgilmore@ochonline.com

Project Description

The consortium seeks to unite and expand care coordination between rural health care providers, rural county health departments, and pharmacies in rural areas to increase medication adherence and improve health outcomes. This network will specifically focus on rural care coordination for patients within this geographical footprint who have heart disease and related underlying factors.

These network partners all have a stake in the well-being and overall health of the target service area patient population but are currently hindered by data systems that do not interface. The network will grow and align care coordination staff within the network partners, purchase technology to appropriately interface data systems, provide remote patient monitoring equipment to capture real-time data needed by all network partners to improve medication adherence, and create a cross-sectional rural coordinated care team among network partners to improve health outcomes related to heart disease and other comorbidities for a vulnerable patient population in extremely poor, southwest Missouri counties.

All network members currently work with rural, underserved populations. Value-based care models exist within each partner organization, including patient-centered medical home, chronic care management, community health workers, and Accountable Care Organization. Care coordination has been successful within each organization to address the social determinants of health, and this funding opportunity will enable the network members to connect the missing link: data sharing among partners to create a comprehensive rural care coordination model throughout the region.

Evidence-Based or Promising Practice Model Being Used or Adapted

The consortium will implement innovative evidence-based care models to connect with external providers and achieve rural coordination of care through modification of three specific models:

FORHP's Small Healthcare Provider Quality Improvement model: Granville Vance District Health Department in Oxford, North Carolina used real-time, quality patient care placed directly into homes of rural patients. The goal of this project was to decrease preventable hospital readmissions for uninsured/underinsured patients with chronic disease. This project has been overwhelmingly successful, demonstrating that 100% of remote patient monitoring participants had no emergency room visits or hospitalizations during the data collection period. SGOH's project will expand this evidence-based care model beyond health department and patient connection to include clinic providers and pharmacies able to access the data available, maximizing the impact exponentially.

West Virginia's Partners in Health Network model is a coordinated approach to health care delivery and a nonprofit organization to focus on collaboration. The results indicate that a web-based, data-sharing care management tool is effective at ensuring a community-based collaborative approach helps keep health care close to home. A web-based tool contributes to efficient patient care coordination, with capabilities allowing for report creation and data graphs and charts. The focus on interoperability among partners is at the core of the project and is used as an evidence-based model guiding this proposal.

California's Health Care Foundation Regional Collaborative Services for Homeless model was identified for the proposed project to focus on cross-sector data sharing, sharing the goal that people have access to the care they need, when they need it, at a price they can afford. Each community has unique partnerships, infrastructure, policies, and procedures that need to be considered when developing data-sharing efforts. The consortium will take these lessons learned beyond the homeless population and improve patient health outcomes through cross-sector data sharing for vulnerable populations within the target service area suffering from heart disease and underlying factors.

Expected Outcomes

- Expand access to and quality of equitable health care services with partnership of health care clinical providers, pharmacies, and county health departments through care coordination strategies exclusively in rural counties in southwest Missouri area.
- Utilize innovative evidence-based care models to improve patient health outcomes.
- Strengthen partnerships built during COVID-19 pandemic to increase medication adherence related to heart disease, capture regular blood pressure readings to improve care coordination, and decrease preventable hospital readmissions for patients with heart disease.
- Increase collaboration among multisector and multidisciplinary network partnerships to address the underlying factors of heart disease related to social determinants of health through data sharing and technology interfaces.
- Develop deliberate and sustainable strategies of care coordination into policies, procedures, staffing, services, and communication systems among the network partners to expand and strengthen the rural care coordination team and ensure rapid identification of at-risk patients who are currently falling through the cracks.

Special Populations Served

- Adults
- Black or African American
- Caucasian or White American
- Hispanic/Latinx
- Native American/American Indian
- Older adults
- Pacific Islander/Asian American
- Uninsured

Area Served

- Mount Vernon, Lawrence County
- Anderson, Goodman, Noel, and Southwest City, McDonald County
- Neosho, Newton County
- Rogersville and Sparta, Webster County

Consortium Partners

Organization	County	State	Organization Type
Alps	McDonald	MO	Pharmacy
McDonald County Health Department	McDonald	MO	County Health Department
Mitchell's Drug Stores	Newton County	MO	Pharmacy
Newton County Health Department	Newton County	MO	County Health Department
Ozarks New Hope	Lawrence County	MO	Health Care Coordination
Webster County Health Unit	Webster County	MO	County Health Department

Kaweah Delta Health Care District

Rural Health Clinic

D78RH50227

Primary Focus Area:
Pregnancy Continuum of Care

Secondary Focus Areas:
Access: Specialty Care,
Coordination of Care Services,
Migrant/Farm Worker Health

Grantee Contact Information

Grantee Contact: Meredith Alvarado

Title: Assistant Director – Rural Clinic Operations

Organization: Kaweah Delta Health Care District (doing business as Kaweah Health)

Address: 400 W. Mineral King Ave, Visalia, CA 93291

Telephone Number: 559-592-7365

Website: www.kaweahhealth.org

Email: mealvara@KaweahHealth.org

Project Description

The purpose of this project is to develop a comprehensive care coordination strategy that will improve the outcomes of marginalized and difficult to reach populations of focus within our rural communities with a goal of improving maternal health outcomes. Kaweah Delta Health Care District (KDHCD; doing business as Kaweah Health) is the largest health care district in California and serves a large, rural geography spanning 4,839 square miles.

To better serve the community, KDHCD has strategically placed rural health clinics throughout the county to expand access to quality care for the rural communities. These rural health clinics provide many services including women’s health, family medicine, psychiatry, and pediatrics. In some communities KDHCD provides the only ob-gyn physicians in the entire area. KDHCD has also worked hard to integrate behavioral health services (both adult and child psychiatry and therapy) into all its rural health clinics.

As part of this project, KDHCD will pursue the implementation of several evidence-based programs and promising practices. First, KDHCD will pursue certification as a Comprehensive Perinatal Services Program (CPSP) provider. In addition, KDHCD will explore the feasibility of the integration of doula into its women’s health care model, as California recently added doula services as a covered Medi-Cal benefit. KDHCD has long employed community health workers and promotoras that have proven to significantly improve outcomes in targeted patient populations. Based on this experience, KDHCD will now explore the concept of integrating

doulas and/or community health workers into its women’s health program. Lastly, KDHCDC will collaborate with community partners to develop multisector and multidisciplinary network partnerships to address not just medical needs of the community, but to also screen for and address social determinants of health needs and barriers.

Evidence-Based or Promising Practice Model Being Used or Adapted

The primary evidence-based model for the maternal care coordination program is for the rural health clinic to become a certified CPSP. The CPSP was created in 1987 to reduce morbidity and mortality among low-income pregnant women and their infants in California. CPSP is a state Medicaid (Medi-Cal) program that provides a model of enhanced obstetric services for eligible low-income pregnant and postpartum women. The network will also explore the opportunity of adding pregnant persons as a population of focus to the California Advancing and Innovating Medi-Cal’s Enhanced Care Management and Community Supports programs and integrate community health workers or doulas to provide these services. For gestational and diabetic post-partum women, the network will also offer enrollment into the existing certified Chronic Disease Self-Management Program called “Empowerment for Better Living.” Women will also be referred to appropriate outreach programs offered through the network partners to include Lindsay Unified School District’s Family Resource Center and Tulare County’s Women, Infants and Children.

Expected Outcomes

The maternal care coordination program will strive to:

- Expand access to quality and equitable care coordination to rural communities (i.e., track number of unique patients served year after year, etc.)
- Utilize innovative evidence-based, promising practice, and/or value-based care models known to demonstrate strong evidence to improve health outcomes, and the planning and delivery of patient-centered health care services (i.e., decrease in severe maternal morbidity; decrease neonatal intensive care unit [NICU] rates; decrease primary cesarean section rates; and improve adherence to prenatal, postpartum, and well-child visit rates, etc.)
- Increase collaboration among multisector and multidisciplinary network partnerships to address the underlying factors related to social determinants of health (i.e., identify specific disparities, their root causes, and work together to address)
- Develop deliberate and sustainable strategies for improving maternal health care coordination policies, procedures, staffing, services, and communication systems.

Longer-term impacts from the project include:

- More perinatal visits for pregnant farmworkers, which will result in potential issues being addressed before birth.
- Healthier babies and mothers, resulting in shorter hospital stays, fewer days in the NICU, babies born at a weight closer to average for their size, and fewer babies born pre-term. In addition, there will be a decrease in maternal and fetal morbidity and mortality in the service region.
- Reduce the rate of prenatal and post-natal depression, as well as improve the overall health of the infants.

Special Populations Served

- Adults
- Black or African American
- Caucasian or White American
- Children/Adolescents
- Hispanic/Latinx
- Infants
- Native American/American Indian
- Pacific Islander/Asian American
- Pregnant people
- Uninsured

Area Served

- Tulare County

Consortium Partners

Organization	County	State	Organization Type
Family Resource Center – Lindsay Unified School District	Tulare	CA	Public School District
Women, Infants and Children	Tulare	CA	County – Health and Human Services Agency

Georgia Center for Oncology Research and Education

501(c)(3) Collaborative

D78RH50226

Primary Focus Area:
Cancer

Secondary Focus Areas:
Access: Specialty Care,
Coordination of Care Services

Grantee Contact Information

Grantee Contact: Sheryl Gabram-Mendola, M.D.

Title: Principal Investigator

Organization: Georgia Center for Oncology Research and Education

Address: 999 Peachtree Street NE Suite 400, Atlanta, GA 30309

Telephone Number: 404-523-8735

Website: www.georgiacancerinfo.org

Email: sgabram@georgiacore.org

Project Description

The project's focus is to bring navigated and coordinated cancer care into Wayne and Appling counties in partnership with rural network members. Three primary service areas will be targeted using evidenced-based interventions to improve the quality of cancer services in these rural communities since it is known that rural cancer patients are at higher risk for shortened survival due to lack of access to a comprehensive oncology infrastructure. The network will bring access to clinical trials and will introduce the chronic care model along with Medicare's transitional care management (TCM) and chronic care management (CCM) into medical oncology practices primarily in Wayne and Appling counties impacting their extended service areas.

Evidence-Based or Promising Practice Model Being Used or Adapted

The network will bring three evidence-based practices that synergistically work together to address the cancer disparities within Wayne and Appling counties and their service areas. The first is the evidence-based practice of patient navigation services, the second is an evidence-based practice of coordinated care by adapting CCM and Medicare's TCM into medical oncology practices, and the third will be the introduction of evidence-based tools that will help the navigator screen and prioritize patients at high risk for barriers to care.

Expected Outcomes

The short-term outcomes for this project will immediately impact the lives of newly diagnosed cancer patients within rural southeast Georgia through:

- Providing patient navigation services,
- Introducing coordinated care to reduce the time to treatment,
- Creating seamless transitions to tertiary cancer centers when necessary, and
- Addressing social determinants of health that result in barriers to timely and quality care.

Intermediate outcomes across the four years will be:

- Maturing processes around access to clinical trials that will result in increases in accruals from baseline,
- Sharing knowledge about the testing and adapting of evidence-based practices designed to reduce rurality-disparities in cancer care,
- Working closely with the statewide association, the Cancer Patient Navigators of Georgia, using bidirectional learning and sharing of information that will lead to successful replication of this project in similar communities across Georgia.

The long-term outcomes that will be accomplished are:

- Reducing disparity by diagnosing cancers at earlier stages,
- Improving cancer survival by reduced complications through comorbidity management,
- Decreasing cancer incidence rates through prevention, education, and improved timeliness to care.

Special Populations Served

- Adults
- Black or African American
- Caucasian or White American
- Hispanic/Latinx
- Older adults
- Uninsured

Area Served

- Appling
- Bacon
- Brantley
- Jeff Davis
- Pierce
- Tattnall
- Toombs
- Wayne

Consortium Partners

Organization	County	State	Organization Type
Appling Healthcare Baxley	Appling	GA	Health Care Organization
Georgia Center for Oncology Research and Education Atlanta	Fulton	GA	Cancer Nonprofit Organization
Jeyanthi Ramanarayanan, M.D. Hematology/Oncology 930 South 1st Street, Jesup	Wayne	GA	Physician Practice Group
Jeyanthi Ramanarayanan, M.D. Hematology/Oncology 105 Tollison Street, Suite C Baxley	Appling	GA	Physician Practice Group
Nancy N. and J. C. Lewis Cancer & Research Pavilion at St. Joseph's/ Candler Savannah	Chatham	GA	Health Care Organization
Wayne Memorial Hospital Jesup	Wayne	GA	Health Care Organization

Mercy Health – Marcum and Wallace Hospital

Critical Access Hospital

D78RH50229

Primary Focus Area:
Coordination of Care Services

Secondary Focus Areas:
Heart Disease

Grantee Contact Information

Grantee Contact: Dana Stepp

Title: Grants Manager

Organization: Mercy Health – Marcum and Wallace Hospital

Address: 60 Mercy Court, Irvine, KY 40336

Telephone Number: 606-723-2115

Website: www.mercy.com

Email: dstepp@mercy.com

Project Description

The Project HOME Network will seek to expand and further develop its network partnerships to include other agencies and stakeholders that have a shared interest in contributing towards the development of a holistic and systematic approach to cardiac care.

Network activities will include the identification of existing gaps and unmet needs within the current continuum of cardiac care. This includes using quantitative data solicited from network members to establish appropriate baseline measures regarding the incidence and prevalence of heart disease in the community.

The network members will develop the appropriate policies, procedures, and protocols for the Transitional Care Model that is relevant to the target service area. The resulting Transitional Care Model will support reductions in unnecessary hospital visits and admissions (or readmissions) through focused patient assessments (that include an evaluation of medication adherence, educational and psychosocial deficits, environmental triggers, potential safety hazards, and social circumstances) and the coordination of care, which matches resources and services to the needs of the patient population and ensures that patients are handed over systematically from one setting to another.

The Project HOME Network will develop a sustainability plan to support the Transitional Care Model beyond the funded grant period, including sustaining key staff positions. The network will evaluate current billing and

workflow processes to identify opportunities to maximize reimbursements across the continuum of patient care. The network will further research potential opportunities for prospective payments, shared savings programs, and fee-for-service revenue to create additional revenue streams to sustain program activities. The network will document resultant cost savings (e.g., reduced readmissions) that can be redirected to sustaining the initiative.

Evidence-Based or Promising Practice Model Being Used or Adapted

The Transitional Care Model is designed to align the rural health delivery system and community care networks with the preferences, needs, and values of high-risk individuals (and their caregivers) in order to improve overall health care experiences and achieve higher-quality health outcomes, while reducing overall care costs. For model developers Dr. Eric Coleman and Dr. Mary Naylor, the purpose of the Transitional Care Model is to ensure the continuity of health care as patients transfer to different levels of care (transfers between health care practitioners and settings, including in-house transfers to stepdown or specialty areas, hospital to home, or skilled nursing facilities). In the Naylor Transitional Care Model, there is a particular emphasis on patient-centeredness, in terms of how patient outcomes are improved when activated and informed patients can verbalize their care preferences to different audiences. The Naylor model also emphasizes a more holistic and comprehensive care approach.

The core components of the Naylor Transitional Care Model include screening, staffing, relationship building, assessing and managing risks and symptoms, patient education, promoting continuity, and fostering coordination.

Screening: The identification of patients with complex needs who are transitioning between different care settings and who are at high risk for poor health outcomes (due to a diagnosis of heart disease). Includes evaluation of new admissions to Marcum Wallace Hospital and risk stratification for readmission to the hospital (utilizing the LACE Index Scoring Tool and other predictive screening instruments), combined with further evaluations of economic stability (financial distress), social and community connectedness, health literacy, neighborhood and physical environment, and food security status.

Staffing: The Project HOME Network understands that effective management of care transitions is not the result of one person or one discipline, but instead depends on a culture of team-based care that supports a more holistic and comprehensive care approach that anticipates, prevents, and mitigates those conditions and life circumstances that contribute to poor care transitions.

Relationship Building: The establishment and development of trusted relationships with patients and family caregivers supports patient-centered, longitudinal care. As part of its transitional care effort, the Project HOME Network will utilize the Institute for Patient and Family Centered Care's Better Together Program to promote improved engagement with patients and family caregivers.

Assessing and Managing Risks and Symptoms: Identifying and addressing priority risk factors and symptoms to prevent acute exacerbations and cardiac emergencies that might require hospitalization or re-hospitalization.

Patient Education: Enabling individuals with heart disease to assume primary responsibility for managing one or more aspects of their disease.

Promoting Continuity: Using information technology to facilitate collaboration between health care providers and promoting information sharing that reduces vulnerabilities across all care transitions.

Fostering Coordination: Establishing linkages between local health care providers and community-based services and social supports to remove the burden of coordination from the patient.

Expected Outcomes

Expected project outcomes include:

- Establish a coordinating structure to optimize patient care and allow patients to reach their maximum health potential within their heart disease experience,
- Increase knowledge, skills, and confidence of patients (and their caregivers) to more effectively manage and make informed decisions about their own health and health care,
- Increase adherence to prescribed therapeutic regimens (through the development of care plans, the monitoring of their implementation, and adjustment over time),
- Reduce hospital readmission rates (through maintenance of health stability following discharge and the improved coordination of care), and
- Realize cost savings for area health providers.

Special Populations Served

- Adults
- Black or African American
- Caucasian or White American
- Children/Adolescents
- Hispanic/Latinx
- Infants
- Older adults
- Pacific Islander/Asian American
- Pregnant people
- Uninsured

Area Served

- Estill County
- Lee County
- Powell County

Consortium Partners

Organization	County	State	Organization Type
Children's Clinic	Estill	KY	Health Care Clinic
Estill County Board of Education	Estill	KY	County School District
Estill County Emergency Medical Services	Estill	KY	County Emergency Medical Service
Estill County Health Department	Estill	KY	County Public Health Department
Estill Development Alliance	Estill	KY	Development Alliance
Estill Medical Clinic, PSC	Estill	KY	Independent Rural Health Clinic
Hospice Care Plus	Madison	KY	Home Health Hospice Agency
Juniper Health, Inc	Breathitt	KY	Federally Qualified Health Center
Kentucky Bluegrass	Madison	KY	Workforce Development Center
Kentucky Homeplace	Perry	KY	Community Health Care Navigation Agency
Kentucky Regional Health Information Organization	Rowan	KY	Regional Health Information Organization
Kentucky River Foothills	Estill	KY	Federally Qualified Health Center
Lee County Health Department	Lee	KY	County Public Health Department
Mercy Health Clinics	Estill, Lee, and Powell	KY	Provider-Based Rural Health Clinic
Mercy Health - Marcum and Wallace Hospital	Estill	KY	Critical Access Hospital
New Vista	Estill	KY	Community Mental Health Center
Reliance Works, LLC	Estill	KY	Second Chance Employment and Substance Use Disorder Treatment Center
Riverview Services	Estill	KY	Primary Care Clinic
US Acute Care Solution	Multiple counties	KY	Emergency Medicine Physician Group
Whitehouse Clinic	Estill	KY	Federally Qualified Health Center

Louisiana Rural Health Association

State Rural Health Association

D78RH50228

Primary Focus Area:
Coordination of Care Services

Secondary Focus Areas:
Community Health Workers,
Heart Disease,
Health Information Technology

Grantee Contact Information

Grantee Contact: Denaé Hebert

Title: Executive Director

Organization: Louisiana Rural Health Association

Address: 133 Highway 402, Napoleonville, LA 70390

Telephone Number: 985-369-3813

Website: www.lrha.org

Email: dhebert@lrha.org

Project Description

The goal of the project is to develop a rural health network to support leveraging of health information exchange (HIE) engagement, community health worker (CHW) engagement, and utilization of the Chronic Care Model (CCM) to build and maintain a strategy and framework to support better health outcomes and to provide whole-person care and wraparound services to rural residents who have heart disease or are at risk of heart disease. The network aims to address the overarching chronic health issues for this patient population by providing more seamless avenues of care continuity and coordination. The key activities that the network will conduct to meet this goal are:

1. Beginning in St. Landry Parish, the network will define and identify the population cohort with support of Opelousas General Hospital data.
2. The network will then develop and implement a process to connect CHWs at St. Landry Parish Health Unit with cohort patients and their care team utilizing the HIE.
3. CHWs will provide care coordination and chronic care management, and will assess and navigate social determinants of health for participants.
4. The network will then identify additional care providers within the target parishes involved in the participants' care and work to engage those providers in the HIE for improved communication and increased care coordination across the parish.

5. After successful implementation in St. Landry Parish, the network will expand the project to one additional parish in each year of the grant for a total of four parishes.
6. The network will leverage the resources of the LaTech Computer Science Department to document the patient outcomes and cost savings and conduct independent research to secure sustainability funding and support.

Evidence-Based or Promising Practice Model Being Used or Adapted

The program integrates three evidence-based models: the HIE model, CHW model, and CCM. By integrating the three models, the whole will be greater than the sum of its parts. By simultaneously expanding the HIE to more providers and CHWs, the CHW Model will be strengthened for the provision of services to people at risk for heart disease. In turn, the CCM Model will be enhanced and improve health outcomes. The end results are higher levels of health and wellness for patients and the larger community. The only modification to the CHW CCM model is that the CHWs will be horizontally integrated with providers instead of vertically integrated into provider facilities. Therefore, CHWs will be housed in a collaborating entity (public health units) instead of within the individual provider organizations themselves. This adaptation takes advantage of the existing CHWs within the target areas.

Expected Outcomes

The expected outcomes of this project are to:

- Improve clinical outcomes for people with and at risk of heart disease through a multisector and multidisciplinary network;
- Integrate three evidence-based strategies into a comprehensive care coordination model; and
- Achieve a sustainable network model.

The overarching result is a seamless health care landscape with increased provider capacity and improved health outcomes.

Special Populations Served

- Adults
- Black or African American
- Caucasian or White American
- Hispanic/Latinx
- Low-income
- Native American/American Indian
- Older adults
- Pacific Islander/Asian American
- Pregnant people
- Uninsured

Area Served

- Acadia Parish
- Avoyelles Parish
- Evangeline Parish
- St. Landry Parish

Consortium Partners

Organization	County	State	Organization Type
Louisiana Tech University	Lincoln Parish	LA	University
Opelousas General Hospital	St. Landry Parish	LA	Hospital
St. Landry Parish Health Unit	St. Landry Parish	LA	Parish Health Unit

Missouri Primary Care Association

Primary Care Association

D78RH50230

Primary Focus Area:
Heart Disease

Secondary Focus Areas:
Coordination of Care Services

Grantee Contact Information

Grantee Contact: Natalie Dykman

Title: Director of Compliance and Value-Based Programs

Organization: Missouri Coalition for Primary Health Care (doing business as Missouri Primary Care Association)

Address: 3325 Emerald Lane, Jefferson City, MO 65109

Telephone Number: 573-636-4222

Website: www.Mo-pca.org

Email: ndykman@mo-pca.org

Project Description

According to the Health in *Rural Missouri Biennial Report, 2020-2021*, Missourians living in rural counties experience higher instances of health disparities compared to urban counties, which produces worsening health behaviors, poorer health outcomes, and more difficulty accessing necessary health care services. The report also notes that heart disease remains the leading cause of death for Missourians, with statistically significant disparities noted between rural and urban populations.

The consortium seeks to address the disparities noted in the report by collaborating with three rural Federally Qualified Health Centers (FQHCs) on the Cardiovascular Care Coordination (3C) program. The 3C program will utilize care coordination and health information technology (HIT) models to provide efficient and effective care coordination services for rural Missourians diagnosed with, or at risk of, heart disease.

The service area includes 17 counties in southern and central Missouri where rural Missourians have a more difficult time accessing health services for reasons including distance to health care providers, lower rates of insurance coverage, and cost. The program will outreach to and connect high-risk patients to a Patient Centered Medical Home (PCMH) at FQHC network members—all of which are recognized PCMHs by the National Committee on Quality Assurance. The 3C program will serve underserved populations who have historically suffered from poorer health outcomes, health disparities, and other inequities such as low socioeconomic status, uninsured/under-insured, and minority populations.

Evidence-Based or Promising Practice Model Being Used or Adapted

This project will incorporate elements of the Care Coordination and HIT models to leverage HIT systems to:

- Support clinical outcome improvement, close care gaps, and facilitate care transitions.
- Connect high-risk residents to a recognized PCMHs (e.g., patients diagnosed with hypertension but not seen in greater than 18 months or patients with more than four emergency department visits in the previous 12 months).
- Facilitate care transitions.
- Engage patients in their treatment plan.
- Improve patient communication.
- Provide patient education.
- Utilize HIT tools to address social determinants of health impacting patients.
- Connect patients with referrals/resources.
- Link patients to other community-based or social services.

Expected Outcomes

The consortium seeks to create a centralized care coordination system at the partnering FQHCs. The program will utilize Care Coordination and HIT models and provide care to patients diagnosed with, or at risk of, heart disease. By ensuring patients have access to optimal care coordination services utilizing a standardized approach based on data and population health analytics, the goals for this program include the following:

- Expand access to and quality of equitable health care services through care coordination strategies exclusively in rural areas.
- Utilize Care Coordination and HIT evidence-based models to improve patient health outcomes and delivery of patient-centered health care services.
- Increase collaboration among multisector and multidisciplinary network partnerships to address the underlying factors related to social determinants of health.
- Decrease rates of preventable hospitalization and emergency room visits due to cardiovascular issues.
- Develop and implement deliberate and sustainable strategies of care coordination into policies, procedures, staffing, services, and communication systems.
- Alleviate the burden of recruiting and retaining support staff that rural FQHCs are experiencing due to workforce shortages.

Special Populations Served

- Adults
- Black or African American
- Caucasian or White American
- Children/Adolescents
- Hispanic/Latinx
- Native American/American Indian
- Older adults
- Pacific Islander/Asian American
- Pregnant people
- Uninsured

Area Served

- Barton
- Barry
- Butler
- Carter
- Camden
- Iron
- Jasper
- Laclede
- McDonald
- Miller
- Newton
- Pulaski
- Reynolds
- Ripley
- Shannon
- Wayne

Consortium Partners

Organization	County	State	Organization Type
Big Springs Medical Association (d/b/a Missouri Highlands Health Care)	Butler, Carter, Iron, Reynolds, Ripley, Shannon, and Wayne	MO	Federally Qualified Health Center
Ozark Tri-County Health Care Consortium, Inc. (d/b/a ACCESS Family Care)	Barry, Barton, Jasper, Lawrence, McDonald, and Newton	MO	Federally Qualified Health Center
Richland Medical Center (d/b/a Central Ozarks Medical Center)	Camden, Laclede, Miller, and Pulaski	MO	Federally Qualified Health Center

Adirondack Health Institute

Nonprofit

D78RH50223

Primary Focus Area:
Heart Disease

Secondary Focus Areas:
Coordination of Care Services,
Diabetes

Grantee Contact Information

Grantee Contact: Katy Cook

Title: Director of Partner Engagement

Organization: Adirondack Health Institute

Address: 21 Plattsburgh Plaza, Plattsburgh, NY 12901

Telephone Number: 518-480-0111

Website: www.ahihealth.org

Email: kcook@ahihealth.org

Project Description

The overarching project goal of this Rural Health Care Coordination grant is to improve health outcomes by improving access to evidence-based Chronic Disease Self-Management Programs (CDSMP). This will be achieved through more effective case management and care coordination that facilitates referrals from clinical to social care providers in four rural counties.

- Initially, the consortium seeks to create the Chronic Disease Care Coordination Network to build an expanded care coordination system working with the Get Healthy North Country Community Integrated Healthcare Network and the North Country Care Coordination Collaborative. Within the participating network provider organizations, several activities are planned:
- Identify multidisciplinary care coordination teams, inclusive of care managers.
- Conduct qualitative and quantitative assessment of regional needs for referrals to self-management programs, existing resources, gaps, and areas for improvement, including barriers to patient participation in CDSMP.
- Engage care coordinators at the partner level to define and implement care management process for identification and referral of adults at risk, to chronic disease self-management programs.
- Review current workflow for identification and referral of eligible clients. Possible methodology may

include process mapping, brainstorming, and decision diagrams.

- Collaborate with partners including local health departments, local Offices for Aging, and the New York Office for Aging to improve shared information regarding risk identification and referral management.
- Leverage existing closed loop referral systems including ADK Wellness Connections via UniteUs, NY Connects, and individual electronic health records with the regional health information exchange, Hixny, and other state platforms, providers, and care management agencies to facilitate community-clinical linkages and communications.
- Connect existing resources and use care management services to expand access to social determinants of health services provided by community-based organizations for high-risk clients with heart disease.
- Collaborate with managed care organizations, Adirondacks ACO, and Northwinds IPA to explore options to bundle care coordination services, chronic disease self-management programs and social determinants of health resources to improve the outcomes of individuals with heart disease.

Evidence-Based or Promising Practice Model Being Used or Adapted

The consortium seeks to improve referrals from clinical to community care providers which is consistent with the Centers for Disease Control's Chronic Disease Prevention model, specifically in the Community-Clinical Domain. It looks to improve health outcomes of adults living with heart disease and/or underlying risk factors including hypertension, diabetes mellitus, pre-diabetes, or tobacco use through a multidisciplinary evidence-based care coordination strategy that equitably expands access to CDSMP and Food as Medicine services in the four counties. The CDSMP suite of programs are evidence-based programs themselves.

Expected Outcomes

Through the implementation of the care coordination initiative, the consortium hopes to achieve a more efficient workflow for referrals between clinical settings and community-based organizations utilizing the existing, and increasing capacity of, the care coordination/care management teams. As more people with social determinants of health issues and co-morbidities gain access to programs like CDSMP and Food as Medicine programs, outcomes of such people will improve. Additional outcomes include:

- Develop a baseline services map to be shared with the network.
- Achieve 15% increase in referrals from baseline by end of grant.
- Patient identification and referral workflows will be tested in pilot program sites for evaluation prior to expanding implementation.
- A summary of best practices is compiled and shared with all clinical and social care providers in the region.
- Plan is identified for improved systems of communication about resources related to heart disease and diabetes for care managers.
- Sustained Food as Medicine program is available in each county.
- Strategies are developed for filling work force shortages.

Special Populations Served

- Adults
- Black or African American
- Caucasian or White American
- Hispanic/Latinx
- Native American/American Indian
- Older adults
- Pacific Islander/Asian American
- Pregnant people
- Uninsured

Area Served

- Clinton County
- Essex County
- Franklin County
- Hamilton County

Consortium Partners

Organization	County	State	Organization Type
Adirondacks ACO	Clinton	NY	Accountable Care Organization
Hudson Headwaters Health Network	Warren County and parts of Clinton, Essex, Franklin, Hamilton counties	NY	Federally Qualified Health Center
North Country Healthy Heart Network	Clinton, Essex, Franklin	NY	Nonprofit Community-based Organization
Northwinds Integrated Health Network IPA, Inc.	Clinton	NY	Behavioral Health, Independent Practice Association
University of Vermont Health Network – Alice Hyde Medical Center	Franklin	NY	Hospital
University of Vermont Health Network – Champlain Valley Physicians Hospital	Clinton	NY	Hospital

Duncan Regional Hospital

Nonprofit

D78RH50255

Primary Focus Area:
Cancer

Secondary Focus Areas:
Community Health Workers,
Coordination of Care Services

Grantee Contact Information

Grantee Contact: Cyndi Crook

Title: Project Director

Organization: Duncan Regional Hospital

Address: 2621 Whisenant Drive, Duncan, OK 73533

Telephone Number: 580-252-5300

Website: www.drhhealth.org

Email: cyndi.crook@drhhealth.org

Project Description

The Duncan Regional Hospital Cancer Care Coordination Network is dedicated to preventing and improving cancer care and outcomes, one of the leading causes of morbidity and mortality in the communities of Cotton, Jefferson, and Stephens counties. The Cancer Care Network includes the Cancer Centers of Southwest Oklahoma, Pathways to a Healthier You (community health improvement organization), Jefferson and Stephens County Health Departments, and the Wichita Mountains Prevention Network. As the only health care entity in two of these counties (Cotton and Jefferson), the network will work together to improve access, quality, and equity of cancer care through care coordination in the counties. By addressing social drivers of health, the goal is to implement care coordination strategies into policies, procedures, staffing, services, and communication systems to sustain a coordinated, cost-effective, patient-centered care system.

Key activities include:

- Convening and focusing the network on improving and expanding care coordination to address cancer and its underlying risk factors.
- Establishing a cancer care coordination network of community health workers and patient navigators.
- Implementing a program of community-based activities to reduce the burden of disease due to cancer through screening, early detection, education, outreach, and activities to reduce cancer's underlying risk factors.

- Implementing cancer care coordination tools, processes, and policies throughout the system of care to span Cotton, Jefferson, and Stephens counties.

Evidence-Based or Promising Practice Model Being Used or Adapted

The network will deploy community health workers and patient navigators at multiple service points to increase screening and engage residents in diagnostics and needed care to optimize outcomes. The Care Coordination in Chronic and Complex Disease Management model will be adopted to guide program design and implementation. This model describes the characteristics, processes, and interactions with and between healthcare teams that lead to effective care coordination. The model will be used with the addition of evidence-based methods to improve coordination and cancer outcomes, including a coordinated screening program, early diagnosis, and enhanced relational coordination.

Expected Outcomes

The Cancer Care Coordination program will:

- Improve systematic processes for comprehensive care coordination related to five leading cancers in the region.
- Implement a multidisciplinary and multisector referral system across the service areas to support coordination of care.
- Increase access to care coordination for people with cancer.
- Increase access to coordinated screening and early diagnosis of cancer.
- Institutionalize care coordination strategies and procedures across the system of care.
- Identify financing mechanisms to sustain comprehensive care coordination strategies beyond the initial grant funding.

Ultimately, the project will lead to improved patient outcomes and patient-centeredness of the system of care, cost savings for patients and payers, and improvements in population health outcomes.

Special Populations Served

- Adults
- Black or African-American
- Caucasian or White American
- Hispanic/Latinx
- Native American/American Indian
- Older adults
- Pacific Islander/Asian American
- Pregnant people

Area Served

- Cotton County
- Jefferson County
- Stephens County

Consortium Partners

Organization	County	State	Organization Type
Cancer Centers of Southwest Oklahoma	Stephens	OK	Health Care
County Health Department	Jefferson/ Stephens	OK	Public Health
Pathways to a Healthier You	Jefferson/ Stephens	OK	Public Health
Wichita Mountains Prevention Network	Jefferson/ Stephens	OK	Public Health

Avera Health

Health System

D78RH50224

Primary Focus Area:
Chronic Lower Respiratory Disease

Secondary Focus Areas:
Coordination of Care Services,
Telehealth

Grantee Contact Information

Grantee Contact: Jamie Janssen

Title: Project Director

Organization: Avera Health

Address: 3900 W Avera Drive, Sioux Falls, SD 57108

Telephone Number: 605-322-4000

Website: www.avera.org

Email: Jamie.janssen@avera.org

Project Description

Avera Health plans to meet the need for rural care coordination for chronic lower respiratory diseases such as chronic obstructive pulmonary disease (COPD) by expanding the utilization of a proven, value-based care and evidence-based telehealth intervention, remote patient monitoring (RPM), to rural residents within a clinical and acute care network. The program's overall goal is to enable care coordination for patients with chronic lower respiratory disease (CLRD) in rural areas by using an analytically driven approach and RPM to improve long-term outcomes.

This will be accomplished through the following objectives: 1) Expand access to RPM for rural patients with COPD, employing data analytics to identify and enroll at-risk patients from clinical network partners; 2) Implement care coordination strategy for patients with CLRD utilizing RPM to reduce readmission rate and emergency department visits; 3) Utilize centralized RPM care coordination team to screen for social determinants of health (SDOH) and provide timely referrals to supportive services, increasing the overall number of patient well-days; and 4) Conduct continuous quality improvement for patient and provider communication, bill coding, and network communication to build a sustainable RPM care coordination program, evaluated annually.

Evidence-Based or Promising Practice Model Being Used or Adapted

Avera Health’s model for care coordination aligns with the evidenced-based Eric Coleman Model of Care Transitions for patients in their transition back home after discharge to prevent rehospitalization. The GOLD measure for severity of CLRD, value-based RPB care model, and risk stratification will support patient care, and the network will operate with evidence-based principles from the Plan, Do, Study, Act and Collective Impact model.

Expected Outcomes

Avera Health expects that this project will support the following outcomes:

- Expanded access to RPM for rural patients with CLRD, employing data analytics to identify and enroll at-risk patients from clinical network partners; implement care coordination strategy for CLDR patients utilizing remote patient monitoring;
- Establishment of a centralized RPM care coordination team to screen for SDOH and provide timely referrals to supportive services; and
- The creation of a sustainable RPM care coordination program. Patients will have reduced emergency department and readmission rates, reduced cost of care, and an increased number of well-days.

Special Populations Served

- Adults
- Black or African American
- Caucasian or White American
- Hispanic/Latinx
- Native American/American Indian
- Older adults
- Pacific Islander/Asian American

Area Served

- Antelope, NE
- Aurora, SD
- Beadle, SD
- Big Stone, MN
- Bon Homme, SD
- Boyd, NE
- Brookings, SD
- Brown, SD
- Brule, SD
- Buena Vista, IA
- Buffalo, SD
- Campbell, SD
- Cedar, NE
- Charles Mix, SD
- Cherokee, IA
- Chippewa, MN
- Clark, SD
- Clay, SD
- Corson, SD
- Cottonwood, MN
- Davison, SD
- Day, SD
- Deuel, SD
- Dewey, SD
- Dickey, ND
- Douglas, SD
- Edmunds, SD
- Emmet, IA
- Faulk, SD
- Garfield, NE
- Grant, SD
- Hand, SD
- Hanson, SD
- Holt, NE
- Hughes, SD
- Hutchinson, SD
- Hyde, SD
- Jackson, MN
- Jerauld, SD
- Jones, SD
- Keya Paha, NE
- Kingsbury, SD
- Kossuth, IA
- Lac Qui Parle, MN
- Lake, SD Rock, MN
- Lincoln, MN
- Lyon, IA
- Lyon, MN

- Lyman, SD
- Marshall, SD
- McCook, SD
- McPherson, SD
- Mellette, SD
- Miner, SD
- Moody, SD
- Murray, MN
- Nobles, MN
- Osceola, IA
- Palo Alto, IA
- Pierce, NE
- Pipestone, MN
- Plymouth, IA
- Pocahontas, IA
- Potter, SD
- Redwood, MN
- Roberts, SD
- Sandborn, SD
- Sioux, IA
- Spink, SD
- Stanley, SD
- Sully, SD
- Todd, SD
- Trip, SD
- Turner, SD
- Walworth, SD
- Wayne, NE
- Yankton, SD
- Yellow Medicine, MN

Consortium Partners

Organization	County	State	Organization Type
Pipestone County Medical Center	Pipestone	MN	Critical Access Hospital
Rural Health Care Inc	Hughes	SD	Federally Qualified Health Center
Spencer Hospital	Clay	IA	Rural Hospital

