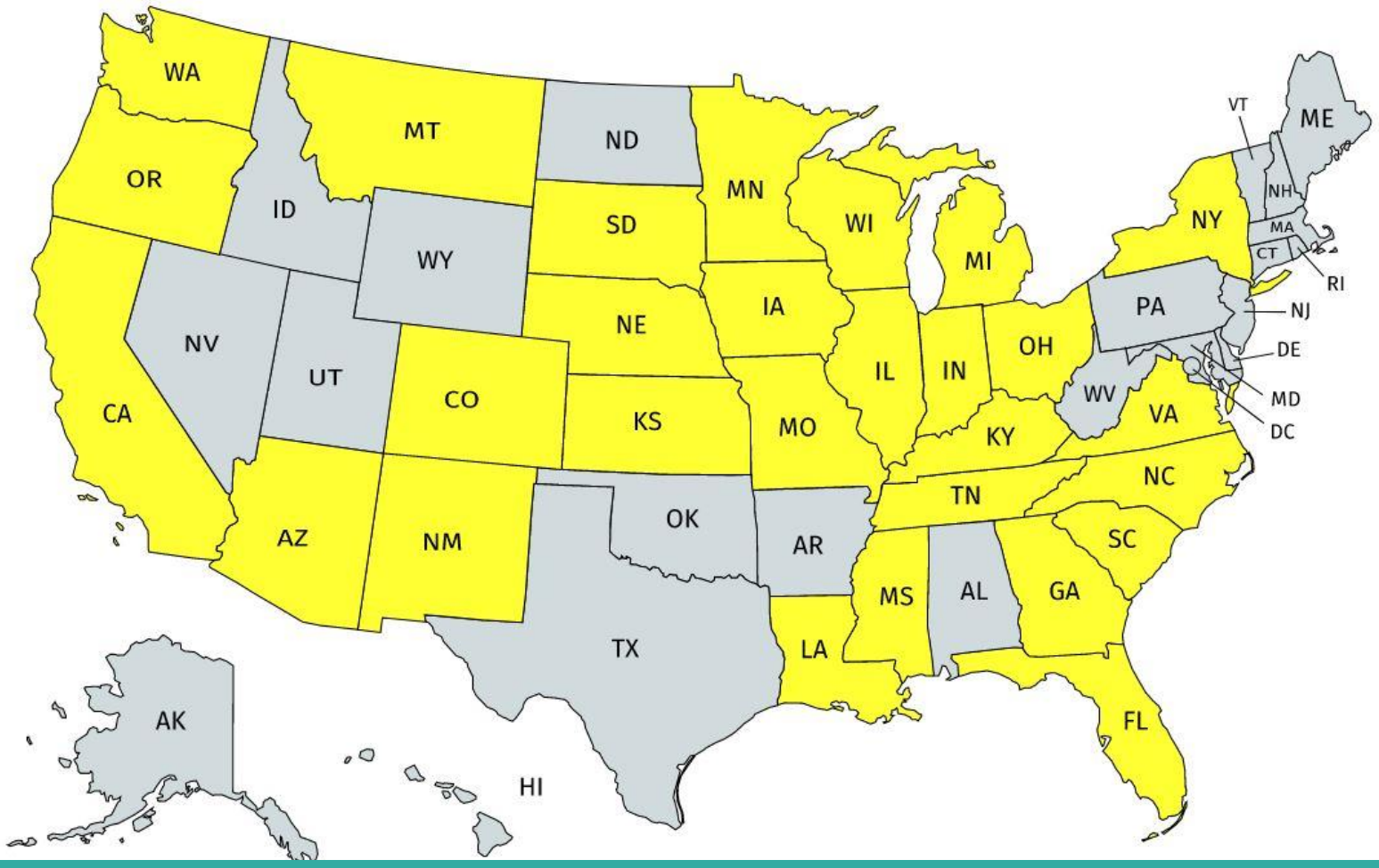
Rural Health Network Development Program

GRANTEE DIRECTORY
2020 - 2023



JUNE 2021

HEALTH RESOURCES AND SERVICES ADMINISTRATION
THE FEDERAL OFFICE OF RURAL HEALTH POLICY

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Introduction

The Federal Office of Rural Health Policy's (FORHP) Community-Based Division provides support to integrated rural health care networks that have combined the functions of the entities participating in the network, including skilled and experienced staff and a high functioning network board, in order to address the health care needs of the targeted rural community.

Through the Rural Health Network Development (RHND) grant program, FORHP encourages innovative solutions to local health care needs identified by local communities and supports rural communities in preparing for changes within the health care environment.

The overarching goals of the RHND Program are to:

- Improve access and quality of health care in rural areas through sustainable health care programs created as a result of network collaboration;
- Prepare rural health networks for the transition to value-based payment and population health management;
- Demonstrate improved health outcomes and community impact;
- Promote the sustainability of rural health networks through the creation of diverse products and services;
- Utilize and/or adapt an evidence-based or promising practice model(s) in the delivery of health care services.

This Directory provides contact information and a brief description of the 44 rural health networks funded during the 2020-2023 grant period.

The purpose of the RHND program is to support rural integrated health care networks that have combined the functions of the entities participating in the network in order to: achieve efficiencies; expand access to, coordinate, and improve the quality of essential health care services; and strengthen the rural health care system as a whole.

Grantees by State

State	Grant Organization
Arizona	Arizona Community Health Workers Association, Inc.
California	Mendonoma Health Alliance
Colorado	Bright Future Foundation For Eagle County
Colorado	Eastern Plains Healthcare Consortium
Colorado	Tri-County Health Network
Florida	St. Johns River Rural Health Network, Inc.
Georgia	Dublin City Schools
Georgia	Rural Health Works, Inc.
Illinois	HSHS Good Shepherd Hospital, Inc.
Illinois	Katherine Shaw Bethea Hospital
Indiana	Indiana University Health Bedford, Inc.
Iowa	Mercy Medical Center – Newton
Iowa	Unity Healthcare
Kansas	Kansas Clinical Improvement Collaborative, LLC
Kentucky	Big Sandy Health Care, Inc.
Kentucky	Purchase District Health Department, Inc.
Kentucky	St. Claire Medical Center, Inc.
Louisiana	Louisiana Rural Ambulance Alliance, Inc.
Louisiana	Winn Community Health Center
Michigan	Huron, County of
Minnesota	Well Being Development
Minnesota	Wilderness Health, Inc.
Mississippi	Delta Health Alliance, Inc.
Missouri	Randolph County Caring Community, Inc.
Montana	Montana State University, Inc.
Nebraska	Community Access To Coordinated Healthcare, Inc.
Nebraska	Northeast Nebraska Public Health Department
New Mexico	Union County Health and Wellness Network, Inc.
New York	Westchester-ellenville Hospital, Inc.
North Carolina	Heritage Hospital, Inc.
Ohio	Hopewell Health Centers, Inc.
Oregon	Northeast Oregon Network
Oregon	Oregon Washington health Network
Oregon	Sky Lakes Medical Center Foundation, Inc.
South Carolina	Palmetto Care Connections
South Dakota	Sacred Heart Health Services
Tennessee	Paris-Henry County Health Care Foundation, Inc.
Virginia	Bay Rivers Telehealth Alliance
Virginia	Strength in Peers, Inc.

Virginia	Virginia Rural Health Association
Washington	Critical Access Hospital Network
Wisconsin	Fort HealthCare, Inc.
Wisconsin	Rural Wisconsin Health Cooperative
Wisconsin	Thedacare Medical Center - Shawano, Inc.

Grantees by Grant Organization Name

Grant Organization	State
Arizona Community Health Workers Association, Inc.	Arizona
Bay Rivers Telehealth Alliance	Virginia
Big Sandy Health Care, Inc.	Kentucky
Bright Future Foundation For Eagle County	Colorado
Community Access To Coordinated Healthcare, Inc.	Nebraska
Critical Access Hospital Network	Washington
Delta Health Alliance, Inc.	Mississippi
Dublin City Schools	Georgia
Eastern Plains Healthcare Consortium	Colorado
Fort HealthCare, Inc.	Wisconsin
Heritage Hospital, Inc.	North Carolina
Hopewell Health Centers, Inc.	Ohio
HSHS Good Shepherd Hospital, Inc.	Illinois
Huron, County of	Michigan
Indiana University Health Bedford, Inc.	Indiana
Kansas Clinical Improvement Collaborative, LLC	Kansas
Katherine Shaw Bethea Hospital	Illinois
Louisiana Rural Ambulance Alliance, Inc.	Louisiana
Mendonoma Health Alliance	California
Mercy Medical Center – Newton	Iowa
Montana State University, Inc.	Montana
Northeast Nebraska Public Health Department	Nebraska
Northeast Oregon Network	Oregon
Oregon Washington health Network	Oregon
Palmetto Care Connections	South Carolina
Paris-Henry County Health Care Foundation, Inc.	Tennessee
Purchase District Health Department, Inc.	Kentucky
Randolph County Caring Community, Inc.	Missouri
Rural Health Works, Inc.	Georgia
Rural Wisconsin Health Cooperative	Wisconsin
Sacred Heart Health Services	South Dakota
Sky Lakes Medical Center Foundation, Inc.	Oregon
St. Claire Medical Center, Inc.	Kentucky
St. Johns River Rural Health Network, Inc.	Florida
Strength in Peers, Inc.	Virginia
Thedacare Medical Center - Shawano, Inc.	Wisconsin
Tri-County Health Network	Colorado
Union County Health and Wellness Network, Inc.	New Mexico
Unity Healthcare	Iowa

Virginia Rural Health Association	Virginia
Well Being Development	Minnesota
Westchester-ellenville Hospital, Inc.	New York
Wilderness Health, Inc.	Minnesota
Winn Community Health Center	Louisiana

Grantees by Focus Areas

Grant Organization	State	Focus Area (P=Primary/S=Secondary)
Rural Wisconsin Health Cooperative	Wisconsin	Advanced Care Planning (S)
Fort HealthCare, Inc.	Wisconsin	Alternative Payment Models (P)
Purchase District Health Department, Inc.	Kentucky	Alternative Payment Models (S)
Dublin City Schools	Georgia	Behavioral Health/Mental Health – General (S)
Heritage Hospital, Inc.	North Carolina	Behavioral Health/Mental Health – General (S)
Huron, County of	Michigan	Behavioral Health/Mental Health – General (P)
Katherine Shaw Bethea Hospital	Illinois	Behavioral Health/Mental Health – General (S)
Montana State University, Inc.	Montana	Behavioral Health/Mental Health – General S)
Northeast Oregon Network	Oregon	Behavioral Health/Mental Health – General (S)
Paris-Henry County Health Care Foundation, Inc.	Tennessee	Behavioral Health/Mental Health – General (S)
Randolph County Caring Community, Inc.	Missouri	Behavioral Health/Mental Health – General (S)
St. Johns River Rural Health Network, Inc.	Florida	Behavioral Health/Mental Health – General (S)
Tri-County Health Network	Colorado	Behavioral Health/Mental Health – General (P)
Virginia Rural Health Association	Virginia	Behavioral Health/Mental Health – General (P)
Well Being Development	Minnesota	Behavioral Health/Mental Health – General (P)
Wilderness Health, Inc.	Minnesota	Behavioral Health/Mental Health – General (S)
Louisiana Rural Ambulance Alliance, Inc.	Louisiana	Behavioral Health/Mental Health - Substance Use Disorder (P)
St. Claire Medical Center, Inc.	Kentucky	Behavioral Health/Mental Health - Substance Use Disorder (P)
Strength in Peers, Inc.	Virginia	Behavioral Health/Mental Health - Substance Use Disorder (P)
Thedacare Medical Center - Shawano, Inc.	Wisconsin	Behavioral Health/Mental Health - Substance Use Disorder (P)
Bright Future Foundation For Eagle County	Colorado	Behavioral Health/Mental Health – Substance Use Disorder (S)
Bay Rivers Telehealth Alliance	Virginia	Behavioral Health/Mental Health - Substance Use Disorder (S)

Community Access To Coordinated Healthcare, Inc.	Nebraska	Care Coordination (P)
Heritage Hospital, Inc.	North Carolina	Care Coordination (P)
Indiana University Health Bedford, Inc.	Indiana	Care Coordination (P)
Katherine Shaw Bethea Hospital	Illinois	Care Coordination (P)
Mendonoma Health Alliance	California	Care Coordination (P)
Rural Wisconsin Health Cooperative	Wisconsin	Care Coordination (P)
Sacred Heart Health Services	South Dakota	Care Coordination (S)
Unity Healthcare	Iowa	Care Coordination (S)
Winn Community Health Center	Louisiana	Care Coordination (S)
Arizona Community Health Workers Association, Inc.	Arizona	Chronic Disease (S)
Big Sandy Health Care, Inc.	Kentucky	Chronic Disease (S)
Community Access To Coordinated Healthcare, Inc.	Nebraska	Chronic Disease (S)
Delta Health Alliance, Inc.	Mississippi	Chronic Disease (P)
Fort Healthcare	Wisconsin	Chronic Disease (S)
Hopewell Health Centers, Inc.	Ohio	Chronic Disease (S)
Huron, County of	Michigan	Chronic Disease (S)
Indiana University Health Bedford, Inc.	Indiana	Chronic Disease (S)
Kansas Clinical Improvement Collaborative, LLC	Kansas	Chronic Disease (S)
Mendonoma Health Alliance	California	Chronic Disease (S)
Northeast Nebraska Public Health Department	Nebraska	Chronic Disease (S)
Oregon Washington health Network	Oregon	Chronic Disease (P)
Palmetto Care Connections	South Carolina	Chronic Disease (S)
Paris Henry County Health Foundation, Inc.	Tennessee	Chronic Disease (S)
Rural Health Works, Inc.	Georgia	Chronic Disease (S)
Rural Wisconsin Health Cooperative	Wisconsin	Chronic Disease (S)
Sky Lakes Medical Center Foundation, Inc.	Oregon	Chronic Disease (S)
Union County Health and Wellness Network, Inc.	New Mexico	Chronic Disease (S)
Westchester-ellenville Hospital, Inc.	New York	Chronic Disease (S)
Winn Community Health Center	Louisiana	Chronic Disease (P)

Arizona Community Health Workers Association, Inc.	Arizona	Community Health Workers (P)
Big Sandy Health Care, Inc.	Kentucky	Community Health Workers (P)
Hopewell Health Centers, Inc.	Ohio	Community Health Workers (P)
Mercy Medical Center – Newton	Iowa	Community Health Workers (S)
Northeast Oregon Network	Oregon	Community Health Workers (P)
Purchase District Health Department, Inc.	Kentucky	Community Health Workers (P)
Randolph County Caring Community, Inc.	Missouri	Community Health Workers (P)
Sky Lakes Medical Center Foundation, Inc.	Oregon	Community Health Workers (P)
Union County Health and Wellness Network, Inc.	New Mexico	Community Health Workers (P)
Westchester-ellenville Hospital, Inc.	New York	Community Health Workers (P)
Indiana University Health Bedford, Inc.	Indiana	Dementia (S)
Northeast Nebraska Public Health Department	Nebraska	Obesity Prevention (P)
Rural Health Works, Inc.	Georgia	Obesity Prevention (S)
Sacred Heart Health Services	South Dakota	Palliative Care (S)
Strength in Peers, Inc.	Virginia	Peer Recovery Specialists
Dublin City Schools	Georgia	School-based Health (P)
HSHS Good Shepherd Hospital, Inc.	Illinois	School-based Health (S)
Rural Health Works, Inc.	Georgia	School-based Health (P)
Well Being Development	Minnesota	School-based Health (S)
Mendonoma Health Alliance	California	Social Determinants of Health (S)
Mercy Medical Center – Newton	Iowa	Social Determinants of Health (P)
Tri-County Health Network	Colorado	Social Determinants of Health (S)
Unity Healthcare	Iowa	Social Determinants of Health (P)
Bay Rivers Telehealth Alliance	Virginia	Telehealth (P)
Critical Access Hospital Network	Washington	Telehealth (P)
Delta Health Alliance, Inc.	Mississippi	Telehealth (S)
HSHS Good Shepherd Hospital, Inc.	Illinois	Telehealth (P)
Kansas Clinical Improvement Collaborative, LLC	Kansas	Telehealth (P)
Palmetto Care Connections	South Carolina	Telehealth (P)

Paris-Henry County Health Care Foundation, Inc.	Tennessee	Telehealth (P)
St. Johns River Rural Health Network, Inc.	Florida	Telehealth (P)
Virginia Rural Health Association	Virginia	Telehealth (S)
Wilderness Health, Inc.	Minnesota	Telehealth (P)
Bright Future Foundation For Eagle County	Colorado	Workforce Development (P)
Critical Access Hospital Network	Washington	Workforce Development (S)
Eastern Plains Healthcare Consortium	Colorado	Workforce Development (P)
Montana State University, Inc.	Montana	Workforce Development (P)
Oregon Washington health Network	Oregon	Workforce Development (S)
Sacred Heart Health Services	South Dakota	Workforce Development (P)
St. Claire Medical Center, Inc.	Kentucky	Workforce Development (S)
St. Claire Medical Center, Inc.	Kentucky	Youth Opioid Prevention (S)

Grantee Profiles

The following section contains contact information and brief descriptions of the 44 Rural Health Network Development grantees funded during the 2020-2023 grant period. These descriptions may include program approach, program goals, and/or key activities for project/program implementation and further development of the engaged networks as they seek to improve the quality of health care in their communities.

Arizona

Arizona Community Health Worker Association, Inc.

Grant Number:	D06RH37493					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	Rural Arizona CHW Workforce Development Network				
	Address:	424 N Christine Ave .				
	City:	Douglas	**State:**	Arizona	**Zip code:**	85607
	Tel #:	928-366-3016				
	Website:	https://www.azchow.org/				
Primary Contact:	**Name:**	Floribella Redondo				
	Title:	Project Director				
	Tel #:	928-366-3016				
	Email:	floribella@azchow.org				
Secondary Contact:	**Name:**	Betsy Sorenson				
	Title:	Network Director				
	Tel #:	520-626-7864				
	Email:	elizabeth@azchow.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Chiricahua Community Health Center*	Cochise	AZ	FQHC
	North Country Health Care (Flagstaff)*	Coconino	AZ	FQHC
	Cochise County Health Department*	Cochise	AZ	Health Dept.
	Yuma County Health Department*	Yuma	AZ	Health Dept.
	Navajo Nation Department of Health and Human Services*	Apache	AZ	Tribal Health Dept.
	Hualapai Health Department*	Mohave	AZ	Tribal Health Dept.
	Southeast Arizona Area Health Education Center*	Santa Cruz	AZ	AHEC
	Campesinos Sin Fronteras*	Yuma	AZ	Nonprofit Org/CBO
	Arizona Community Health Worker Association/AzCHOW*	Cochise	AZ	Nonprofit Org/CBO
	Arizona Department of Health Services*	Maricopa	AZ	State Agency
	University of Arizona Prevention Research Center*	Pima	AZ	University
	Arizona Advisory Council on Indian Health Care*	Maricopa	AZ	Governor-Appointed Commission
	Arizona Complete Health*	Yuma	AZ	Payer

	Northern Arizona University Center for Health Equity Research*	Coconino	AZ	University

Counties the project serves:	Apache County, AZ			
	Cochise County, AZ			
	Coconino County, AZ			
	Mohave County, AZ			
	Navajo County, Az			
	Santa Cruz County, AZ			
	Yuma County, AZ			

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☒
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☒
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☒
	Infants and toddlers (up to 3 years)	☒	School-age children (Middle/high school ~13-17 years)	☒
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Community Health Workers
	Secondary Focus Area:	Chronic Disease

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	The Rural Arizona CHW Development Network will be a sustained., diverse, driving force for the CHW workforce in Arizona in order to improve access to health care, health outcomes and quality of life for rural Arizonans.
	Objective	By June 30, 2023, participatory structure and operations will enable the Network to flourish and be sustained as a champion for Arizona's rural CHW workforce.
	Objective	By June 30, 2023, the Network will build the capacity of rural CHWs in all ten core competencies and maximize CHW voluntary certification per Arizona state law.
	Objective	By June 30, 2023, the Network will work with health care system providers--both community-based and clinical--to assess needs and build the capacity to incorporate CHWs in care coordination and integrated behavioral health to improve health outcomes and reduce costs.
	Objective	By June 30, 2023, the Network will work with Arizona policy makers, the Medicaid system (AHCCCS) and health plans to advance financing options to support CHW services.

Project Description:

Fourteen diverse partner organizations have come together to build the Rural Arizona Community Health Worker (CHW) Workforce Development Network into a driving force for the expansion, diversity, integration, and sustainability of CHW/Tribal Community Health Representatives (CHR)/ Promotores de Salud (PP) services in a seven-county region.

The Network has a plan to strengthen its partnership by leveraging CHW/CHR and PP services as the catalyst for redesigning the structure, function, planning, sustainability, and growth of its operations. With a systems focus, grant funding will be used to increase the number of certified community health workers (CHW) based upon the successful C3 Project model, integrate CHW services into the health care systems of targeted communities through a recruitment and training process, and identify and pursue strategies to sustain and scale rural CHW services. The Network will work on strengthening its operational procedures to ensure

maximum member engagement in decision making, strategic planning and sustainability planning. There will be regular process and performance measures that will inform program strategies and impact.

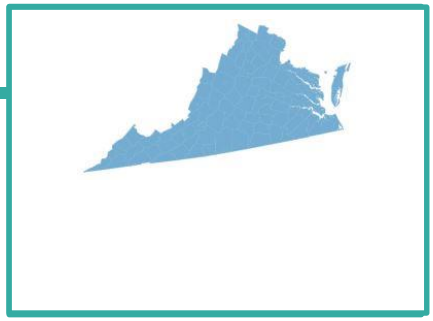
The Rural Arizona CHW Workforce Development Network was formed out a 2018 RHN Planning grant with a vision of ensuring that CHW/CHR/PP's become recognized as part of the healthcare workforce solution in rural Arizona. The fourteen partnering entities have strong but unique histories of utilizing CHWs to increase access to health care in rural areas of Arizona, improvement of health care quality among rural health care providers and improvement in health outcomes among rural patients and community residents. The five rural health care sectors represented include: FQHCs, County Health Departments, Tribal Health Departments, Non-Profit/CBOs, and State Government/Academic Institutions. Six of the partners are located in rurally designated communities and leadership consists of an Elected Leadership Team and the Network Director who relies on committees and task forces to ensure progress.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Three Evidence-Based/Promising Practice will be utilized.

1) The Chronic Care Model (CCM) identifies the essential elements of a health care system that encourage high quality chronic disease care. These elements are the community and health systems. The community includes resources and policies that promote self-managed support. Health systems pertain to the organization of health care, which includes delivery system design, decision support and clinical information systems. In combination, the evidence-based practices under each element foster productive interactions between informed patients who take an active part in their care and their care providers who have the resources and expertise they need.
2) Community Health Worker Scope of Practice has a large body of evidence that now supports CHW effectiveness in many settings. The C3 project recommends ten core competencies for the CHW scope of practice, in addition to 11 skills and a variety of qualities. The first five core competencies demonstrate how CHWs can improve access to care and health outcomes in rural communities: #1 –Cultural mediation; #2 –Culturally appropriate health education and information; #3 – Care coordination, case management and system navigation; #4 -Coaching and social support; #5 –Advocacy for individuals and communities.
3) Behavioral health integration, integrating primary care and behavioral health, is a concept many states are adopting. Arizona's Medicaid system now requires its funded health plans to integrate both services for its health plan members, and providers are increasingly moving toward integration. The models to integrate primary care and behavioral health focus on changes in primary care practice roles and support for co-location or coordination to address populations with mild to moderate behavioral health conditions. These models require significant workforce-related changes, including team-based care and changes in staff roles, including CHWs.

Project Officer (PO):	**Name:**	Krista Mastel				
	Tel #:	301-443-0491				
	Email:	KMastel@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA):	**Name:**	Ann Abdella				
	Tel #:	404-413-0314				
	Email:	abdella@a2rh.net				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303



Virginia

Bay Rivers Telehealth Alliance

Grant Number:	D06RH37494					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	Eastern Shore Telehealth Consortium				
	Address:	618 Hospital Rd., Bldg. A				
	City:	Tappahannock	**State:**	Virginia	**Zip code:**	22560
	Tel #:	804.443.6286				
	Website:	http://bayriverstelehealth.org/				
Primary Contact:	**Name:**	Donna D Hale				
	Title:	Executive Director				
	Tel #:					
	Email:	execdirector@bayriverstelehealth.org				
Secondary Contact:	**Name:**	Mary Ochsner				
	Title:	Network Director				
	Tel #:					
	Email:	director@easternshoretelehealth.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Bay Rivers Telehealth Alliance (BRTA)*		VA	Nonprofit Org./CBO
	Eastern Shore Community Service Board (ESCSB)*		VA	Nonprofit Org./CBO
	Eastern Shore Health District (ESHD)*		VA	Health Dept.
	Riverside Shore Memorial Hospital (RSMH)*		VA	Hospital
	Eastern Shore Regional Jail (ESRJ)*		VA	Jail

Counties the project serves:		
	Accomack County, VA	Northampton County, VA

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☒
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☐	Other:	☐

	Other:	☐	Other:	☐
Focus Areas:	**Primary Focus Area:**	Telehealth		
	Secondary Focus Area:	Behavioral Health/Mental Health - Substance Use Disorder		

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Develop a sustainable Eastern Shore Telehealth Consortium (ESTC) for the development of strategic virtual health initiatives designed to increase resources, innovation, and coordination of health services on the Eastern Shore of Virginia
	Objective	During the grant period, create a viable and sustainable organizational structure for a partnership network to promote and implement virtual health strategies.
	Goal	Increase the use of evidence-based/culturally appropriate Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) interventions through community partnerships and telehealth-enabled innovations (*direct care services).
	Objective	Enhance training opportunities for the 170 members of the existing workforce designed to increase exposure to evidence-based/informed, promising practices and culturally appropriate OUD/SUD interventions for prevention, treatment and recovery through telehealth enabled platforms.
	Objective	Enhance linkages to evidence-based practices for medication assisted treatment (MAT) and other SUD services offered in partnerships between Eastern Shore Community Services Board (ESCSB), Riverside Shore Memorial Hospital (RSMH), the Eastern Shore Health Department (ESHD), and the regional jails (ESRJ) for 130 clients with OUD
	Objective	Expand access to peer recovery and recovery support services that help people initiate and remain in recovery and relapse prevention for 130 clients with OUD
	Goal	Evaluate the effectiveness of the proposed interventions to determine their impact and sustainability.
	Objective	Evaluate the ESTC services progress towards achieving desired clinical outcomes.
	Objective	Evaluate the effectiveness of the ESTC network in establishing an infrastructure for Rapid Cycle Quality Improvement and sustainability.

Project Description:

Bay Rivers Telehealth Alliance (BRTA) is a non-profit telehealth network based in Tappahannock, Virginia, serving residents of the Eastern Shore of Virginia, among other rural areas. BRTA's vision is for virtual health strategies to contribute to better health and well-being for populations in Virginia communities, through its mission to help its members serve communities by supporting virtual health projects that improve health and health care. Over its fifteen-year history, BRTA has been successful in expanding access to medical care for rural populations via telehealth technologies, including remote, live interactive video conferencing and remote patient monitoring. BRTA will expand access to care for individuals living on the Eastern Shore of Virginia, by replicating its successes and creating the Eastern Shore Telehealth Consortium (ESTC). The ESTC will initially focus on expanding access to prevention, treatment, and recovery services for individuals with opioid use disorder (OUD) and substance use disorder (SUD) living on the Eastern Shore of Virginia

This project focuses on the creation of a viable, sustainable organizational structure for the ESTC; recruitment, on-boarding, training, and on-going supervision of ESTC staff; establishment of an ESTC office; development of plans relating to communications, marketing, and sustainability as well as a strategic plan, and a business model for ESTC; provision of evidence-based training to providers on SUD/OUD interventions via telehealth; provision of telehealth training to ESTC staff and partners; Medication Assisted Treatment (MAT) certification of providers; establishment of a Bridge to Emergency Department and Hub and Spoke model of OUD/SUD treatment; provision of clinical support services for MAT and SUD clients, including substance abuse clinicians, case management services, and peer recovery support; evaluation of the effectiveness of the project and the sustainability of the ESTC network. It is expected that this project will strengthen the ability of partners on the Eastern Shore to leverage resources to meet the needs of individuals with or at risk of SUD/OUD through a formal consortium; increase the use of evidence-based/culturally appropriate OUD/SUD interventions for prevention, treatment, and recovery through telehealth-enabled platforms; reduce morbidity and mortality related to SUD/OUD.

Evidence Based/ Promising Practice Model Being Used or Adapted:

BRTA will introduce three evidence-based practices into the work of the ESTC and one evidence-informed practice including:

1) Yale Emergency Medicine ED Initiated Buprenorphine Treatment Program (https://medicine.yale.edu/edbup/overview/). This EBP enables 24/7/365 treatment of individuals experiencing SUD in the emergency department (ED) as follows. Patients present at the ED seeking help with SUD, or are identified during the course of their visit as experiencing complications related to drug use. They are screened using The Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS) Tool which consists of a combined screening component (TAPS-1) followed by a brief assessment (TAPS-2) for those who screen positive. They are then assessed for OUD per the DSM 5 and for withdrawal using the clinical opioid withdrawal scale. They are then given induction treatment with buprenorphine and discharged with a referral to on-going medical treatment and psychosocial support. This model will be implemented by the ESTC as described, but with the additional of telehealth-enabled support for the on-going medical treatment and psychosocial support. Specifically, RSMH will provide MAT induction and refer patients to the ESCSB for on-going treatment and psychosocial support. The partners to the ESTC will also explore how medical treatment can be provided in the county jail for those who have been incarcerated, as well as whether telemedicine can be used to supervise the distribution and visualization of medications being taken. For example, the partners will explore whether a nurse practitioner could use telemedicine to monitor office based opioid treatment at the jail.
2) Vermont Hub-and-Spoke Model of Care for Opioid Use Disorder (https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke). Hub and Spoke is Vermont's evidence-based system of MAT, supporting people in recovery from opioid use disorder. MAT uses medication such as methadone and buprenorphine, as part of a comprehensive opioid use disorder treatment program that includes counseling. MAT is the most effective treatment for most people and is supported by the American Medical Association, the American Academy of Addiction Psychiatry, and the American Society of Addiction Medicine. Federal regulations designate two settings where Medication Assisted Treatment can take place, Opioid Treatment Programs and Office Based Opioid Treatment settings. Vermont takes this structure as a starting point, and strengthens and connects the elements.
3) Project Echo (https://echo.unm.edu/). The ECHO Model™ is an evidence-based model using adult learning techniques and interactive video technology to connect groups of community providers with specialists at centers of excellence in regular real-time collaborative sessions. The sessions, designed around case-based learning and mentorship, help local healthcare professionals and other support personnel to gain the expertise required to provide needed services. Providers gain skills and confidence; specialists learn new approaches for applying their knowledge across diverse cultural and geographical contexts. As the capacity of the local workforce increases, lives improve. The model will be implemented as described in order to train clinicians and peer recovery specialists in best practices with regard to preventing, treating, and supporting recovery from SUD. The partners to the ESTC will provide continuing training to providers on the Eastern Shore to support implementation of evidence-based practices through Virginia Department of Health's Opioid Project Echo Programs and other workforce development training initiatives.
4) Bay Rivers Telehealth Alliance Remote Patient Monitoring for Chronic Disease Management (https://www.ruralhealthinfo.org/project-examples/1016). BRTA's evidence-informed program serves patients in rural areas who have co-occurring chronic diseases and behavioral health problems that interfere with their management of their chronic disease. Patients enroll at the time of ER or hospital discharge. Remote Patient Monitoring(RPM) equipment, capable of sharing standard vital signs (blood pressure, oxygenation, weight), is drop-shipped to the patient's home. Soon after, a health coach visits the patient and uses an evidence-based assessment to further assess and build patients' understanding of both their behavioral health and chronic disease challenges. Specific to this project is a behavioral health assessment. This approach aims to discover eligible patients for health coaching for six months. If a high-risk patient is identified during screening, they are referred to a behavioral health organization for further care. RPM is recommended for a 90-day period. Health information is transmitted to the partner health system's coordination center where incoming data is assessed by nurses. Any values outside an expected range or not transmitted are evaluated by phone or home or office visit. Patients may also call their health coach or the monitoring center with any questions. Two-week trend data are integrated into the patient's electronic health record allowing primary care providers to review this information in a process similar to the workflow for new lab or X-ray results. This model will be implemented broadly as described, with health information being transmitted to Riverside Health System's coordination center where it will be assessed by nurses.

However, rather than health coaches being dispatched to visit clients, it will be behavioral health staff from ESCSB. Capacity to share the biometric monitoring with partners will be explored.						
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Kentucky

Big Sandy Health Care, Inc.

Grant Number:	D06RH37495					
Organization Type:	FQHC					
Grantee Organization:	**Project Name:**	ReachEKY Health Care Access Network				
	Address:	1709 KY Route 321, Ste. 3				
	City:	Prestonsburg	**State:**	Kentucky	**Zip code:**	41653
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Big Sandy Health Care, Inc.*	Floyd	KY	FQHC
	Floyd County Health Department*	Floyd	KY	Health Dept.
	Johnson County Health Department*	Johnson	KY	Health Dept.
	Magoffin County Cooperative Extension Service*	Magoffin	KY	University Dept.
	Pike County Cooperative Extension Service*	Pike	KY	University Dept.
	Sandy Valley Transportation Services, Inc.*.	Floyd	KY	Nonprofit Org./CBO
	Lakefront Church of God*	Magoffin	KY	Faith-based Org.

Counties the project serves:		
	Floyd County, KY	Martin County, KY
	Johnson County, KY	Pike County, KY
	Magoffin County, KY	

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☒
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐

	Latinos	☒	Uninsured	☒
	Native Americans	☐	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Community Health Workers
	Secondary Focus Area:	Chronic Disease

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Reduce the burden of chronic disease among the target population.
	Objective	Increase capacity to provide chronic care management services in the service area
	Goal	Increase access to health and social services for the target population
	Objective	Increase access to fresh fruits and vegetables for 150 low-income patients with chronic disease
	Objective	Increase access to medical transportation for 100 patients with chronic disease
	Objective	Develop service delivery mechanisms that increase patient access to care
	Goal	Strengthen the Network
	Objective	Enhance Network leadership through employment of a Network Director
	Objective	Develop a long-term sustainability plan for the Network
	Objective	Increase Network membership by at least three members each year of the grant period
	Objective	Identify key performance measures and resulting outcomes
	Objective	Develop strategic direction in order to guide Network activities
	Objective	Contribute to an evidence base that shows potential for replication of the model in other rural communities
	Objective	Promote the Network among various audiences
	Objective	Develop a business approach to sustainability for the Network
	Objective	Develop a strategy to sustain the Network

Project Description:

ReachEKY HealthCare Access Network's overarching goal is to decrease barriers to care and improve health outcomes for patients with chronic disease. The Big Sandy region of eastern Kentucky includes Floyd, Johnson, Magoffin, Martin and Pike counties and includes a population of 140, 318. (U.S. Census, 2018). Low levels of education and persistently high rates of poverty and unemployment are prevalent in the region. The population suffers from rates of chronic disease –including diabetes, heart disease, chronic lower respiratory disease (COPD) and cancer –that exceed state and national rates. Despite the passage of the Affordable Care Act and expanded Medicaid in Kentucky, a disproportionate number of residents in the region still are without health insurance. Residents also experience other barriers to care related to social determinants of health including food insecurity and lack of transportation. Kentucky has the highest food insecurity rate in the nation among 50 to 59-year-olds. (Ziliak, et al., 2019).

The Reach EKY Health Care Access Network is comprised of three traditional health care partners, including two local health departments and a federally-qualified health center and three non-traditional health care partners, including cooperative extension, a faith-based ministry that includes a food pantry, and a medical transportation agency. The Network will use Community Health Workers (CHWs) employed by the applicant organization to provide care coordination designed to reduce barriers to care including lack of transportation, inability to access healthy foods, and inability to navigate the health care system. The goals of the Network are to reduce the burden of chronic disease, increase access to health and social services for the target population, and to implement innovative funding arrangements to sustain chronic care management services. Another goal of the project is to increase the number of Community Health Workers in the service area, providing a viable and sustainable grassroots workforce that can assist health care providers meet the Triple Aim of improved patient experience, improved population health and decreased cost.

Anticipated outcomes of the project include: a sustainable network, increased capacity to provide patient-centered care, increased patient self-efficacy to manage chronic disease, improved clinical measures for patients with chronic disease, and fewer emergency department visits and hospitalizations. The Network will accomplish this through a model of shared leadership, shared governance and shared resources.

Evidence Based/ Promising Practice Model Being Used or Adapted:

This project will utilize several evidence-based/promising practices including:

1) Vertical Rural Health Network Model to provide structure for a health care system that includes the use of both traditional and non-traditional health care providers. The success of the grant goals and objectives is dependent upon the organizational and governance structure of the Network. The Integrated Vertical Rural Health Network Model has been supported and promoted by HRSA and the Federal Office of Rural Health Policy as an effective health care model that provides a coordinated continuum of care for local residents. The Integrated Vertical Rural Health Network Model has also been shown to be sustainable for local health care providers and the communities in which they serve
2) Promising practice of employing CHWs to provide these services because it is well-documented in the literature and because the Network and its members have had success in using the model before. CHWs are community members who work in community settings and who serve as connectors between patients and providers to promote health. CHWs are employed to address a wide range of health issues including women's health and nutrition, child health and prenatal care, asthma, immunizations, diabetes, cardiovascular disease, and cancer. A national study found that key functional areas for CHW activity included creating more effective linkages between the community and the health care system, providing health education and information, assisting and advocating for underserved individuals to receive appropriate services, and providing informal counseling. CHWs are of and rom the community where they will work, making them more accessible, approachable, and trusted by community members who need services.
3) The evidence-based Chronic Disease Self-Management Program.as CSDMP provides a broader spectrum of general self-efficacy strategies that can help individuals cope with their disease. These might include techniques to deal with frustration, fatigue, pain and isolation; maintain and improve strength, flexibility and endurance; use medications as prescribed; communicate effectively with family, friends and providers; ensure proper nutrition; make decisions related to health care; and evaluate new treatments. CDSMP is designed to enhance regular treatment and disease-specific education. (Stanford, 2017)

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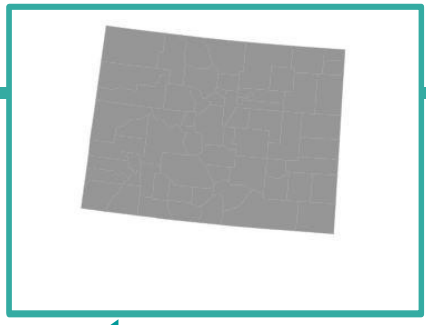

Colorado

Bright Future Foundation For Eagle County

Grant Number:	D06RH37496					
Organization Type:	Nonprofit Organization (other than a network nonprofit)					
Grantee Organization:	**Project Name:**	Expanding and Enhancing the Behavioral Health Workforce in Rural Colorado: The Colorado Psychology Intership Consortium				
	Address:	1060 W Beaver Creek Blvd., Unit 201				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$299.968
	Jul 2021 to Jun 2022	$299,968
	Jul 2022 to Jun 2023	$299,693

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Bright Future Foundation	Eagle	CO	
	Eagle Valley Behavioral Health	Eagle	CO	
	Stride Community Health Center	Denver	CO	

Counties the project serves:			
	Eagle County, CO	Arapahoe County, CO	
	Denver County, CO	Douglas County, CO	
	Adams County, CO	Jefferson County, CO	

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☒
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☒
	Latinos	☒	Uninsured	☒
	Native Americans	☐	Other: Rural	☒
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Workforce Development
	Secondary Focus Area:	Behavioral Health/Mental Health - Substance Use Disorder

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Between July2020 and June2023, expand CO-PIC's cross-agency collaborative training capacity by adding2 behavioral health training sites to the existing network.
	Objective	Recruit, review, and select 2 partner sites to join the network during Grant Year 1.
	Objective	Onboard 2 new partner sites in Grant Year 2
	Objective	The network will recruit doctoral intern trainees to be placed at new member training sites in Grant Year 3.
	Goal	Between July2020and June2023, the network's existing training curriculum will be enhanced through the addition of new annual training activities and rotations.
	Objective	Create new didactic seminar series, to include a focus on OUD/SUD, Suicide Prevention and Culturally-Competent Behavioral Healthcare. Generate and incorporate community input on additional specialized didactic training.
	Objective	Provide interns with training from national experts in OUD/SUD through attendance at a professional conference.
	Objective	Provide interns with training from national experts in Suicide Prevention through attendance at a professional conference.
	Objective	Provide interns with adjunctive training from experts in OUD/SUD through the obtainment of online simulation skills training for dual diagnosis patients (mental health & addiction).
	Goal	Between July 2020 and June 2023, create internal capacity to sustain ongoing specialized intern training opportunities in OUD/SUD and Suicide Prevention through faculty development.
	Objective	Provide faculty with training from national experts in OUD/SUD through attendance at a professional conference.
	Objective	Provide faculty with training from national experts in Suicide Prevention through attendance at a professional conference.
	Objective	Provide faculty with training from national experts in internship accreditation requirements through attendance at an online professional training.
	Objective	Provide faculty with training from experts in OUD/SUD through the obtainment of online simulation skills training for dual diagnosis patients (mental health & addiction).
	Goal	By June 2023, the rural behavioral healthcare workforce will be expanded and enhanced through the retention of at least 60% of trainees.
	Objective	Improve recruitment and retention potential by increasing salary of doctoral psychology intern trainees
	Objective	Collaborate with community partner sites to create postdoctoral positions for graduating interns.
	Objective	Track retention of interns in local healthcare workforce, including retention of diverse interns.

Project Description:

The Colorado Psychology Internship Consortium (CO-PIC) was conceived as a behavioral health workforce initiative, and the initial development of the training network was funded in 2015 by a one-year Health Resources and Services Administration (HRSA) Rural Health Network Development Planning Grant. Since that time, CO-PIC has evolved into a mature, APA-accredited doctoral psychology internship consortium which provides high quality behavioral health services to rural, vulnerable, and underserved populations in Colorado. The agencies active in the network include: Bright Future Foundation, Eagle Valley Behavioral Health, and STRIDE Community Health Center.

This project will expand and enhance the CO-PIC network through the addition of specialized training opportunities which will meet the specific unmet behavioral health needs of the target population, as well as new training sites. Through this grant mechanism, the network will enhance its current training curriculum by incorporating specialized training in suicide prevention, intervention for and prevention of Opioid Use Disorder/Substance Use Disorder (OUD/SUD), and culturally competent behavioral healthcare. This specialized training will be provided to the faculty at the network's training sites, as well as to the doctoral psychology trainees at each site. Training the faculty members will allow for the further dissemination of these skills to the trainees beyond the life of the grant. In addition to enhancement of the training curriculum, the grant will allow for the expansion of the existing network through the inclusion of two additional training sites. These sites will be selected and incorporated into the network as an activity of the grant, and will allow for furtherance of the cross-agency collaboration and behavioral health workforce development that are the key focus of the network.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The work plan includes the use of online modules in providing training for interns and faculty in Evidence Based Practices for OUD/SUD prevention and intervention. These online trainings use standardized tools and simulation training exercises and involve interns and faculty interacting with a digitized, standardized patient/or Avatar coach using role play scenarios. Each module includes learning content informed by leading subject matter experts, interactive exercises, and an immersive virtual reality conversation with a simulated patient. These modules include training in the following two EBPs:

1) Alcohol Screening and Brief Intervention Screening and Brief Intervention (SBI) is a structured set of questions designed to identify individuals at risk for alcohol use problems, followed by a brief discussion between an individual and a service provider, with referral to specialized treatment as needed. Screening asks several questions to determine whether individuals are misusing alcohol. Brief interventions are counseling sessions that last 5 to 15 minutes. Their purpose is to increase the person's awareness of his or her alcohol use and its consequences and then motivate the person to either reduce risky drinking or seek treatment. The provider works with the person on willingness and readiness to change his or her drinking behavior. SBI is designed for use by service providers who do not specialize in addiction treatment, uses motivational approaches based on how ready the person is to change behavior, and gives feedback and suggestions. It has been shown by research to be effective in reducing alcohol use and alcohol-related adverse consequences, including injury. Alcohol Screening and Brief Intervention is a manualized protocol made available by the American Public Health Association. KEY CITATION: American Public Health Association and Education Development Center, Inc. (2008). Alcohol screening and brief intervention: A guide for public health practitioners. Washington DC: National Highway Traffic Safety Administration, U.S.Department of Transportation.
2) Motivational Interviewing (MI) is an evidence-based treatment that addresses ambivalence to change. MI is a conversational approach designed to help people with the following: Discover their own interest in considering and/or making a change in their life (e.g., diet, exercise, managing symptoms of physical or mental illness, reducing and eliminating the use of alcohol, tobacco, and other drugs); Express in their own words their desire for change (i.e., "change-talk"); Examine their ambivalence about the change; Plan for and begin the process of change; Elicit and strengthen change-talk; Enhance their confidence in taking action and noticing that even small, incremental changes are important; Strengthen their commitment to change. Motivational Interviewing has a strong evidence base for its use with mental health and substance use disorders as well as other chronic conditions such as diabetes, cardiovascular conditions, and asthma. The approach upholds four principles—expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy. .KEY CITATION: William R. Miller and Stephen Rollnick (2012). Motivational Interviewing: Preparing People For Change (Third Edition). New York, NY: The Guilford Press.

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Nebraska

Community Access To Coordinated Health Care, Inc. (CATCH)

Grant Number:	D06RH37497					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	Improving Care Coordination between Primary Care Clinics and Local Health Departments in Rural Nebraska				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Elkhorn Logan Valley Health Department	Cuming	NE	Health Dept.
	Four Corners Health Department	York	NE	Health Dept.
	North Central District Health Department	Holt	NE	Health Dept.
	Public Health Solutions Health Department	Saline	NE	Health Dept.
	Southeast District Health Department	Nemaha	NE	Health Dept.
	Three Rivers District Health Department	Dodge	NE	Health Dept.
	Community Access to Coordinated Health Care, Inc..	Lancaster	NE	Nonprofit Org./CBO
	Blue Valley Community Action	Jefferson	NE	Nonprofit Org
	Brown County Hospital	Brown	NE	CAH/RHC
	Community Medical Center	Richardson	NE	CAH/RHC
	Methodist Fremont Health	Dodge	NE	Hospital
	Midtown Health Center	Madison	NE	FQHC

	Niobrara Valley Hospital	Boyd	NE	CAH
	Osmond General Hospital	Pierce	NE	CAH
	Saline Medical Specialties	Saline	NE	RHC
	York General	York	NE	CAH
	York Medical Clinic	York	NE	RHC
	Brown County Hospital	Brown	NE	CAH/RHC

Counties the project serves:	Burt County, NE	Keya Paha County, NE
	Cuming County, NE	Knox County, NE
	Madison County, NE	Pierce County, NE
	Stanton County, NE	Rock County, NE
	Butler County, NE	Fillmore County, NE
	Polk County, NE	Gage County, NE
	Seward County, NE	Jefferson County, NE
	York County, NE	Saline County, NE
	Antelope County, NE	Thayer County, NE
	Boyd County, NE	Johnson County, NE
	Brown County, NE	Nemaha County, NE
	Cherry County, NE	Otoe County, NE
	Holt County, NE	Pawnee County, NE
	Richardson County, NE	Dodge County, NE
	Saunders County, NE	Washington County, NE

	Population	Yes	Population	Yes
Target population served:	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☒
	African Americans	☒	Pacific Islanders	☒
	Caucasians	☒	Pregnant Women	☒
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☒
	Infants and toddlers (up to 3 years)	☒	School-age children (Middle/high school ~13-17 years)	☒
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Care Coordination
	Secondary Focus Area:	Chronic Disease

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Expand the CATCH Network capacity to provide more advanced technical assistance, (TA) assure efficiency in network care coordination initiatives, and monitor progress based on PIMS and other selected performance measures.
	Objective	By August 1,2020 expand network capacity and establish a meeting schedule.
	Objective	By November 1, 2020 provide more advanced technical assistance to network members.
	Objective	By July 1 2023 Expand number of clinics involved in Network Care Coordination Initiatives.
	Objective	By Nov 1,2020 identify performance measures to monitor grant progress.
	Goal	Identify high-risk chronic care patient populations with heart failure, hypertension, diabetes, COPD, and depression; the co-morbid combinations of these needs; and the associated behavioral and social risk factors.

	Objective	By October 1, 2020 select tools that will be used to identify the patient's clinical, life-style behaviors, and social needs and to determine care coordination risk level.
	Objective	By March 31, 2021 develop comprehensive care plans, including referrals to community-based interventions for each enrolled high-risk patient across the network.
	Goal	Implement evidence-based interventions and care coordination activities that will improve individual and population health outcomes, reduce health disparities, and decrease costs.
	Objective	By April 30, 2021 implement high quality comprehensive care treatment plans to meet the needs of high risk patients.
	Objective	By April 30, 2020 implement evidence based community intervention programs such as NDPP and FSP to meet the needs of high-risk patients.
	Objective	By June 30,2021 review workflow processes, referral protocols, and data-sharing procedures to determine the changes that are needed to improve efficiencies and patient outcomes.
	Goal	Monitor progress by evaluating the changes in health outcomes and the overall impact on the community.
	Objective	By October 31, 2020 identify the PIMS and other indicators that will be used to evaluate key processes(e.g., referrals), outcomes of ICCN & evidence-based programs (e.g. self-care management, behavior change effects) and population health outcomes (e.g. utilization).
	Objective	Prepare and disseminate the initial evaluation report that includes changes in health outcomes, the impact on the community, the estimated cost-savings and recommendations for improvement.
	Goal	Develop a sustainability model that will assure the continuation of the project beyond the grant period.
	Objective	By June 30, 2022 identify potential funding sources to support the continuation of the project.
	Objective	By January 2023develop and implement strategies to assure sustainability (Medicare's Chronic Care Management Program, Comprehensive Primary Care Plus, Medicare Shared Savings Program, and Medicaid pilot projects).

Project Description:

The overarching goal of this project is to improve care coordination between primary care clinics and local health departments to meet the clinical (physical and behavioral), unhealthy lifestyle behaviors, and social needs of high-risk chronic care patients with heart failure, hypertension, diabetes, COPD, and depression.

The target population is spread across 30 rural counties in Nebraska that are served by 55 primary care clinics and six local health departments. The population of the service area is 26,072 but the primary focus is on individuals with heart failure, hypertension, diabetes, COPD, and depression. The Community Action to Coordinated Healthcare, Inc. (CATCH), has 16 members, representing 8 independent primary care clinics/clinics owned by critical access hospitals, 1 Federally Qualified Health Care Clinic, 6 local health departments (LHDs), and 1 community action agency. The CATCH Network was formed in 1994 and been awarded grants for care coordination projects from Nebraska Every Woman Matters Program, Komen and others.

The major care coordination activities will be based on using a comprehensive screening tool to identify the clinical, lifestyle risk factors, and social needs of high-risk patients with the diseases listed above. Once these patients have been identified a clinical treatment plan and a preventive health promotion plan will be developed. The role of the clinic is to provide clinical treatment and work with behavioral health professionals to address behavioral health needs. They will also collaborate with LHDs to enroll patients in health promotion programs such as the National Diabetes Prevention Program, the Chronic Care Self-Management Program, and the Freedom from Smoking Program. LHDs will also be responsible for contacting patients about their social needs and working with other community-based organizations such as the Food Bank to address these needs (e.g., food insecurity and inadequate

housing).There are several expected outcomes, including (1) expanded access to health services, particularly to prevention and other programs that address social and behavioral health needs, (2) lower health care costs by reducing unnecessary hospital admissions and emergency department visits, and (3) improved individual and community/population health outcomes.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Although the number of evidence-based programs and practices may be expanded during the course of the project, each local health department will be involved in overseeing the implementation of the following programs:

1) National Diabetes Prevention Program (NDPP) is an evidence-based lifestyle change program established by the CDC which has been demonstrated to delay or prevent the development of type 2 diabetes among people at high risk. A May 2001 study published in the New England Journal of Medicine found that type 2 diabetes can be prevented by changing the lifestyles of high risk patients. The CDC facilitates the Diabetes Prevention Recognition Program (DPRP) and provides quality assurance measures by which organizations demonstrate the ability to effectively deliver the lifestyle change program. Recognition is earned by meeting certain standards and operating procedures. This information can be found at www.cdc.gov/ diabetes/prevention/recognition. The purpose of the DPRP is to recognize organizations that demonstrate the ability to deliver an effective type 2 diabetes prevention lifestyle intervention. It also helps to assure that decisions regarding individual participation, patient referral, and health insurance benefits are based on accurate, reliable, and trustworthy information.
2) Freedom from Smoking® Program (FSP) evidence is highly effective at helping people to quit smoking. Developed by the American Lung Association, FSP is considered one of the most effective smoking cessation programs in the country. The program is based on proven addiction and behavior change models and uses a comprehensive variety of pharmacological and psychological-based principles and techniques to help smokers gain control over their behavior.
3) In Nebraska, the CDSMP (https://www.selfmanagementresource.com/) is usually referred to as the Living Well Program. This program is designed to help people with chronic conditions (e.g., heart disease, hypertension, diabetes, and depression) learn how to manage their health. According to the Rural Health Information Hub, it is a six-week workshop which was originally developed at Stanford University over 20 years ago. Each week, a 2.5-hour session is led by two trained peer facilitators, one of whom has a chronic condition. It covers skill-building related to problem-solving, dealing with difficult emotions, and communicating effectively with family, friends, and health professionals. The sessions also include health strategies related to healthy eating, safe exercise, and using medications appropriately.

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Washington

Critical Access Hospital Network

Grant Number:	D06RH37499					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	NWRHN Telehealth Collaborative				
	Address:	714 W Pine St.				
	City:	Newport	**State:**	Washington	**Zip code:**	99156
	Tel #:	509-998-8290				
	Website:	www.nwrhn.org				
Primary Contact:	**Name:**	Jac Davies				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$286,372
	Jul 2021 to Jun 2022	$290,275
	Jul 2022 to Jun 2023	$296,241

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Columbia Basin Hospital	Grant	WA	Critical Access Hospital
	Coulee Medical Center	Grant	WA	Critical Access Hospital
	Columbia County Health System	Columbia	WA	Critical Access Hospital
	East Adams Rural Health	Adams	WA	Critical Access Hospital
	Ferry County Hospital	Ferry	WA	Critical Access Hospital
	Garfield County PHD	Garfield	WA	Health Dept.
	Lincoln County PHD	Lincoln	WA	Health Dept.
	Newport Hospital and Health Services	Pend Oreille	WA	Critical Access Hospital
	Odessa Memorial Healthcare	Lincoln	WA	Critical Access Hospital
	Othello Community Hospital	Adams	WA	Critical Access Hospital
	Pullman Regional Hospital	Whitman	WA	Critical Access Hospital
	Samaritan Healthcare	Grant	WA	Critical Access Hospital
	Tri-State Memorial Hospital	Asotin	WA	Critical Access Hospital
	Whitman Hospital and Medical Center	Whitman	WA	Critical Access Hospital

Counties the project serves:		
	Adams County, WA	
	Asotin County, WA	
	Columbia County, WA	

	Ferry County, WA	
	Garfield County, WA	
	Grant County, WA	
	Lincoln County, WA	
	Pend Oreille County, WA	
	Whitman County, WA	

Target population served:	Population	Yes	Population	Yes
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:		
	Primary Focus Area:	Telehealth
	Secondary Focus Area:	Workforce Development

Project goals & objectives:	Goal/ Objective	Description
	Goal	Increase sustainability of rural health systems through sharing of health care resources and services.
	Objective	Establish framework for telehealth-based sharing of resources and training.
	Objective	Increase number of rural health systems using telehealth for health care services.
	Objective	Promote new services within rural communities and to providers considering relocating to those communities.
	Goal	Improve access to health care services for rural residents.
	Objective	Increase the number of rural patients with diagnosed heart or kidney disease or with serious infections diseases that are receiving care from specialists.
	Objective	Decrease the number of readmissions for rural patients admitted to hospital care for heart or kidney disease.
	Goal	Increase opportunities for rural family medicine residents to train in diverse rural communities.
	Objective	Develop telehealth-based program for family medicine residents to connect with rural clinics
	Objective	Increase the number of rural practice sites for family medicine residents
	Objective	Increase the availability of family medicine providers for rural communities

Project Description:

The Northwest Rural Health Network (NWRHN) is developing a Telehealth Collaborative to promote the sharing of specialists and the availability of training between rural health systems through a standardized telehealth framework that will leverage existing resources and simplify the process of finding and implementing new services. The Telehealth Collaborative will initially focus on three high need specialties –cardiology, nephrology and infectious disease. NWRHN members with staff who practice in those specialties will offer services via telehealth to other Network members. In addition, the Telehealth Collaborative will partner with a new Rural Family Medicine residency program to develop methods for increased residency training opportunities in smaller rural facilities and help residents gain experience in using telehealth systems. The NWRHN is a horizontal network of 14 independent rural health systems located in nine eastern Washington State counties with a total population served of over 255,000 across 15,000 square miles. For the Telehealth Collaborative, the focus is on patients with heart and kidney disease or those with

infectious diseases that need specialty care. In addition to improving access to care and health outcomes for these individuals, the NWRHN Telehealth Collaborative will help strengthen participating systems by keeping resources and funding local and also will improve recruitment and retention at rural systems by enabling a provider to live and work in a rural community while serving patients around the region.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The Rural Health Information Hub cites many examples of telehealth programs being used to increase access to specialty services for rural communities. The overall model has been well proven as an effective strategy. However, in most examples the telehealth services are provided by a large academic medical center or commercial vendor. The NWRHN Telehealth Collaborative seeks not only to increase access to services but also to leverage a telehealth framework to promote sustainability of rural health systems. The focus is services that are developed by and for rural health systems, enabling rural health systems to retain funding that would otherwise be sent outside the region. There is one example that demonstrates what the Collaborative hopes to accomplish. The Hospital Cooperative in southeast Idaho has built a network that enables rural health systems to provide telehealth-based services to each other (https://www.hospitalcooperative.org/telehealth/). Their program was started with seed funding from the Office for the Advancement of Telehealth in 2007. They used their initial grant funding for project staff to gather information, develop policies and procedures, and get the program started. Once established, they have found that the individual hospitals are able to proceed on their own using those initial tools and without the need for centralized support staff. As new needs arise, hospitals consult with their network peers to see if anyone else can provide the service, and then work together on implementation.

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	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Mississippi

Delta Health Alliance, Inc.

Grant Number:	D06RH37500					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	The Delta Diabetic BLUES (Better Living Utilizing Engagement Strategies)				
	Address:	435 Stoneville Rd.				
	City:	Leland	**State:**	Mississippi	**Zip code:**	38756
	Tel #:	662-686-7004				
	Website:	http://lelandmedicalclinic.org				
Primary Contact:	**Name:**	Lesa Wise				
	Title:	Project Director				
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	Email:	lwise@deltahealthalliance.org				
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	Title:	Associate VP of Health Programs				
	Tel #:	662-686-7004				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$299,857
	Jul 2021 to Jun 2022	$299,877
	Jul 2022 to Jun 2023	$299,934

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Leland Medical Clinic	Washington	MS	Rural Health Center
	Leflore County Health Center	Leflore	MS	Community Health Clinic
	Endocrine Clinic	Shelby	TN	Specialty Provider
	Social Service Collaborative	Washington	MS	Consortium
	Delta EATS	Washington	MS	Consortium
	Mississippi Dept. of Health	Hinds	MS	State Agency
	Mississippi Telehealth Assn.	Madison	MS	Nonprofit Org./CBO

Counties the project serves:	
	Coahoma County, MS
	Leflore County, MS
	Quitman County, MS
	Tallahatchie County, MS
	Washington County, MS

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children	☐

			(Middle/high school ~13-17 years)	
	Latinos	☒	Uninsured	☒
	Native Americans	☐	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Chronic Disease
	Secondary Focus Area:	Telehealth

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	To improve quality and delivery of health care services as they relate to treatment of diabetes and related health services for this rural population.
	Objective	A minimum of 90 rural patients every 12 months with a diagnosis of diabetes or pre-diabetes will receive care in their community from community-based providers, which is both accessible and cognizant of local and community needs, aiding to reduce disparities.
	Objective	After 12 months of continuous program care, 80% of participants will meet or exceed one or more of their individualized "ABC" diabetes goals, including A1C (<6.5 for most), Blood pressure (<130/80 mm Hg), and total Cholesterol levels (100-199 mg/dL).
	Objective	Eighty percent of rural patients receiving diabetes treatment services will demonstrate statistically significant improvements after 12 months of care in measures of patient self-efficacy, activation and involvement in the design and implementation of their care plans.
	Goal	To facilitate and strengthen community-based resources to treat diabetes and related illnesses within our rural communities.
	Objective	Every 24 months, 12 or more providers from local clinics will receive specialized treatment knowledge and information [Continuing Medical Education (CME) and Nursing Continuing Education Units (CEUs)] from a center of excellence in endocrinology, with 70% demonstrating statistically significant improvements in pre-/post- scores on knowledge of evidence-based models of diabetes care and self-efficacy.
	Objective	All participating rural clinics will improve provider capability to effectively manage complex diabetes cases.
	Objective	Seventy-five percent of enrolled patients will utilize one or more support services within the community referred to by this network, including transportation, physical and mental health care, and dietary assistance, supporting ease of access and quality of life.
	Goal	To improve care coordination and co-management of ECHO diabetes patients between rural providers and specialists in the region.
	Objective	Clinicians with diabetic patients will experience a statistically significant increase over time in receipts of specialist reports, improved frequency of medication reconciliation, increased use of advanced care plans, and transmission of Summary of Care Records between providers.
	Objective	A minimum of 24 sessions each year will be conducted by our consulting endocrine specialists and rural providers to complete clinical evaluation and screening to determine and promote patient readiness, with periodic review of cases that are not treatment-ready to ensure appropriate linkage to other services.
	Goal	Collect data, analyze measures, and evaluate outcomes of the project. Disseminate results and develop a long-term sustainability plan for ongoing operations.
	Objective	Establish data collection systems at participating clinics for pre-/post- evaluation within six (6) months of implementation.

	Objective	Collect and analyze data every month to drive Continuous Quality Improvement activities on improving diabetes outcomes in rural communities.
	Objective	Analyze outcomes and develop annual evaluation reports every 12 months. Disseminate to local, regional, state and national audiences.
	Objective	Utilizing program results, seek permanent funding opportunities to sustain diabetes programs, support services, and clinician education.

Project Description:

The purpose of the Delta Diabetic BLUES Network initiative is to reduce the morbidity and mortality of diabetes in rural, low-income, minority communities of the Mississippi Delta. This new collaborative was specifically formed to serve low-income residents of the wholly rural counties of Coahoma, Leflore, Quitman, Tallahatchie and Washington in the heart of the Mississippi Delta. The total population of the targeted area is 124,500, 70.3% are Black/African American, only 77.2% of adults have a high school degree, 35.4% of adults live below the federal poverty level, 41.7% of adults are obese, 15.3% of adults have been diagnosed with diabetes and our mortality from diabetes is more than double the national average (54.4 deaths per 100,000 compared to U.S. average of 24.2 deaths per 100,000).

The network includes the Leland Medical Clinic - a certified Rural Health Center in Leland, MS operated by Delta Health Alliance, the Leflore County Health Center – a Community Health Clinic in Greenwood, MS, and the Endocrine Clinic of Memphis, TN. Other partners include the Social Service Collaborative, the Delta EATS neighborhood garden program, the Mississippi Department of Health and Mississippi Telehealth Association. Our Network's purpose is to bring new access to endocrinologists to impoverished, medically underserved communities struggling with high rates of diabetes and poor health outcomes.

The network's purpose is to reduce the morbidity and mortality of diabetes in rural, low-income, minority communities. To accomplish this goal, the network will utilize telehealth consultations, education and mentoring between endocrinology specialists and community-based clinicians at two rural health clinics in the heart of the Delta, enabling an existing Mobile Medical Clinic, which can be deployed to serve rural businesses, clinics, schools and community centers. Activities will include implementation of the evidence-based ECHO chronic disease model, screening and patient education, development of customized goals for each diabetic resident with action plans to achieve those goals, community involvement through focus groups and a Patient Advisory Board, assistance enrolling in social support services including transportation access and increase coordination between city governments and other community-based resources.

Clinical data gathered and analyzed through an electronic health record will be used to evaluate adherence to treatment plans, pre-/post- improvements in health education, access to and outcomes from endocrinology visits, HbA1c testing and changes to levels over time, changes to BMI, HbA1C and lipid levels.

Evidence Based/ Promising Practice Model Being Used or Adapted:

A program planning committee, which includes representatives of a Patient Advisory Council, participating clinicians, and health science researchers selected the evidence-based ECHO Model as the approach to meet program needs for improved efficiencies, access and systems of diabetes care in the rural communities. The ECHO Model connects groups of rural community providers with specialists at centers of excellence in regular real-time collaborative sessions. Through this connectivity, the team works together to manage chronic conditions of rural patients while expanding remote providers' knowledge base through shared case studies. This model has been demonstrated as an effective approach to improving diabetes outcomes in Kentucky, New Mexico, Arizona and the U.S. Associated Pacific Islands.

It will be adapted by adopting this structure of referrals and connectivity while also incorporating in-person meetings from a specialist within clinics and the provision of diabetes education within the community. The principles of the ECHO Model use technology to leverage scarce resources; share best practices to reduce disparities; apply case-based learning to strengthen the competencies of rural clinicians while mastering the complexity of diabetes care; and evaluate and monitor outcomes and processes for continuous quality improvement of our healthcare protocols and systems. Using videoconferencing, primary care providers (PCPs) receive direct support from specialists as well as increased knowledge though shared case-based learning and monitoring, and clinics receive assistance with the development and monitoring of patient treatment plans. Patients are also enabled to ask questions, make suggestions, discuss solutions, and build a community of practice. Clinicians – including community

health workers – gain improved capacity for serving patients who otherwise would be without specialized care or would receive care removed from their community and receive live support through telementoring. In turn, rural communities are provided with better access to care, the opportunity for local providers to expand their medical expertise and knowledge base, reduction in transportation requirements and associated costs, and increased convenience of local treatment for patients with chronic conditions. To augment the ECHO Model to fit into the community, the project will also incorporate monthly in-person visits by an endocrinology specialist to measure progress and to shore up resources. Furthermore, he will be available on a case-by-case basis to interact directly with patients and providers in the clinical setting when necessary.					
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Georgia

Dublin City Schools

Grant Number:	D06RH37501					
Organization Type:	School Board					
Grantee Organization:	**Project Name:**	Dublin City School Health Network				
	Address:	207 Shamrock Dr.				
	City:	Dublin	**State:**	Georgia	**Zip code:**	31021
	Tel #:	478-353-8000				
	Website:	http://www.dublincityschools.us/				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Dublin City Board of Education*	Laurens	GA	School Board
	South Central Health District*	Laurens	GA	Health Dept.
	Community Service Board of Middle GA*	Laurens	GA	Nonprofit Org./CBO
	Fairview Park Hospital*	Laurens	GA	Hospital
	Laurens County Family Connection*	Laurens	GA	Consortium

Counties the project serves:	Laurens County, GA	

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☐	Pre-school children (3-4 years)	☒
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☐	School-age children (elementary ~ 5-12 years)	☒
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☒
	Latinos	☒	Uninsured	☒
	Native Americans	☐	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	School-based Health
	Secondary Focus Area:	Behavioral Health/Mental Health - General

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	To develop and maintain the collaborative relationships among the Dublin City School Health Network members that will integrate systems of care (administratively, clinically and financially) in order to (a) achieve efficiencies; (ii) expand access to, coordinate and improve the quality of essential health care services; and (iii) strengthen the local rural health care system as a whole.
	Objective	Provide school nursing services in each of the schools in the school system.
	Objective	Provide on-site mental/behavioral health services in each of the schools in our system.
	Objective	Create and implement standardized clinical protocols that will assist in the improvement of the delivery of health services.
	Objective	Provide ongoing training opportunities for parents/ guardians, school nurses, counselors, other school system staff members and community collaborative members regarding relevant physical and mental/ behavioral health issues.
	Objective	Develop and implement an effective sustainability plan for sustaining network related services.

Project Description:

The network seeks to develop and maintain the collaborative relationships among the Dublin City School Network members that will integrate systems of care (administratively, clinically and financially) in order to (i) achieve efficiencies; (ii) expand access to, coordinate and improve the quality of health services; and (iii) strengthen the local rural health care system as a whole.

The five official objectives of the network's project includes:

1) Provide school nursing services in each of the schools in the school system.
2) Provide on-site mental/behavioral health services in each of the schools in the school system.
3) Create and implement standardized protocols that will assist in the improvement of the delivery of mental/behavioral health services.
4) Provide ongoing training opportunities for parents/guardians, school nurses, counselors, other school system staff members and community collaborative members regarding relevant physical and mental/behavioral health issues
5) Develop and implement an effective sustainability plan for sustaining network related services post grant.

Project activities will include: providing school nursing services; providing a depression screening assessment for all students enrolled in the school system; providing mental/ behavioral health services; providing support group services (regarding mental/behavioral health issues); developing and implementing standardized clinical protocols; developing and implementing an ongoing quality improvement process; providing ongoing training opportunities for parents/guardians, school nurses, counselors, other school system staff members and community collaborative members regarding relevant physical and mental/behavioral health issues.; and developing a sustainability plan for the network and this program.

Evidence Based/ Promising Practice Model Being Used or Adapted:

[Minority racial/ethnic pediatric populations and those living in poverty are at greater risk of exposure to trauma, development of mental health disorders and school failure yet are less likely to have access to mental health services. Schools staffed with mental health providers is one strategy for decreasing health care disparities.

The provision of school-based mental health services has been found to be beneficial for students, especially at-risk students. One research study published in the Journal of the American Academy of Child and Adolescent Psychiatry, used random-effects meta-analytic procedures to synthesize effects of school-based mental health services for elementary school-age children. Forty-three controlled trials evaluating 49,941 elementary school-age children met the selection criteria. The study found that, overall, school-based services demonstrated small-to-medium effect in decreasing mental health problems, with the largest effects found for targeted intervention, followed by selective prevention, compared with universal prevention. Mental health services integrated into students' academic instruction, those targeting externalizing problems, those incorporating contingency management and those implemented multiple times per week showed particularly strong effects. The study concluded by stating that considering the

serious barriers precluding youth from accessing necessary mental health care, the present meta-analysis suggests child psychiatrists and other mental health professionals are wise to recognize the important role that school personnel, who are naturally in the children's lives, can play in decreasing child mental health problems. Another study examined the impact of school-based health services on academic indicators. The analysis used a latent variable growth curve modeling approach to examine longitudinal outcomes over five school semesters for at-risk ninth grade school-based health services users and nonusers from Fall 2005 to Fall 2007. It involved a total of 2,306 students. Propensity score analysis was used to control for self-selection factors in the user and non user groups. Results indicated a significant increase in attendance for students who used school-based health services compared to nonusers. Grade point average increases over time were observed for school-based mental health users compared to nonusers.						
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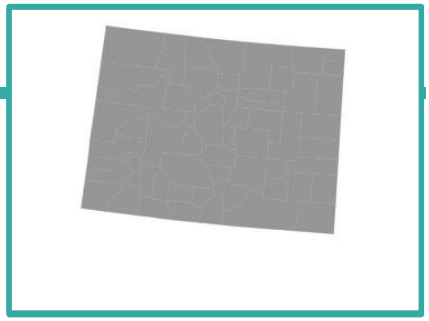
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303



Colorado

Eastern Plains Healthcare Consortium

Grant Number:	D06RH37494					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	Building Shared Primary Care Workforce Recruitment and Retention Capacity in Colorado's Eastern Plains				
	Address:	111 6th Street				
	City:	Hugo	**State:**	Colorado	**Zip code:**	80821
	Tel #:	303-506-4428				
	Website:	www.easternplainshealth.org				
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	Title:	Network Director				
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	Email:	carmen@coloradonursingcenter.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$298,415
	Jul 2021 to Jun 2022	$298,817
	Jul 2022 to Jun 2023	$297,732

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Melissa Memorial Hospital	Philips	CO	Critical Access Hospital
	Lincoln County Hospital	Lincoln	CO	Critical Access Hospital
	Yuma District Hospital	Yuma	CO	Critical Access Hospital
	Kiowa County Hospital District	Kiowa	CO	Critical Access Hospital

Counties the project serves:	
	Philips County, CO
	Washington County, CO
	Lincoln County, CO
	Kit Carson County, CO
	Kiowa County, CO
	Cheyenne County, CO
	Yuma County, CO

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☐	Pre-school children (3-4 years)	☐
	African Americans	☐	Pacific Islanders	☐
	Caucasians	☐	Pregnant Women	☐

	Elderly (65+)	☐	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☐	Uninsured	☐
	Native Americans	☐	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Workforce Development

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Implement a "Grow Your Own" (GYO) Eastern Colorado Rural Healthcare Professional (APRN, RN, BH) Recruitment and Pipeline Development Program.
	Objective	Develop multiple Academic-Practice Partnerships (APPs).
	Objective	Recruit 12 full-time GYO Fellows.
	Objective	Provide $60,000 to 12 GYO Fellows over three years.
	Objective	Provide non-financial support for GYO Fellows
	Objective	Implement Rapid Cycle Quality Improvement (RCQI) Continuous Improvement.
	Goal	Implement Leadership Skills for a Culture of Retention (LSCR) Training Program.
	Objective	Implement Leadership Skills for a Culture of Retention (LSCR) Training Program.
	Objective	Implement Rapid Cycle Quality Improvement (RCQI) Continuous Improvement.
	Goal	Implement a Shared Staffing Program (SSP) for clinical staff across all network members.
	Objective	Develop and trial run Shared Staffing Program (SSP) protocols and systems, identify initial SSP staff volumes.
	Objective	Implement SSP program across all members
	Objective	Reduce dependence on recruitment agencies.
	Objective	Implement Rapid Cycle Quality Improvement (RCQI) Continuous Improvement.
	Goal	Implement a program of interprofessional team development to support the Shared Staffing Program, increase clinical staff productivity/resiliency and reduce turnover/burnout.
	Objective	Customize team training program to network member needs and recruit participants
	Objective	Implement R&R Focused Team Skills training program.
	Objective	Provide 1:1 and group coaching.
	Objective	Implement Rapid Cycle Quality Improvement (RCQI) Continuous Improvement.
	Goal	Implement a Customized Set of CAH Employee Engagement and Organizational Assessment Workforce Survey Tools
	Objective	Customize a suite of workforce engagement survey tools for CAH R&R needs
		Implement new R&R focused employee survey tools
	Objective	Implement Rapid Cycle Quality Improvement (RCQI) Continuous Improvement.
	Goal	Develop and Implement a RHND Program Sustainability Plan for Post-Federal Funding.
	Objective	Develop and Implement a RHND Sustainability Plan.

Project Description:

This Rural Health Network Development (RHND) Project, Building Shared Primary Care Workforce Recruitment and Retention Capacity in Colorado's Eastern Plains, will build a regional network composed of four Critical Access Hospitals (CAHs) serving seven counties in rural eastern Colorado. This Project will implement five innovative, shared-service responses to the region's difficult primary care workforce recruitment and retention (R&R) issues. Given growth, retirements and continuing turnover, network members face annual hiring and turnover rates of 25% to 100%. This project will create previously unavailable economies of scale

to both achieve efficiencies as well as strengthen the eastern Colorado healthcare system as a whole. The result will be reduced staff turnover, increased healthcare system capacity and team performance, improved continuity of care, and reduced R&R-related workforce expenses. This RHND Project will implement five separate but integrated R&R program initiatives: (a) "Grow Your Own" Healthcare Workforce Recruitment Pipeline Program; (b) Leadership Skills to Develop and Support a "Culture of Retention"; (c) Increase Provider Retention and Reducing Burnout Through Interprofessional Teams; (d) Implement a Shared Primary Care Workforce Staffing Program; and (e) Significantly increase the capacity of network members to develop actionable and insightful clinical and non-clinical workforce data.

Evidence Based/ Promising Practice Model Being Used or Adapted:

[This RHND network project will draw on several promising and evidence-based practices in the development and implementation of the five R&R focused initiatives. A number of the underlying program concepts draw on insights and research of the National Academy of Medicine 2019 Report: Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being.

The interprofessional collaborative practice (IPCP) and leadership training programs draws on six years of HRSA-supported IPCP training programs implemented across Colorado by the Colorado Center for Nursing Excellence, working with multiple healthcare and education partners. Support for these IPCP training activities came from two HRSA grants awarded since 2013. The most recent was HRSA Primary Care Training Enhancement (PCTE) funding (Grant #T0BHP29991, 2016-2021, "Building Skills for Effective Interprofessional Teams: A Statewide Collaboration"). Before that, IPCP funding was received from the HRSA NEPQR IPCP support (Grant #UD7HP26042, 2013-2016, "Increasing the Effectiveness of Community Health Center IPCP Teams").

The implementation of the Spherit workforce assessment tools will build on the experience gained through the HRSA-funded NEPQR program (Grant # UK1HP31720, "Achieving Systemic Impact: A Statewide Primary Care Nursing Collaborative) and the HRSA-funded NEPQR program (Grant # D11HP08388, 2011-2014, "Nurse Leadership Development for Long Term Care")

The "Grow Your Own" rural healthcare workforce recruitment and pipeline development project draws on experience with GYO programs that has been developed since 2013 by the Colorado Center for Nursing Excellence. In addition to funding provide by private Colorado foundations, this experience draws on the HRSA ANEW funding (Grant #T94HP31872, 2018-2020, "A Statewide Three-APRN School Academic-Practice ANEW Collaborative"). The Center is currently working with multiple funding sources to support over 140 APRN GYO Fellows across Colorado.

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Wisconsin

Fort HealthCare, Inc.

Grant Number:	D06RH37502					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	Rock River Health Care Network				
	Address:	611 Sherman Ave. E				
	City:	Fort Atkinson	**State:**	Wisconsin	**Zip code:**	53538
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Fort Healthcare	Jefferson	WI	Healthcare System
	Greater Watertown Community Health Foundation	Jefferson	WI	Nonprofit Org./CBO
	Rock River Free Clinic	Jefferson	WI	Nonprofit Org./CBO
	Watertown Regional Medical Center	Dodge	WI	Hospital
	Rainbow Hospice Care	Jefferson	WI	Hospice
	Community Dental Clinic	Jefferson	WI	Dental Clinic
	Watertown Area Cares Clinic	Dodge	WI	
	Jefferson County Health Department	Jefferson	WI	Public Health Dept.
	Watertown Department of Public Health	Dodge	WI	Public Health Dept.

Counties the project serves:		
	Jefferson County, WI	
	Dodge County, WI	
	Walworth County, WI	

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐

	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☐	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Alternative Payment Models
	Secondary Focus Area:	Chronic Disease

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Improve quality, coordination, & cost of health care services at Federally Qualified Health Center (FQHC) Look-Alike & among Network member health care provider entities
	Objective	By June 30, 2021, the Network will launch a FQHC Look-Alike , implement at least 5 integrated priority services, increase number of community, chronic disease, & behavioral health referrals & improve proportions of referral engagements
	Objective	In Years 2 and 3, will have growth from baseline established in Year 1. A refresh of outcome measures to obtain revised baseline will be completed at time of FQHC launch in Year 1. Reduced ED utilization & volume charges expected in Year 2.
	Goal	Increase community member access to health care & services
	Objective	By June 30 , 202 1, the Network will increase the number of attributed persons (denominator) in the FQHC HealtheRegistries.
	Objective	Year 2 & 3 objectives are expected to show an increase from baseline & have growth in both years.
	Goal	Improve health outcomes for the target population, through strengthened & expanded services under a newly established FQHC
	Objective	By June 30, 2021, the Network will improve all project-specific clinical measures in the FQHC HealtheRegistries from baseline
	Objective	Year 2 & 3 objectives will have growth from baseline established in Year 1. There will be goal setting for the FQHC in Years 2 and 3

Project Description:

Rock River Health Care Network's project activities/services align with three primary goals/objectives: 1) Improve the quality, coordination, and cost of health care services at the FQHC and within Network member health care provider entities; 2) Increase community member access to health care and services; and 3) Improve health outcomes for the target population, through strengthened and expanded services under a newly established FQHC Look-Alike.Year 1 activities are: hiring Project Director (Interim in place) and Behavioral Health Provider; refining Network goals and governance regarding FQHC; adapting and installing electronic health record and data management systems for Network coordination and HRSA reporting; establishing FQHC; planning for FQHC services; coordinating referral systems and processes across Network; training staff and educating patients; and initiating strategic community outreach to increase access to care. Once FQHC is secured in Year 1, the Network will add a340BDrug Pricing Program. Years 2 and 3 are implementation-focused with dissemination of results, incorporating a systems approach for sustainability of evidence-based practice. Year 3 will explore replicability and expansion to other areas (e.g., trauma-informed care, telehealth). Project activities will incorporate evidence-based, promising practice and support three legislative aims.

Expected outcomes of the project include achievements that align with project goals/objectives and HRSA, Healthy People 2020, and National Quality Forum priorities: 1) Improve the quality, coordination, and cost of health care services–e.g., improved Health Information Technology, strengthened Network communications and work group coordination, etc.;2) Increase community member access to health care and services–e.g., increased number of persons seen at the new FQHC; increased referrals and engagement to Network/community resources, etc.; and 3) Improve health outcomes for the target population–e.g., increased self-management;

improved clinical markers of disease management, etc. The Network expects improvements in project-specific process and outcome measures and HRSA-required measures.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Evidence-based Practices and Models will Promote Successful Program Implementation, including Value-based Care and Population Health Management. The project will draw from a continuous QI culture, including FHC's foundation of evidence-based QI practice infused within primary care and application of the Chronic Care Model as a QI model for improving high-quality chronic disease management at both individual and systems levels. It also will incorporate the Associates in Process Improvement's (API) Model for Improvement by using Plan-Do-Study-Act (PDSA) cycles to test select ideas and changes, particularly with new builds to HIT platforms across the Network and the piloting of services and other interventions. The proposed health care services, largely delivered by the FQHC once it is established, will incorporate evidence-based practice.

A few effective approaches that will contribute to the project include SBIRT and SPARC, Inc.®, for example. To achieve expected outcomes, the Network will build upon a provision of patient-centered care, use of multidisciplinary teams, collaboration, and community partnerships ;health equity lens; and its growing population health management and data analytics capabilities in improving the quality of care and health outcomes for the target population.

The delivery of cost-effective, coordinated healthcare services will align with a value-based care (VBC) approach and population health management. FHC and WRMC have value-based contracts with payers that require reporting on quality measures, and they publicly report data to Wisconsin Collaborative for Healthcare Quality (WCHQ) on focused measures for patients. Examples that will also be project-specific measures are breast, cervical, and colorectal cancer screenings; influenza immunization; and blood pressure control (less than 140/90). VBC principles help inform and guide the other Network member health care provider entities that do not currently have the capacity and resources to be at the forefront in this area. As the FQHC established under this project signs contracts with payers, the Network expects these contracts to contain similar VBC principles to those that FHC and WRMC contain. Moreover, effective 2019, FHC became a member of Caravan Health Accountable Care Organization (ACO) 17 LLC, known as Central Oregon ACO,which has many shared QI goals. Central Oregon ACO(FHC), for example, bridges population health initiatives into its VBC approach to care. .Many project elements align with this ACO's quality principles. For instance, the ACO 1) prioritizes completing annual wellness visits and closing gaps to lower health expenses on Medicare patients having complex chronic disease and 2) encourages staff engagement in progressive QI work using PDSA.

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North Carolina

Heritage Hospital, Inc.

Grant Number:	D06RH37503					
Organization Type:	Hospital					
Grantee Organization:	**Project Name:**	Edgecombe Early Sepsis Intervention Program (EESIP)				
	Address:	111 Hospital Dr.				
	City:	Tarboro	**State:**	North Carolina	**Zip code:**	27886
	Tel #:	252-641-8293				
	Website:	https://www.vidanthealth.com/Locations/Hospitals/Vidant-Edgecombe-Hospital				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$249,125
	Jul 2021 to Jun 2022	$299,776
	Jul 2022 to Jun 2023	$297,567

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Vidant Edgecombe Hospital	Edgecombe	NC	Hospital
	Edgecombe County Health Dept.	Edgecombe	NC	Health Dept.
	Carolina Family Health Center, Inc.	Edgecombe	NC	FQHC
	Access East, Inc	Pitt	NC	FQHC
	Area L AHEC	Pitt	NC	AHEC
	Eastpoint Human Services	Edgecombe	NC	Nonprofit Org./CBO
	Rural Health Group	Halifax	NC	FQHC
	Opportunities Industrialization Center	Nash	NC	Nonprofit Org./CBO
	Edgecombe County Rescue Squad	Edgecombe	NC	EMS

Counties the project serves:	
	Edgecombe County, NC
	Halifax County, NC

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐

	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Care Coordination
	Secondary Focus Area:	Behavioral Health/Mental Health - General

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Decrease the sepsis mortality rate in ECRHN's service area.
	Objective	Increase the knowledge of sepsis warning signs and appropriate responses.
	Objective	Decrease the time between identifying sepsis and administering antibiotics.

Project Description:

Edgecombe Early Sepsis Intervention Program (EESIP) overarching goal is to reduce sepsis mortality by improving knowledge of sepsis' warning signs and reducing the time between identifying sepsis and administering antibiotics.

Edgecombe County Rural Health Network (ECRHN) supports healthcare delivery system reform through an effective network that addresses the social determinants of health and population health management by collaborating in delivering care, extracting and analyzing data, reducing barriers, increasing efficiency, and sharing and generating resources.

EESIP's activities include: hire and onboard the Project Director; attend community events to promote sepsis awareness/education for the public; conduct sepsis trainings for medical and behavioral health professionals, first responders, allied health professionals, social workers, and caregivers; conduct trainings on using Lactic Acid Meters for the EMS agencies; develop and test protocols for in-field use of Lactic Acid Meters; and distribute Lactic Acid Meters to all rescue squad/ambulances.

Expected Outcomes include:

- an increase in the number of patients in the intervention group seeking treatment in the primary care setting for potential sepsis by 10% in each year;
- a decrease in the number of patients seeking treatment for suspected sepsis in the emergency room setting by 10% each year; and a decrease the time to appropriate antibiotic treatment for sepsis cases by 20%;
- an increase the pre-hospital treatment of sepsis with antibiotic therapy to 50% of patients with ultimate sepsis diagnosis;
- a decrease in overall sepsis inpatient days in the hospital by 40%; and
- a decrease the sepsis mortality in the initiative area by 30%.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The ECRS follows UP-15 Suspected Sepsis Protocols developed by the North Carolina College of Emergency Physicians. These protocols ensure safe, efficient and effective interventions to relieve pain and suffering and improve patient outcomes without inflicting harm. They ensure a structure of accountability for Medical Directors, EMS agencies, pre-hospital providers, and facilities to provide continual performance improvement. The Institute of Medicine calls for developing standardized, evidence-based pre-hospital care protocols for the triage, treatment, and transport of patients. These protocols establish expectations of pre-hospital care in North Carolina. The 2017 update expands on the 2012 and 2009 versions and incorporates evidence-based guidelines, expert opinion, and historically-proven practices to ensure the highest quality pre-hospital patient care available. The North Carolina Chapter of Emergency Physicians develops and provides final approval.

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Ohio

Hopewell Health Centers, Inc.

Grant Number:	D06RH37504					
Organization Type:	FQHC					
Grantee Organization:	**Project Name:**	Partnering to Achieve Compliance and Savings (PACS)				
	Address:	1049 Western Ave.				
	City:	Chillicothe	**State:**	Ohio	**Zip code:**	45601
	Tel #:	740-773-1006				
	Website:	www.hopewellhealth.org				
Primary Contact:	**Name:**	Sherry Shamblin				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Community Health Improvement Associates	Washington	OH	Nonprofit
	United Healthcare		OH	Payer
	Molina		OH	Payer
	The Health Plan		OH	Payer
	Washington County Health Department	Washington	OH	Health Dept.
	Athens County Health Department	Athens	OH	Health Dept.
	Meigs County Health Department	Meigs	OH	Health Dept.
	Ross County Health Department	Ross	OH	Health Dept.

Counties the project serves:	
	Athens County, Ohio
	Meigs County, Ohio
	Ross County, Ohio
	Washington County, Ohio

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐

	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☐	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Community Health Workers
	Secondary Focus Area:	Chronic Disease

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Strengthen the organizational and infrastructure capacity of the PACS Consortium members to implement and sustain a model of Chronic Care Management that includes Community Health Workers as part of the clinical care team (CHW-Based CCM) for those who live in the project region.
	Objective	The PACS Consortium builds enrollment in CHW-based CCM.
	Objective	Use HHC (as regional FQHC) as the lead administrative agency for the PACS Consortium to reduce geographic and governmental barriers that exist for county-level health departments; and utilize HHC's Billing Structure for members who do not have this capability.
	Objective	Insurers/managed care plans inform PACS planning efforts, the implementation of CHW-based CCM, and sustainability planning for the consortium.
	Objective	Sustain movement towards a payment model for CHW-based CCM through local health department.
	Objective	Expand CHW-based CCM geographically.
	Objective	Continue to evolve a data-informed consortium to measure outcomes, monitor progress, prove benefit of model, and sustain model post-grant.

Project Description:

Partners have joined together to build on a consortium, Partnering to Achieve Compliance and Savings (PACS), that will accomplish the goal of strengthening the organizational and infrastructure capacity of the PACS Consortium members to implement and sustain a model of Chronic Care Management that includes Community Health Workers as part of the clinical care team (CHW-Based CCM) for those who live in the project region.

In pursuit of this goal, these core strategies will be employed: (1) Evolution of the PACS Consortium to have a regional approach for widespread testing and evaluation of the impact of Community Health Workers on Chronic Care Management and to assure sufficient members of insurers can be enrolled to reasonably calculate savings and substantiate investment by insurers; (2) Use of HHC (as regional FQHC) as the lead administrative agency for the PACS Consortium to reduce geographic and governmental barriers that exist for county-level health departments and utilize HHC's Billing Structure for members who do not have this capability; (3) Involvement of multiple insurers/managed care plans in the PACS Consortium to inform the implementation of CHW-based CCM and to inform sustainability planning with other consortium members; (4) The conducting of savings analyses due to CHW-based CCM through both individual health plans and through pooling data from the participating health plans that will guide consortium's efforts to implement a payment model in the region; (5) Development of a data-informed consortium to measure outcomes, monitor progress, prove benefit of model, and sustain model post-grant; (6) Use of AmeriCorps members trained as CHW's to provide Chronic Care Management (CCM) for PACS partner agencies as a means of quickly ramping up enrollment at modest cost in order to further inform Consortium's Strategic and Sustainability Plans; (7) Engagement with elected officials and professional organizations by the Ohio Association of Community Health Centers (OACHC) and the Ohio Alliance for Innovation in Population Health (OAIPH) (both contributing letters of support for PACS) to examine potential policy changes; and (8) Continual maintenance of a 3 Year Strategic Plan and Sustainability Plan for PACS Consortium to guide roll out of CHW based CCM once reimbursement is attained.

The project has the potential to lead to reimbursement by insurers for certain CHW services, creating hundreds of new jobs and leading to a sustainable new workforce. We expect this service to improve the health of thousands of Appalachian residents, improve the system of care, and reduce healthcare costs.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Marshall University, in collaboration with Duke University and Williamson Health and Wellness Center, a federally-qualified health center in Mingo County, West Virginia, has developed a model of care coordination using CHWs that has demonstrated remarkable clinical success in managing high-risk diabetes patients. This model was originally funded by the Centers for Medicare & Medicaid Services Model(CMMI) through a Health Care Innovation Award; the project title was From Clinic to Community: Achieving Health Equity in the Southern United States. .High-risk patients were selected using a risk algorithm developed by Duke University, but generally high-risk means multiple chronic conditions and frequent emergency room visits and/or hospitalizations. These are costly patients that utilize a disproportionate amount of health care resources.

This model demonstrated an average A1C reduction for 149 patients of 2.5 percentage points within six months; the average A1C baseline score was 10%and it declined to 7.5%. .Typically, clinical or pharmaceutical interventions resulting in a one point reduction in A1C are considered clinically significant. In addition, ED visits decrease by 55 (22%) and hospital visits decreased by 62(30%) over 18 months. This model is being replicated in rural Appalachia, in ten counties in West Virginia, four n Kentucky and five in Ohio, by 13 rural health care agencies. Chronic Care Management (CCM) is led by a care management team that involves a mid-level provider, a nurse, and CHWs. The role of the team is to receive referrals from providers, assess patients' level of risk, and enroll eligible patients in intensive CCM. Once enrolled the team assesses patients' health status, creates care plans and follows up on patients on a regular basis.

The mid-level provider leads the team and meets weekly for case reviews. The nurse on the team manages the clinical side of care management such as making referrals, contacting patients' primary care providers, and helping to set up clinical appointments. The CHWs link patients with community services and conduct regular home visits to assist patients with medication adherence, chronic disease self-management, healthy eating, and active living goals. The CHWs receive their instructions for patient care at the weekly care management meetings and are in regular contact with the team nurse. They are full time, permanent, employees of the sponsoring health centers.

While CHWs across the country function in a wide range of roles with commensurate skills, in this project their focus is on encouraging and supporting patients to manage their condition. Their fundamental skills are helping patients make self-management decisions, and teaching problem-solving skills. Because this project serves high-risk patients, the CHWs do not function independently. As members of the care management team, they are supervised directly by the team's nurse and mid-level provider. Their training centers on understanding diabetes self-management and on how to engage patients in self-management behaviors.

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	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Illinois

HSHS Good Shepherd Hospital, Inc.

Grant Number:	D06RH37505					
Organization Type:	Hospital					
Grantee Organization:	**Project Name:**	The Illinois Telehealth Network (ITN): Building Capacity and Sustainability to Increase Multi-Specialty Health Care Access for Rural and Underserved Populations				
	Address:	200 S Cedar St.				
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	Website:	www.hshsgoodshepherd.org				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Shelbyville Community School District*	Shelby	IL	School District
	Sav Mor Pharmacy*	Clay	IL	Pharmacy
	Salem Township Hospital*	Marion	IL	Critical Access Hospital
	Locust St Regional Center*	Macoupin	IL	Behavioral Health Resource Center
	HSHS Good Shepherd Hospital*	Shelby	IL	Rural Hospital
	HSHS St. Joseph's Hospital Breese*	Clinton	IL	Rural Hospital
	Carlinville Area Hospital*	Macoupin	IL	Critical Access Hospital
	Thomas Boyd Memorial Hospital*	Greene	IL	Critical Access Hospital
	Memorial Hospital*	Hancock	IL	Critical Access Hospital
	Warner Hospital and Health Services*	DeWitt	IL	Rural Hospital
	HSHS St. Mary's Hospital*	Macon	IL	Hospital
	HSHS St. Antony's Hospital	Effingham	IL	Hospital
	HSHS Holy Family Hospital*	Bond	IL	Rural Hospital
	Mason District Hospital*	Mason	IL	Critical Access Hospital
	HSHS St. Joseph's Hospital Highland*	Madison	IL	Critical Access Hospital
	Hillsboro Area Hospital*	Montgomery	IL	Critical Access Hospital
	Jersey Community Hospital*	Jersey	IL	Rural Hospital

	HSHS St. Francis Hospital*	Montgomery	IL	Critical Access Hospital
	Kirby Medical Center*	Piatt	IL	Critical Access Hospital
	HSHS St. Elizabeth's Hospital*	St. Clair	IL	Hospital
	Pana Community Hospital*	Christian	IL	Critical Access Hospital
	Sarah D. Culbertson*	Schuyler		Critical Access Hospital
	Southern Illinois Healthcare Foundation*	St.Clair	IL	FQHC
	HSHS ACO, LLC*	Sangamon	IL	ACO
	HSHS St. John's Hospital*	Sangamon	IL	Hospital
	HSHS Medical Group*	Sangamon	IL	Physician Group
	Prairie Cardiovascular Consultants*	Sangamon	IL	Physician Group
	HSHS Physician Clinical Integration Network*	Sangamon	IL	Physician Group

Counties the project serves:	Marion County, IL	Hancock County, IL
	Shelby County, IL	DeWitt County, IL
	Clay County, IL	Macon County, IL
	Macoupin County, IL	Effingham County, IL
	Clinton County, IL	Bond County, IL
	Schuyler County, IL	Sangamon County, IL
	St. Clair County, IL	Christian County, IL
	Jersey County, IL	Piatt County, IL
	Madison County, IL	Montgomery County, IL
	Greene County, IL	Mason County, IL

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☒
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☒
	Latinos	☒	Uninsured	☒
	Native Americans	☐	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Telehealth	
	Secondary Focus Area:	School-based Health	
	Other Focus Area:	Cardiology Behavioral Health-Substance Use Disorder	☒ Secondary ☒ Secondary

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Expand current services.
	Objective	Grow patient services at existing sites.
	Objective	Add new locations to existing telemedicine programs(Tele-Stroke, Tele-Behavioral Health).
	Goal	Develop three new Focus Area services.
	Objective	Partner with Prairie Cardiology to start a tele-cardiology pilot project\ by 2024.
	Objective	Build a school-based telehealth program with Shelbyville Community School District by 2024.

	Objective	Plan and implement an OUD/SUD telemedicine assessment and treatment pilot by 2024.
	Goal	Support program sustainability and network operations.
	Objective	Strengthen ITN's ability to sustain operations without federal funding through funding diversification strategies.

Project Description:

This 2020-2023 RHND project proposes three telehealth activities to (1) expand current services; (2) develop three new Focus Area services; (3) support program sustainability. The three new Focus Area services are: Opioid/substance use disorder telemedicine, school-based telehealth and tele-cardiology. Expected Outcomes/Impact: This RHND project will improve the access, coordination, quality and delivery of telemedicine services for patients in rural underserved Illinois shortage areas to increase access to essential health care. To implement this project, four new members have been added to the Illinois Telehealth Network including an opioid/substance use disorder treatment center, a rural township hospital, a rural school district, and a rural pharmacy. Thus, a substantially expanded new rural population and area will be served.

More than 1.7 million rural dwellers and patients in disadvantaged and underserved shortage areas of central and southern Illinois have limited or no access to essential health care services, and many of their providers have limited capacity. To address this need, the nonprofit Illinois Telehealth Network (ITN) was formed with an elected board, bylaws, and mission "to promote the capacity of Members to improve access to health care, in rural, underserved and disadvantaged communities, through the application of telehealth and telemedicine solutions," and vision to "connect and share resources, strengthen rural health care and save lives."

Evidence Based/ Promising Practice Model Being Used or Adapted:

To support program implementation, successful evidence-based promising practices are utilized. For example, to support the new Illinois Telehealth Network (ITN) RHND Focus Area of school based telehealth, the Indiana Rural Schools Clinic Network (IRSCN)RHI Hub best practice will be utilized and adapted. One critical success factor of the Indiana program is that it partnered with Indiana Managed Care entities, and this will be an important success factor with the ITN pilot in Shelbyville, Illinois. Care will be payer-agnostic, and all students will receive any needed care regardless of ability to pay. Insurance payers will be billed and there will be a sliding scale payment option. Uninsured students may be covered by an alternative program. A role for "insurance navigators" may be considered for children that are enrolled in public schools received free and reduced-fee lunches(a federal poverty eligibility indicator for Medicaid). ITN may need to secure telemedicine equipment and provide training. A patient evaluation may depend upon a school nurse to use the telehealth system's stethoscope, otoscope, or dermascope for skin exams, functioning as the remote provider's eyes, ears, and hands. Limited school based laboratory testing for strep throat, influenza, and urine problems, tests may be performed by the school nurse.

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Michigan

Huron, County of

Grant Number:	D06RH37506					
Organization Type:	Other: County Government					
Grantee Organization:	**Project Name:**	Adaption in Action: A Network Response to Emerging Needs				
	Address:	1142 S Van Dyke Rd.				
	City:	Bad Axe	**State:**	Michigan	**Zip code:**	48413
	Tel #:	989-673-8117				
	Website:	www.hchd.us				
Primary Contact:	**Name:**	Kay E Balcer				
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Secondary Contact:	**Name:**	Kari White				
	Title:	Program Coordinator				
	Tel #:	810-895-2918				
	Email:	tchpinfo@gmail.com				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300.000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300.000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Huron County Health Department	Huron	MI	Health Department
	Lapeer County Health Department	Lapeer	MI	Health Department
	Sanilac County Health Department	Sanilac	MI	Health Department
	Tuscola County Health Department	Tuscola	MI	Health Department
	Thumb Community Health Partnership	Huron	MI	Nonprofit Network Org.

Counties the project serves:	
	Huron County, MI
	Lapeer County, MI
	Sanilac County, MI
	Tuscola County, MI

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒

	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Behavioral Health/Mental Health - General
	Secondary Focus Area:	Chronic Disease

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	The long-term **goal of the Network** is to provide a coordinated regional effort to identify, plan for, and provide interventions that will lead to a healthier community.
	Goal	The **project goal** is that a sustainable cross-sector network will be positioned to identify community needs and gaps in services and use this information to respond to focus priorities: behavioral health and chronic disease.
	Objective	Increase the utilization of data for decision making related to community and population health.
	Objective	Strengthen the cross-sector system for addressing the health and healthcare needs of the community.
	Objective	Increase the alignment of regional networks and achieve greater efficiency and sustainability.
	Objective	Utilize the existing internal structure and staff of the Huron County Health Department, Michigan Thumb Public Health Alliance, and Thumb Community Health Partnership to meet the reporting, fiscal, and grant monitoring requirements of the project.

Project Description:

This project is located in the mitten shaped portion of Michigan commonly referred to as the Thumb. The region is home to approximately 152,000 rural residents and consists of four counties—Huron, Lapeer, Sanilac, and Tuscola. The area has a higher level of unemployment, lower median income, and lower educational status than the Michigan average. There are a number of health disparities in the region. Over the last two decades, organizations in the region have worked collaboratively to reduce organizational silos. Although multiple health groups have sprung up to address needs, they are structured mostly by type of organization or topic. In an effort to address these "collaboration silos," the Michigan Thumb Public Health Alliance (MTPHA) and the Thumb Community Health Partnership (TCHP) have joined forces on the project—Adaption in Action: A Network Response to Emerging Needs.

MTPHA will be the governing network and is composed of the four local public health departments. TCHP has a membership that includes mental health authorities, public health departments, hospitals, and a human service agency. TCHP will provide substantial leadership on the project. Working together, MTPHA and TCHP will determine the name, composition, structure, and function of the new cross-sector network being developed through the project. Consolidating separate collaborative efforts will enable a more coordinated approach and build adaptive capacity for addressing emerging health needs. This project builds upon the community health assessment process developed by TCHP during a Rural Health Care Network Planning Grant awarded in 2019.

This cross-sector network is expected to achieve efficiencies; expand access; coordinate and improve the quality of essential health care services; and strengthen the rural health care system as a whole. The project is developed around three frameworks: Mobilizing Action through Planning and Partnership, the Sustainable Network Model–Adaptive Networks, and System Change. Grant-funded activities include:

- Piloting a regional health assessment process;
- Creating and implementing a Healthcare Workforce Development Plan;
- Developing a process for compiling, monitoring, and analyzing data;
- Developing and piloting one project for each of two priority health needs: Chronic Disease and Behavioral Health; and
- Establishing funding and sustainability strategies and strengthening the network structure and partnerships.

Evidence Based/ Promising Practice Model Being Used or Adapted:

MTPHA and TCHP will use these three frameworks as part of the Network Development Grant project:

a. Mobilizing Action through Planning and Partnerships (MAPP) will be the framework for community assessment activities. MAPP is a best practice planning process developed by the National Association of County and City Health Officials and supported by the Center for Disease Control. In previous work, the process was effectively used to discover root causes of the identified priorities: Chronic Disease-Obesity and Behavioral Health. Two adaptations will be made to the MAPP process. As a wide variety of assessments have already taken place, those results were reviewed related to each phase and gaps were identified in the data. The MAPP process also is highly focused on the public health system and roles. This partnership is cross sector and will be adapting the process to consider all healthcare system sectors. Moving forward, the MAPP toolkit will be utilized to guide assessment and community engagement activities outlined in the work plan.

b. The six system components included in the ABLe Change System Change Framework will be utilized. The ABLe Change Framework is a model designed to help communities more effectively address complex issues affecting children and families. The model is based upon the premise that communities can achieve transformative results when they make system and community conditions the intentional targets of their strategies. The model also promotes a community engagement infrastructure that supports real-time learning and action across diverse stakeholders and sectors. Designed by Drs. Pennie Foster-Fishman and Erin Watson at Michigan State University, the ABLe Change Framework draws upon research from the successes and failures of prior organizational, community, service system, and international change efforts. The Network Director has received training in this framework and the ABLe change website includes tools and processes that are free to the public upon registration.

c. The Infinite Game and Adaptive Capacity is a model for network sustainability. This model was presented to network members during the Network Planning Grant by CRL Consultants. This Sustainable Network Model involves a continuous cycle of Scanning, Sensemaking, Leveraging, and Adding Value.

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Indiana

Indiana University Health Bedford, Inc.

Grant Number:	D06RH37507					
Organization Type:	Hospital					
Grantee Organization:	**Project Name:**	Rural Dementia Network of South Central Indiana				
	Address:	2900 16th St.				
	City:	Bedford	**State:**	Indiana	**Zip code:**	47421
	Tel #:	317-962-8258				
	Website:	https://iuhealth.org				
Primary Contact:	**Name:**	Diana Matthews				
	Title:	Program Director				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$222,103
	Jul 2021 to Jun 2022	$217,411
	Jul 2022 to Jun 2023	$219,895

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	IU Health Paoli Hospital	Orange	IN	Hospital
	IU Health Bloomington Hospital	Monroe	IN	Hospital
	Alzheimer's Resource Service	Monroe	IN	Nonprofit Org.
	Hoosier Uplands	Lawrence	IN	State Agency
	Solutions Center	Lawrence	IN	Nonprofit Org.

Counties the project serves:	Lawrence County, IN	Orange County, IN

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☐	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Care Coordination
	Secondary Focus Area:	Chronic Disease

	Other Focus Area:	Dementia	☒ Secondary

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Formalize a network of health care providers and community health partners to improve population health management for persons living with dementia (PLWD) and their care partners in rural south central Indiana.
	Objective	Formalize the governing board and meeting schedule for the Network.
	Objective	Identify, recruit, and engage additional stakeholders as formal and informal partners, including those to meet the unique needs for Orange County.
	Objective	Establish mechanisms to measure and track health care utilization and relevant clinical outcome measures among the target population and share data within the network in order to improve care coordination for PLWD and their care partners.
	Objective	Ensure the sustainability and viability of the Network beyond the grant period.
	Goal	Improve the quality, accessibility, and coordination of health care services for PLWD and their care partners in Lawrence and Orange Counties.
	Objective	Train staff in long-term care facilities and other senior-serving institutions in best practices for dementia ..
	Objective	Train CNA and HHA students in dementia friendly practices through the "Dementia Friendly Care Partner Development Certification Program (DFCPDP)".
	Objective	Improve coordination of health care services for PLWD and their care partners
	Goal	Educate community members and local businesses in best practices to recognize and support PLWD and their care partners and equip care partners and the business community to meaningfully support the Network's purpose
	Objective	Teach care partners best practices in supporting PLWD and leadership in advocacy efforts.
	Objective	Foster a dementia-friendly environment in the local business community.

Project Description:

Network Purpose and Members: Rural south central Indiana is uniquely addressing the population health challenge of dementia through a collaborative approach. Key stakeholders have come together to support People Living with Dementia (PLWD) and their care partners, recently achieving designation as "Dementia Friendly Lawrence County." This existing cross-sector collaboration will serve as the foundation for the proposed "Rural Dementia Network of South Central Indiana". One of the Network members will be the Alzheimer's Resource Service (ARS), a unique resource center for PLWD, their care partners, and the broader community located in nearby Monroe County. This grant provides dedicated resources to formally establish the Network—with IU Health Bedford Hospital as the fiduciary agent—in order to improve health care delivery and health outcomes for PLWD and their care partners in these two rural counties. The Network will leverage the power of a formal coalition approach to address dementia as a population health challenge in a manner that would not be possible through individual entities. In addition to IU Health Bedford Hospital, other Network members include IU Health Paoli Hospital, IUHealth Bloomington Hospital, and together will ensure fidelity to the dementia friendly communities model and will contribute leadership and mentoring from ARS personnel.

Expected project outcomes include training staff in long-term care facilities and other senior-serving institutions in best practices for dementia care, training certified nursing assistant and home health aide students in dementia friendly practices, improving the coordination of health care services for PLWD and their care partners, training care partners to optimally support PLWD, fostering a dementia-friendly environment in the local business community, identifying outcome health care utilization and clinical measures and establishing tracking mechanisms to for those measures, establishing memory clinics, and ensuring sustainability of the Network beyond the three-year grant period.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The Network will leverage several evidence-based and promising practice models to meet the healthcare needs of PLWD and their care partners. These include the National Association of Area Agencies on Aging "Dementia Friendly Communities" model, the Positive Approach to Care (PAC) training model by Teepa Snow, the Virtual Dementia Tour program by Second Wind Dreams, and the UCLA Longevity Center's "Alzheimer's Prevention Program" and its licensure program.

Alzheimer's Disease International states that dementia friendly communities, "not only seek to preserve the safety and wellbeing of those living with dementia, [but] also empower all members of the community to celebrate the capabilities of persons with dementia, and view them as valuable and vital members of the towns, cities, villages and countries in which they reside." The "dementia friendly" model emphasizes breaking down stigma and the need for communities to actively accept and value people with dementia. The model also ensures that PLWD and their care partners are central to the process. "Dementia friendly communities" demonstrate the following characteristics:
•Cross-sector connection of three or more sectors dedicated to advancing dementia friendliness, recognizing that every part of the community must work together to create a dementia-friendly culture. Such sectors typically include: banking, legal, law enforcement, first responders, health care systems (including hospitals), faith communities, local government agencies, restaurants, grocery stores, libraries, residential facilities, and rehabilitation facilities.
•Inclusion and leadership of PLWD
•An entity to serve as a champion and fiscal sponsor
•Adoption of dementia friendly practices across the community, using either the national Dementia Friendly America toolkit or local sector-based outreach and training.

Three cities/counties in Indiana are currently designated as Dementia Friendly Communities–Bloomington (Monroe County), Lawrence County, and Hamilton County (a suburb of Indianapolis). ARS's Community Health Coordinator, Amanda Mosier, is the liaison to Dementia Friendly America(DFA)for the state of Indiana. All three DFCs in Indiana report their activities to her and she reports them to DFA. DFA provides its network of communities with a community toolkit, sector-specific guidance, webinars and technical assistance regarding best practices, peer support.

Other evidence-based and promising practices to be used by the Network include Teepa Snow's Positive Approach to Care®(PAC) and Second Wind Dream's Virtual Dementia Tour. As described in the Methodology section, the PAC model enhances life and relationships of those living with brain change by fostering an inclusive global community. The PD and ND will also receive training in the evidence-based Virtual Dementia Tour®(VDT) program by Second Wind Dreams and train health care providers in Lawrence and Orange Counties in this model. VDT uniquely provides "a window into the world of dementia through the evidence-based dementia simulation training." The VDT uses research-based, patented sensory tools and instruction to enable persons without dementia to experience the physical and cognitive challenges faced by PLWD. The ND and PD also plan to visit the UCLA Longevity Center to learn from their best practice programs and become licensed in their memory education programs. The UCLA Longevity Center is a pioneering leader in the field of longevity, translating scientific discoveries into practical applications.18In addition to the evidence-based dementia friendly communities model and the training programs described above, the Rural Dementia Network of South Central Indiana is also based on literature in the field such as the following:•National Center for Complex Health and Social Needs, the Center for Health Care Strategies, and the Institute for Healthcare Improvement's "Blueprint for Complex Care" •The Gerontological Society of America's "Living with Dementia: A Meta-synthesis of Qualitative Research on the Lived Experience"

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Kansas

Kansas Clinical Improvement Collaborative, LLC

Grant Number:	D06RH37508					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	Kansas Rural Remote Physiologic Monitoring (RPM) Initiative				
	Address:	2220 Canterbury Dr.				
	City:	Hays	**State:**	Kansas	**Zip code:**	67601
	Tel #:	913-945-5440				
	Website:	http://kcic-care.com/				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Citizens Medical Center	Thomas	KS	Critical Access Hospital
	Ellsworth County Medical Center	Ellsworth	KS	Critical Access Hospital
	First Care Clinic	Ellis	KS	FQHC
	Hayes Medical Center	Ellis	KS	Hospital
	Norton County Hospital	Norton	KS	Critical Access Hospital
	University of Kansas Center for Telemedicine and Telehealth	Douglas	KS	Academic/University

Counties the project serves:	
	Ellis County, KS
	Ellsworth County, KS
	Norton County, KS
	Thomas County, KS

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children	☐

			(Middle/high school ~13-17 years)	
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Telehealth
	Secondary Focus Area:	Chronic Disease

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Develop Remote Physiologic Monitoring Program
	Objective	Identify, evaluate, and select appropriate monitoring devices
	Objective	Develop criteria for patients to be monitored
	Objective	Design and execute on processes for patient education and device deployment
	Objective	Educate practitioners on the use of RPM in patient management
	Objective	Develop and execute on monitoring protocols, including flow of relevant data
	Objective	Recruit and train clinical staff to serve as monitors
	Objective	Establish, test, and implement documentation, coding, and billing processes
	Objective	Monitor and evaluate performance and make appropriate modifications
	Objective	Develop and distribute tools to assist rural providers in implementing RPM programs
	Goal	Sustain Program and Measure Performance
	Objective	Develop and execute on detailed timeline to achieve initial delivery of CCM services
	Objective	Develop detailed sustainability budget for RPM program with specified milestones
	Objective	Develop methodology and compile relevant data to demonstrate impact of RPM program on outcomes and total cost of care

Project Description:

Through the Kansas Rural Remote Physiologic Monitoring Initiative ("RPM Initiative"), the Kansas Clinical Improvement Collaborative, LLC, a rural accountable care organization ("ACO") comprised of provider organizations in 32 rural Kansas counties, will support an initial cohort of rural provider organizations in implementing and sustaining remote physiologic monitoring("RPM") services for rural residents suffering from chronic conditions and develop and distribute resources for other rural providers interested in pursuing RPM services.

The Kansas Clinical Improvement Collaborative ("Care Collaborative"), an established rural clinically integrated network, will use its proven performance improvement model and well-established trust relationships with participating providers to plan, implement, and evaluate remote physiologic monitoring ("RPM") services for rural residents with chronic conditions. Since 2018, Medicare has reimbursed providers for RPM services, which have been proven to improve outcomes and lower costs for patients with chronic conditions. Such reimbursement, however, is not sufficient to cover associated start-up costs. Also, rural providers lack expertise to establish such programs.

The RPM Initiative will involve the following core activities: (1) Identify, evaluate, and select appropriate monitoring devices; (2) Develop criteria for patients to be monitored; (3) Design and execute on processes for patient education and device deployment; (4) Educate practitioners on the use of RPM in patient management; (5) Develop and execute on monitoring protocols, including flow of relevant data; (6) Recruit and train clinical staff to serve as monitors; (7) Establish, test, and implement documentation, coding, and billing processes; (8) Monitor and evaluate performance and make appropriate modifications; and (9) Develop and distribute technical assistance to assist rural providers and networks in implementing RPM programs.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The RPM Initiative will leverage the Care Collaborative's successful CCM Program. That program has demonstrated improved outcomes and lower total costs of care for individuals receiving those services. The CCM Program also has achieved sustainability with Medicare reimbursement and its contribution to the Care Collaborative's success in earning shared savings in the MSSP.

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Illinois

Katherine Shaw Bethea Hospital

Grant Number:	D06RH37509					
Organization Type:	Hospital					
Grantee Organization:	**Project Name:**	Right Care, Right Place, Right Time II				
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	Website:	www.ksbhospital.com				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$299,999
	Jul 2021 to Jun 2022	$299,999
	Jul 2022 to Jun 2023	$299,999

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Kreider Services	Lee	IL	Nonprofit Org.
	Sinnissippi Centers	Lee	IL	Nonprofit Org.

Counties the project serves:		
	Lee County, IL	Whiteside, IL
	Ogle, IL	

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☒
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☒
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☒
	Infants and toddlers (up to 3 years)	☒	School-age children (Middle/high school ~13-17 years)	☒
	Latinos	☒	Uninsured	☒
	Native Americans	☐	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:		
	Primary Focus Area:	Care Coordination
	Secondary Focus Area:	Behavioral Health/Mental Health - General

Project goals & objectives:	Goal/ Objective	Description
	Goal	Implement “Right Care, Right Place, Right Time” project.
	Objective	Develop core operational leadership team to refine model and implement “Right Care, Right Place, Right Time” project.
	Objective	Complete assessment of current resources and status to establish baseline.
	Objective	Integrate internal KSB resources, key partners, and build community investment.
	Objective	Build knowledge/resources and skills in workforce and partners.
	Objective	Transform identified primary care practices to patient-centered medical homes under the NCQA PCMH program.
	Goal	Improve health outcomes for children and adults (Right Care).
	Objective	Improve health outcomes through more effective coordination with specialty care, coordinate with other multi- disciplinary teams, and track outcomes.
	Objective	Identify patients with chronic, complex conditions and co-develop targeted, patient-centered care plans including goals and interventions, barriers and self-management strategies.
	Objective	Implement an integrated behavioral health model in identified primary care practice.
	Objective	Implement robust quality improvement program in family practices.
	Goal	Improve access to care (Right Time).
	Objective	Build awareness to gaps in care and develop targeted outreach in response.
	Objective	Strengthen clinical practice alignment with community-based services for child, family and adult care.
	Objective	Deploy non-traditional venues of care and expand access to existing venues of care.
	Objective	Increase capacity of key services within the network.
	Goal	Reduce fragmentation of services to children and adults and improve transitions across settings of care (Right Place).
	Objective	Develop an assessment plan to establish current baseline of degree of fragmentation, identify contributing factors, and implement improvement activities.
	Objective	Solidify existing connections with network members and build robust connections with new members to optimize decision making at all levels and minimize transitional barriers for patients/families.
	Objective	Integrate care and social support for patients with behavioral health comorbidities and establish efficient linkages with community-based providers and services when higher levels of care are necessary.
	Goal	Develop sustainability of enhanced network.
	Objective	Strengthen primary care and behavioral health learning communities.
	Objective	Establish structural and fiscal sustainability of the PCMH and associated components, linkages, and networks.

Project Description:

Project Right Care, Right Place, Right Time II, a project led by Katherine Shaw Bethea Hospital of Dixon, Illinois, seeks to transform KSB’s primary care (adult and families) to a patient-centered medical home model with an emphasis on behavioral health integration. The medical home model will be enabled by a population health platform that will provide care teams with a risk-stratified, longitudinal view of their patient population. Analytics of this platform will give care teams the insight to focus outreach and tailor programs/resources towards the most vulnerable populations.

Services that will be launched and/or expanded as part of this project include: Chronic Care Management, Transitional Care Management, Annual Wellness Visits, Care Coordination and a variety of behavioral health services. The aim will be to achieve PCMH recognition from NCQA in two (2) primary care clinics: Family Health Center of Dixon and Oregon Clinic. This project will

expand on the scope of the pediatric model to include the adult population. It will also aim to expand on the existing network to include partners in adult chronic care management including long-term care, hospice, and supportive care.

Expected Outcomes include:
• Developed process flow for coordination of services• Improved efficiency of referral process with loop closure
• Expanded service options for children and adults
• Reduced hospital readmissions and unnecessary ER visits
• Decreased referrals to resources outside the region
• Improved coordination of services for children, families and adults
• Improvement on quality indicators related to diabetes, hypertension, obesity, ADHD, and depression• Greater understanding of health disparities within the community
• Enhanced network working together to improve health for the entire community (cradle to grave)
• Network is fiscally sustainable through increase in preventative services (closing gaps in care)
• Tailored community wellness campaigns targeting vulnerable/at-risk population within community.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The PCMH and Care coordination are both models identified as a best practice or promising practice on the national level. The Vermont Blueprint for Health "is a state-led, nationally-recognized initiative that helps health care providers meet the medical and social needs of people in their communities. Medical Homes are the foundation of the Blueprint, along with Practice Facilitators who help them continuously improve care, and Community Health Teams who expand available services to include free care coordination, counseling, substance abuse treatment support, health coaching and more...All Blueprint work is closely integrated with health and human service organizations through Community Collaboratives that guide care delivery and payment reforms at the local level" (http://blueprintforhealth.vermont.gov/blueprint101). The overarching goal of this project is consistency with Blueprint's goals of better care, better health and better control of health care costs.

Project Officer (PO):	**Name:**	Maribel Nunez				
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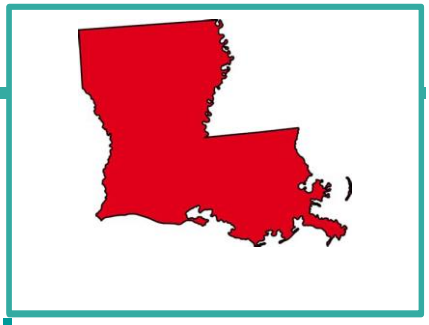
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA):	**Name:**	Eric Baumgartner				
	Tel #:	404-413-0314				
	Email:	etbaumgartner@bellsouth.net				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303



Louisiana

Louisiana Rural Ambulance Alliance, Inc.

Grant Number:	D06RH37510					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	End the Epidemic LA Network				
	Address:	5010 Highway 1				
	City:	Napoleonville	**State:**	Louisiana	**Zip code:**	70390
	Tel #:	985-513-3593				
	Website:	www.louisianaambulancealliance.org				
Primary Contact:	**Name:**	Donna Newchurch				
	Title:	CEO Louisiana Rural Ambulance Alliance				
	Tel #:	985-513-3593				
	Email:	donna@newchurchassoc.com				
Secondary Contact:	**Name:**	Rachel Jackson				
	Title:	Program Coordinator				
	Tel #:	225-663-2758				
	Email:	rachel@louisianaambulancealliance.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Jackson Parish Ambulance Service	Jackson	LA	Emergency Medical Services
	Pafford EMS	Lincoln	LA	Emergency Medical Services
	Louisiana Association for Behavioral Health	Acadia	LA	Non-profit Org.
	State Office of Rural Health	East Baton Rouge	LA	State Agency
	Louisiana Department of Health	East Baton Rouge	LA	State Agency
	Louisiana Office of the Attorney General	East Baton Rouge	LA	State Agency
	Acadian Companies	Lafayette	LA	Emergency Medical Services

Counties the project serves:		
	Allen Parish, Louisiana	Lincoln Parish, Louisiana
	Assumption Parish, Louisiana	Livingston Parish, Louisiana
		Madison Parish, Louisiana
	Avoyelles Parish, Louisiana	Morehouse Parish, Louisiana
	Beauregard Parish, Louisiana	Natchitoches Parish, Louisiana
	Bienville Parish, Louisiana	Ouachita Parish, Louisiana

	Bossier Parish, Louisiana	Rapides Parish, Louisiana
	Caddo Parish, Louisiana	Red River Parish, Louisiana
	Calcasieu Parish, Louisiana	Richland Parish, Louisiana
	Caldwell Parish, Louisiana	Sabine Parish, Louisiana
	Cameron Parish, Louisiana	St. Charles Parish, Louisiana
	Catahoula Parish, Louisiana	St. James Parish, Louisiana
	Claiborne Parish, Louisiana	St. John The Baptist Parish, Louisiana
	Concordia Parish, Louisiana	St. Landry Parish, Louisiana
	De Soto Parish, Louisiana	St. Martin Parish, Louisiana
	East Carroll Parish, Louisiana	St. Mary Parish, Louisiana
	Evangeline Parish, Louisiana	St. Tammany Parish, Louisiana
	Franklin Parish, Louisiana	Tangipahoa Parish, Louisiana
	Grant Parish, Louisiana	Tensas Parish, Louisiana
	Iberia Parish, Louisiana	Terrebonne Parish, Louisiana
	Winn Parish, Louisiana	Union Parish, Louisiana
	Jackson Parish, Louisiana	Vermilion Parish, Louisiana
	Jefferson Davis Parish, Louisiana	Vernon Parish, Louisiana
	Lafayette Parish, Louisiana	Washington Parish, Louisiana
	Lafourche Parish, Louisiana	Webster Parish, Louisiana
	LaSalle Parish, Louisiana	West Carroll Parish, Louisiana

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☐	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☐	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Behavioral Health/Mental Health - Substance Use Disorder

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Strengthen the existing End the Epidemic Louisiana Network.
	Goal	Support and/ or develop local rural community based End the Epidemic Networks.
	Goal	Achieve efficiencies through identification of opportunities to leverage federal, state, and local resources specific to the opioid epidemic
	Goal	Achieve efficiencies through identification and adoption of process to avoid duplication of services and resources in rural communities
	Goal	Develop and adopt End the Epidemic Louisiana Statewide Network (Statewide) Sustainability Plan.
	Goal	Support the development and adoption of End the Epidemic Network Sustainability Plans at the local rural level.

Project Description:

Louisiana's rural residents are, on average, less healthy, less educated, less able to access healthcare, un or underinsured, and older than their urban counterparts. These rural residents have less access to employment opportunities and are poorer than urban

residents. Unfortunately ,Louisiana's rural communities face a number of challenges in gaining access to health care in general. These challenges include lack of specialized health services, health workforce shortages, and potentially greater stigma related to substance use disorder due to living in smaller communities. Opioid abuse and addiction has increased by 327% over the last five years in Louisiana. Research shows that rural opioid users are more likely to have socioeconomic vulnerabilities including limited educational attainment, poor health status, being uninsured, and low income. Furthermore, more than half of rural counties nationally (60.1 percent) still lack a physician with a waiver to prescribe buprenorphine.

End the Epidemic LA was launched in November of 2016 and is an initiative of a Network composed of the Louisiana Rural Ambulance Alliance (LRAA), Louisiana Association for Behavioral Health (LABH); State Office of Rural Health; Louisiana Department of Health (SORH); Office of the Louisiana Attorney General (AG); Pafford EMS; and Jackson Parish EMS. It is governed by a Governing Board with each member represented; an MOU has been executed. The initiative is dedicated to supporting treatment for and prevention of substance use disorder in rural Louisiana through collaboration, education, and outreach.

End the Epidemic LA Network will meet six specific goals incorporating the legislative aims of achieving efficiencies; expanding access to, coordinate, and improve the quality of essential health care services; and strengthen the rural health care system as a whole as they respond to the opioid crisis in rural Louisiana. This will be done through the establishment of local, rural End the Epidemic Networks in each of the seven Louisiana Department of Health Regions with rural designations.

The expected outcome of the End the Epidemic Louisiana Network project is that Louisiana's rural communities will be equipped to address and respond to the opioid epidemic in their communities. Project activities include:
1) Strengthen the existing End the Epidemic Louisiana Network;
2) Strengthen the rural health care system as a whole through support / development of local, rural community-based End the Epidemic Networks;
3) Achieve efficiencies through identification of opportunities to leverage federal, state, and local resources specific to the opioid epidemic;
4) Achieve efficiencies through identification and adoption of processes to avoid duplication of services and resources in rural communities;
5) Develop and adopt End the Epidemic Louisiana Network sustainability plan;
6) Support the development and adoption of End the Epidemic Network sustainability plans at the local rural level.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The End the Epidemic Network will utilize the best practices from a program based in Ohio with similar goals and objectives in the development, execution and evaluation of its program. Pacific Institute for Research and Evaluation (PIRE) and Ohio University (OU) worked together to provide training, technical assistance, and leadership development to local communities. They formed a consortium using the hub and spoke model. There was a master consortium made of Ohio University (OU), Pacific Institute for Research and Evaluation (PIRE), and a project director from each county. Then, each county has a consortium that brings together community partners. This allowed partnerships to be formed that may not have been formed originally. Through this route of application, PIRE and OU were able to maximize the impact of services that the communities received.

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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

California

Mendonoma Health Alliance

Grant Number:	D06RH37511					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	Mendoma Health Alliance (MHA) Rural Health Network				
	Address:	38958 Cypress Way				
	City:	Gualala	**State:**	California	**Zip code:**	95445
	Tel #:	707-412-3176, Ext. 102				
	Website:	www.mendonomahealth.org				
Primary Contact:	**Name:**	Micheline M White				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$298,645
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Redwood Coast Medical Services	Mendocino	CA	FQHC
	Coast Life Support District	Mendocino	CA	Emergency Medical Services
	Santa Rosa Memorial Hospital	Sonoma	CA	Hospital

Counties the project serves:	Sonoma County, CA	Mendocino County, CA

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Care Coordination
	Secondary Focus Area:	Social Determinants of Health

	Other Focus Area:	Chronic Disease	☒ Secondary

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Improve population health by implementing evidence-based practices.
	Goal	Improve the quality of health care services which are accessible locally.
	Goal	Expand the use of innovative strategies to reach patients in distant and remote locations.
	Objective	Strengthen collaboration among Network partner organizations to support transition to a community health model.
	Objective	Expand, increase and improve vital health resources throughout the RHN service area.
	Objective	Conduct program planning and assessment.
	Objective	Pursue financial and programmatic sustainability beyond the period of performance.

Project Description:

The purpose of this program is to support and enhance the MHA Rural Health Network to meet the health care needs of residents of the coastal communities in southern Mendocino and northern Sonoma Counties. MHA's mission is to improve local access to wellness education, prevention services, and quality healthcare through creative solutions in collaboration with our community. The MHA RHND Program supports our efforts to develop a regional system of care and more readily adapt to technological and financial changes in the U.S. health care delivery system with an emphasis on improving population health. This effort supports all three of the statutory charges: achieving better system efficiencies; expanding access to, coordinating, and improving essential health care services; and strengthening the rural health network.

To achieve designated objectives, MHA has detailed a set of activities that are focused within four Key Initiatives: 1: Prevention & Wellness; 2: Chronic Care Management; 3: Access to Care; and 4: Emergency Care Services.

The projects six intended outcomes include:
1.Reduction in medical transports due to unmanaged chronic conditions;
2.Improved quality and health care delivery through improved coordination and financial incentives;
3.Reduced hospital admissions and readmissions;
4.Improved chronic disease care through the use of technology and collaboration;
5.Enhanced sharing of patient data and information across multiple settings and providers;
6.Improved patient-centered care and patient involvement in self-management.

Evidence Based/ Promising Practice Model Being Used or Adapted:

MHA is committed to reviewing and implementing selected evidence-based practices to achieve successful program implementation. Specific practices are detailed in Attachment 10: Evidence-Based Practice Abstract. While MHA utilizes more than a dozen evidence-based practices, several of the most central practices include:
•A Matter of Balance fall prevention program
•Balanced Scorecard Network evaluation tool
•Eric Coleman Model of Care Transitions
•Health Information Exchange electronic health data sharing platform
•HHS National Pain Strategy
•Motivational Interviewing
•Patient Centered Medical Home
•Stanford Self-Management Resource Center "Living a Healthy Life with Chronic Conditions"

Project Officer (PO):	**Name:**	Robyn Williams				
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	Email:	RWilliams@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857

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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Iowa

Mercy Medical Center - Newton

Grant Number:	D06RH37512					
Organization Type:	Hospital					
Grantee Organization:	**Project Name:**	Rural Community Health Integration Network: Addressing Health-Related Social Needs in Central Iowa				
	Address:	204 N 4th Ave. E				
	City:	Newton	**State:**	Iowa	**Zip code:**	50208
	Tel #:	641-792-1273				
	Website:	www.mercyone.org/newton				
Primary Contact:	**Name:**	Leisa Zylstra				
	Title:	Foundation and Mission Manager				
	Tel #:	641-787-3179				
	Email:	lzylstra@skiffmed.com				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$299,454
	Jul 2021 to Jun 2022	$297,695
	Jul 2022 to Jun 2023	$299,978

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Knoxville Hospital and Clinics	Marion	IA	Health System
	Dallas County Hospital and Family Medicine Clinics	Dallas	IA	Health System

Counties the project serves:	
	Jasper County, IA
	Marion County, IA
	Dallas County, IA

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:		
	Primary Focus Area:	Social Determinants of Health
	Secondary Focus Area:	Community Health Workers

Project goals & objectives:	**Goal/ Objective Goal**	**Description**
		Improve patient and population health outcomes by expanding the network care management program to identify and address patients' health-related social needs.

	Objective	By the end of the grant period, all Network members will implement standardized social needs screening. Strategy: Offer health-related social need screening to at least 70% of eligible patients.
	Objective	By the end of the grant period, all Network members will implement standardized social needs follow-up protocol. Strategies: 1) Each Network site will integrate community health workers into local care teams, and 2) community health workers will follow-up with at least 50 percent of the patients who request assistance.
	Objective	By the end of the grant period, Network sites will identify and coordinate with community-based organizations that provide services to meet patient social needs. Strategies: 1) Use data to identify community-based organization that are most successful in meeting patient needs, and 2) Identify opportunities for partnerships with community-based organizations.

Project Description:

MercyOne Newton Medical Center (lead applicant), Knoxville Hospital and Clinics, and Dallas County Hospital and Family Medicine Clinics, acting as the MercyOne Rural Community Health Integration Network (the Network), along with partner, MercyOne Population Health Services Organization, are implementing a project that will expand organizations' continuum of care by developing network members' ability to identify and address patients' health-related social needs. Acting as a network will facilitate a coordinated, efficient, sustainable, and cost-effective response to the social needs affecting patients' health outcomes. All Network sites are located in rural Central Iowa communities that face health and economic disadvantages. In this environment, the addition of social needs screening and follow-up in the health care setting will make a positive impact on patients and the community as a whole. Sites will implement a social needs program that screens patients for social needs and provides a community health worker (CHW) to partner with those who request assistance. By expanding care management services to include care for social needs, patients' health outcomes are expected to improve as well as their ability to meet their own basic needs. Network sites are hospital and clinic systems that are also part of the larger MercyOne Health System and its Central Iowa Clinically Integrated Network. MercyOne is a connected system of health care facilities dedicated to helping patients live their best lives. The system is composed of over 40 hospitals and medical centers and more than 230 clinics across Iowa and into surrounding states. MercyOne's mission focuses on caring for the poor and underserved, and this project is a direct fit with this mission.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The Network will implement the MercyOne Social Needs model, which includes elements of evidence-based models from across the nation. MercyOne is participating in CommonSpirit Health's Total Health Roadmap project, which is implementing social needs screening and follow-up in Iowa, Kentucky, and Colorado. This project has used evidence-based tools and practices, such as motivational interviewing and standardized training, and is collecting data regarding implementation and outcomes. The Network Project Director will work closely with MercyOne staff who are involved with the Total Health Roadmap pilot project to ensure coordination and use of best practices. In addition, local implementation of the MercyOne model has proven that it is feasible and offers benefits to both patients and the health care system.

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	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Montana

Montana State University, Inc.

Grant Number:	D06RH37513					
Organization Type:	University					
Grantee Organization:	**Project Name:**	Montana Behavioral Health Workforce Network Development				
	Address:	307 N Montana Ave.				
	City:	Bozeman	**State:**	Montana	**Zip code:**	59715
	Tel #:	406-994-2381				
	Website:	http://healthinfo.montana.edu/				
Primary Contact:	**Name:**	Kristin Juliar				
	Title:	Director				
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	Email:	kjuliar@montana.edu				
Secondary Contact:	**Name:**	Beth Carter				
	Title:					
	Tel #:					
	Email:	beth.carter@montana.edu				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$299,998
	Jul 2021 to Jun 2022	$299,992
	Jul 2022 to Jun 2023	$299,980

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Montana Office of Rural Health/Area Health Education Center	Gallatin	MT	AHEC
	Montana Primary Care Association	Lewis and Clark	MT	Nonprofit Org.
	Montana Hospital Association's Health Research Education Foundation	Lewis and Clark	MT	Nonprofit Org.
	Mountain Pacific Quality Health	Lewis and Clark	MT	Nonprofit Org/QIO
	Rocky Mountain Tribal Leaders Council	Yellowstone	MT	Tribal
	Montana Peer Network	Clark	MT	Nonprofit Org.

Counties the project serves:	Statewide: All 56 counties in Montana	

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children	☐

			(Middle/high school ~13-17 years)	
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Workforce Development	
	Secondary Focus Area:	Behavioral Health/Mental Health - General	
	Other Focus Area:		☐ Primary ☐ Secondary

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	An effective and sustainable behavioral health workforce development system that strengthens the delivery of care and improves access to services throughout rural and frontier Montana.
	Objective	The Montana Behavioral Health Workforce Network (MBHWN) will achieve efficiencies in training of behavioral health and supporting personnel.
	Objective	MBHWN will support behavioral health services delivery and the application of integrated behavioral health (IBH) delivery throughout rural and frontier Montana.
	Objective	Montana ORH/AHEC will provide administrative function to coordinate MBHWN activities, evaluate MBHWN strategies and develop mechanisms for sustainability.

Project Description:

The goal of the MBHWN is an effective and sustainable behavioral health workforce development system that strengthens the delivery of care and improves access to services throughout rural and frontier Montana. There are six network members representing the state's community health centers, critical access hospitals, tribal communities, quality improvement network and the recovery community. Members include the Montana Office of Rural Health/Area Health Education Center at Montana State University, Montana Primary Care Association, Montana Hospital Association's Health Research Education Foundation, Mountain Pacific Quality Health, Rocky Mountain Tribal Leaders Council, and Montana Peer Network.

Network Activities/Services will include:

- Objective 1: The Montana Behavioral Health Workforce Network (MBHWN) will achieve efficiencies in training of behavioral health and supporting personnel.
- Objective 2: MBHWN will support behavioral health services delivery and the application of integrated behavioral health (IBH) delivery throughout rural and frontier Montana.
- Objective 3: Montana ORH/AHEC will provide administrative function to coordinate MBHWN activities, evaluate MBHWN strategies and develop mechanisms for sustainability.

The MBHWN has identified numerous expected outcomes resulting from the proposed work plan. These outcomes are expected throughout rural, frontier and Tribal communities in Montana. In summary, these outcomes included efficient and responsive behavioral health professions training, expanded access to behavioral health services, expanded delivery and sustainability of integrated behavioral health care, and a sound and sustainable network to support behavioral health care.

Evidence Based/ Promising Practice Model Being Used or Adapted:

MBHWN will utilize two evidence-based models for behavioral health training as identified on the RHIhub:

- Mental Health First Aid which is an 8-hour course that trains rural community members to recognize and respond to persons with mental health and substance abuse. "Numerous studies of this method have found that course participants are better able and more likely to help others regarding mental health issues."
- Project ECHO® which aids remote care providers to work with a team to expand their knowledge and manage conditions of rural patients. "Patient management and care provided by rural providers through ongoing education and mentoring from Project ECHO® has proved as effective as treatment provided by specialists at a university medical center."

In addition, there are a number of efforts going on nationally related to integrated behavioral health, many funded or related to SAMHSA. Some of the literature that supports workforce development strategic planning includes: The Behavioral Health Workforce Needed for Integration with Primary Care: Information for Health Workforce Planning, Susan M Skillman, MS, Cyndy R Snyder, PhD, Bianca K Frogner, PhD, Davis G Patterson, PhD April 2016. "Integrating behavioral health and primary care services is key to accomplishing the overall goals of the Affordable Care Act of 2010 to increase access to health care and improve patient outcomes. Integration also supports the "Triple Aim" of achieving better health, better care experiences, and lower health care costs. This descriptive study provides information that can be used by policymakers, practitioners, educators and other health workforce planning stakeholders to develop plans and policies to increase access to behavioral health care services through primary care settings.

The SAMHSA-HRSA Center for Integrated Health Solutions promotes the development of integrated primary care and behavioral health services to better address the needs of individuals with mental health and substance use conditions whether seen in specialty behavioral health or primary care setting. CIHS specifically identifies the models described in our proposal (National Council for Behavioral Health, the Collaborative Care Model) and the training programs developed by these model programs as best practices https://www.integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care#integrated%20models%20of%20BH%20in%20PC .

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	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Nebraska

Northeast Nebraska Public Health Department

Grant Number:	D06RH37514					
Organization Type:	Public Health Department					
Grantee Organization:	**Project Name:**	NNRHN Infrastructure and Health Outcome Improvement Project				
	Address:	215 N Pearl St.				
	City:	Wayne	**State:**	Nebraska	**Zip code:**	68787
	Tel #:	402-375-2200				
	Website:	http://www.nnphd.org				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Providence Medical Center	Wayne	NE	Critical Access Hospital
	Pender Community Hospital	Thurston	NE	Critical Access Hospital
	Winnebago Tribal Health Department	Thurston	NE	Tribal Health Department
	University of Nebraska Medical Center	Lancaster	NE	University Hospital

Counties the project serves:			
	Cedar County, NE	Thurston County, NE	
	Dixon County, NE	Wayne County, NE	

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐

Focus Areas:		
	Primary Focus Area:	Obesity prevention and reduction
	Secondary Focus Area:	Chronic Disease

Project goals & objectives:	Goal/ Objective	Description
	Goal	Improve access and quality of health care in rural areas through sustainable community health needs assessment (CHNA) and community health improvement planning (CHIP) to create effective health care programs as a result of network collaboration.
	Objective	Strengthen this evolving network to achieve efficiencies and sustainability by strengthening NNRHN infrastructure and encouraging a culture that fosters relationships, trust and respect across members.
	Objective	Increase the types and numbers of organizations in the NNRHN.
	Goal	Prepare NNRHN for the transition to value-based payment and population health management.
	Objective	Collect clinical data on select NQF measures and share with NNRHN members.
	Goal	Reduce the levels of overweight/obesity found in the 18-74 year old population within the service area.
	Objective	Reduce the levels of overweight/obese adults 18-74 by 10% of baseline.

Project Description:

The vision of the Northeast Nebraska Rural Health Network (NNRHN) is *Working Together We Create s Healthier Community.* NNRHN includes five healthcare organizations: 1) The Providence Medical Center (PMC), a Critical Access Hospital (CAH); 2) The Pender Community Hospital (PCH) a CAH; 3) The Winnebago Tribal Health Department; 4) University of Nebraska Medical Center, an institution of higher learning and the Northeast Nebraska Public Health Department (NPPHD) the collaborative lead.

Network Project Activities/Services include: 1) shared protocols and training; 2) Completion of a triennial CHNA and CHIP; 3) NNRHN member National Quality Forum (NQF)performance data sharing and peer learning improve quality leading to better health outcomes and improved reimbursement for members under value-based purchasing; 4) Implementation of a community-wide weight loss intervention program based on evidence-based practices (EBPs).

Expected Outcomes of the project are: 1) NNRHN network members will be in the top tier for payment bonuses in value-based care programs and continuing peer-learning within 5 years; 2) 10% increase in NQF measures for adult and childhood obesity; 3) 450 adults registered in the NNRHN weight management program in year three; 4) Decrease in the % of adults 18-74 that are obese.

Evidence Based/ Promising Practice Model Being Used or Adapted:

EBPs include health coaching apps and self-monitoring of food intake and activity using a mobile technology application, prescribed program intervention for at risk patients and the use of health coaches for in-person and telephone assistance with behavioral modification and trouble shooting. These programs were selected because overweight/obesity was a top community priority that came out of a 2018-2019 Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP) developed NNRHN. Overweight and obesity are very high in the service area and is a risk factor in multiple health problems including heart disease, cancer and diabetes

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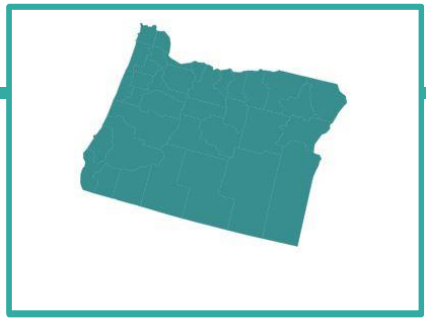
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303



Oregon

Northeast Oregon Network

Grant Number:	D06RH37515					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	Wellness in Early Life, Northeast Oregon Network				
	Address:	2008 Third Street, Suite A				
	City:	La Grande	**State:**	Oregon	**Zip code:**	97850
	Tel #:	541-624-5101				
	Website:	www.neonoregon.org				
Primary Contact:	**Name:**	Liberty Avila				
	Title:	Network Director				
	Tel #:	541-910-1929				
	Email:	lavila@neonoregon.org				
Secondary Contact:	**Name:**	Stephanie Anthony				
	Title:	Project Director				
	Tel #:	541-910-3360				
	Email:	santhony@neonoregon.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Eastern Oregon Healthy Living Alliance	Lake	OR	Nonprofit Org.

Counties the project serves:			
	Baker County, Oregon	Umatilla County, Oregon	
	Grant County, Oregon	Union County, Oregon	
	Malheur County, Oregon	Wallowa County, Oregon	
	Morrow County, Oregon		

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☐	Pre-school children (3-4 years)	☒
	African Americans	☒	Pacific Islanders	☒
	Caucasians	☒	Pregnant Women	☒
	Elderly (65+)	☐	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☒	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:		
	Primary Focus Area:	Community Health Workers
	Secondary Focus Area:	Behavioral Health/Mental Health - General

Project goals & objectives:	Goal/ Objective	Description
	Goal	Expand the Network to Include New Counties, Partners, and Programs.
	Goal	Integrate New County and Partner Leadership into operational and decision-making structures of NEON and the Hub Leadership Team.
	Goal	Strengthen High Risk Families with Young Children to Increase Resiliency of Parents and Children and Improve Health and Educational Outcomes.
	Goal	Improve Patient and Population Health Outcomes and Academic Readiness Indicators.
	Goal	Realign Financial Incentives for Care Coordination Towards a Payment for Outcomes Model.
	Goal	Achieve Ongoing Sustainability of The Pathways Hub and Integrated Nurse Home Visiting Programs.

Project Description:

For this program, NEON will partner with Eastern Oregon Healthy Living Alliance (EOHLA), which currently serves the 12 counties of Eastern Oregon that make up the service area of the regional Medicaid payer. This partnership will allow NEON to expand its service area for the NEON Pathways Community Hub, a fully operational and evidence-based Agency for Health Care Research and Quality (AHRQ) best practice Pathways Hub model, from 5 to 7 counties. It will also expand the population served by the Hub to include parents in the prenatal and postpartum period or with children up to age 4 who are experiencing health barriers and who would benefit from CHW services, a population currently not serviced by the Hub. In addition to current Hub services, the program will partner with public health departments in the service area to expand an emerging integrated nurse home visiting program and shift it to a value-based payment model, with the goal of incentivizing quality and efficiency. In this program, nurses visiting mothers in the home during the prenatal, postpartum, and early childhood periods complete depression screenings and connect with contracted credentialled therapists who build relationships with parents and provide in-home therapy sessions using the evidence-based Child Parent Psychotherapy (CPP) Model. The CHW, nurse home visitor, and credentialled therapist will form a community-based treatment team for these highest risk families. The project will also provide training and a learning collaborative for home visiting professionals to ensure that they feel confident to meet complex needs of community members and to ensure program success.

Wellness in Early Life seeks to strengthen families during a critical developmental stage by promoting positive attachment and bonding, meeting social and medical needs, building trust between at-risk families and behavioral health providers, and expanding the availability of in-home services, which can be critical in the remote areas this project serves. Over 3 years, the project will serve 165 high-risk families with supportive care coordination and enroll 90 parents in behavioral health services to be provided in the home, which can be critical in the postpartum period when long-distance travel to access services can be difficult. Over time, the program will increase the number of normal birthweight babies born, support critical early childhood screenings for lead exposure and vaccination status, increase kindergarten readiness, reduce the incidence of child abuse and neglect, and improve health for both parents and children.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Practice 1: Pathways Community Hub Model
The Community Health Access Project (CHAP) implemented the Pathways Model, which employs community health workers who connect at-risk individuals to evidence-based care through the use of individualized care pathways designed to produce healthy outcomes. This model promotes timely, efficient care coordination through incentives and prevents service duplication through use of a Community Hub, a regional point of patient registration, and quality assurance supporting a network of agencies involved in providing care to the target population. The first implementation of the model in Richland County, OH, resulted in increased services to at-risk women and a decline in the rate of low birth weight babies.

Practice 2: Nurse-Family Partnership Model
The Nurse-Family Partnership (NFP) is an evidence-based home visiting program model that pairs first-time mothers who have low incomes with maternal and child health nurses in order to promote healthy pregnancies, child development, and economic self-

sufficiency. Nurses provide their clients with 64 home visits over two and a half years, from pregnancy until the child reaches two years of age.

Practice 3: Child-Parent Psychotherapy
Child-Parent Psychotherapy is an intervention model for children aged 0-5 who have experienced at least one traumatic event and/or are experiencing mental health, attachment, and/or behavioral problems, including posttraumatic stress disorder. The treatment is based in attachment theory but also integrates psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories. Therapeutic sessions include the child and parent or primary caregiver. The primary goal of CPP is to support and strengthen the relationship between a child and his or her caregiver as a vehicle for restoring the child's cognitive, behavioral, and social functioning. Treatment also focuses on contextual factors that may affect the caregiver-child relationship.

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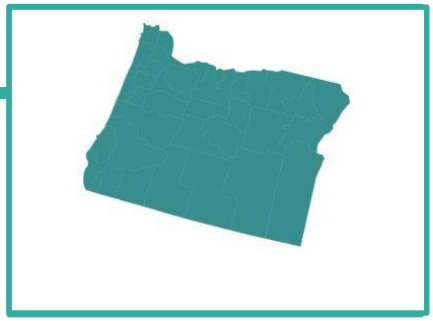
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303



Oregon

Oregon Washington Health Network

Grant Number:	D06RH37516					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	OWhN Network Development Project				
	Address:	404 SE Dorion Ave., Ste. 410				
	City:	Pendleton	**State:**	Oregon	**Zip code:**	97801
	Tel #:	541-429-8844				
	Website:	www.OWhN.org				
Primary Contact:	**Name:**	Amy Ashton-Williams				
	Title:	Project Director				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$299,160
	Jul 2021 to Jun 2022	$299,680
	Jul 2022 to Jun 2023	$299,995

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Good Shepherd Hospital	Umatilla	OR	Critical Access Hospital
	Morrow County Health Department	Morrow	OR	County Health Dept.
	Morrow County Health District	Morrow	OR	Health System
	Providence St. Mary Medical Center	Walla Walla	WA	Hospital
	Walla Walla County Health Department	Walla Walla	WA	County Health Dept.
	Yellowhawk Tribal Health Center	Umatilla	OR	Tribal Health Center
	Umatilla County Human Services	Umatilla	OR	County Health Dept.
	CHI St. Anthony Hospital	Umatilla	OR	Critical Access Hospital
	Lifeways, Inc.	Umatilla	OR	Nonprofit Org.
	Blue Mountain Community College	Umatilla	OR	Academic/College

Counties the project serves:		
	Umatilla County, OR	Union County, OR
	Morrow County, OR	Walla Walla County, WA

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☒
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐

	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Chronic Disease
	Secondary Focus Area:	Workforce Development

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Improve recruitment services for primary care and behavioral health professionals by recruiting directly in Pacific Northwest Universities and by providing continuous information on professional work opportunities within the OWhN service area.
	Goal	Provide ongoing billing support to the member organizations of the network and other providers requesting technical assistance to maximize OUD/SUD billing collections.
	Goal	Improve chronic disease services and community education through the hiring of a 4 day per week chronic disease educator to work with network partners, elderly centers, and the Native American and Latino communities to address high rates of chronic disease within the network's service area.
	Goal	Carry out other collaborative activities to strengthen the rural care system of Northeast Oregon and Southeast Washington.

Project Description:

This project will address what has been determined to be the three highest priority needs of the network based on its 2015 strategic plan and the findings of OWhN's recently completed opioid planning grant. These are: 1.) To establish a regional recruitment program to improve access to primary care and behavioral health services; 2.) To develop a regional billing capability to prepare the network's members for the transition to value based payments; and 3.) To improve health outcomes through the development of a community based chronic disease monitoring and education program. These needs will be addressed through the hiring of three full and part-time health professionals, training, and on-site technical assistance in areas of recruitment and billing.

Rural northeast Oregon and southeast Washington face numerous challenges in addressing the health care needs of their communities. The most pressing of these is a lack of access to primary care and behavioral health services across all four counties in the service area. Based on the network's previous opioid planning grant, the OWhN service area has a deficiency of over 100 primary care and behavioral health professionals. It was also determined during this project that many organizations across the network's service area were not billing for opioid and other services. Thus, improving billing systems and collections is necessary before the region's providers will be able to move toward a value based care payment system. Lastly, there are very limited chronic disease education programs occurring across network's service area. OWhN will establish the first regional quality improvement program to be implemented in eastern Oregon. This will allow the network to focus on a broad range of population health issues for the first time. The outcomes of this project are expected to be significant increases in primary care and behavioral health professionals working within the service area, significant increase in billing revenues for the network's partners, and long term decreases in chronic disease rates as more clients are screened and referred for needed services.

OWhN plans to accomplish this work using these eleven different approaches: 1.) OWhN will hire a full time recruiter to coordinate recruitment activities, placements, site visit, and National Health Service Corp placements in the four counties served by the partnership; 2.)OWhN will complete a five year plan for addressing provider deficiencies within its service area; 3.)A full-time billing consultant will be hired to assist members with initiation of billing services or affecting improvements in collections; 4.)Training will be provided to members of OWhN and other providers on state and Federal billing requirements and effective billing procedures; 5.)Recommendations for standard billing practices to improve efficiency and maximize billing through team management will be provided to members; 6.)A health needs assessment will be compiled; 7.)Preventative activities (community education and free screening clinics) will be provided in years two and three of the grant; 8.)A business plan for OWhN will be completed by the end of year three; 9.)A regional quality improvement committee will be established to focus on population health issues; 10.)Team

management and other training will be provided to improve the efficiency of existing programs; 11.)Data to document project outcomes will be collected, assessed by the QI Committee, and documented in the project's external evaluation.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Training of members and implementation of evidence based practices (EBPs) has, and will continue to be an important focus of the network. During its opioid planning grant, OWhN completed an inventory of current evidence based practices (EBPs) in use by OUD/SUD providers in its service area. During this inventory, it was found that these organizations were using a total of 16 evidence based practices. As part of its strategic planning process, a total of ten additional EBP's were recommended, several of which are currently in the process of being implemented. A similar inventory will be completed for this project.

Over the years, OWhN has carried out many activities to improve the use of evidence based practices. These include a four hour training class arranged through Oregon Health and Science University held in April of 2016, formation of an EBP protocol team, and use of evidence based screening tools and teaching materials during community chronic disease clinics. These activities will be continued throughout the RHND project. The network's quality improvement committee will be responsible for implementation of EBPs during the grant. Due to numerous requests from its members, OWhN expects to hold a second EBP class during years two and three of the project. OWhN will also use evidence based screening tools and an evidence based needs assessment in implementing proposed chronic disease programs.

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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

South Carolina

Palmetto Care Connections

Grant Number:	D06RH37517					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	South Carolina Virtual Access Telehealth Network (SC VATN)				
	Address:	1880 Main Hwy				
	City:	Bamberg	**State:**	South Carolina	**Zip code:**	29003
	Tel #:	803-245-2672				
	Website:	https://www.palmettocareconnections.org				
Primary Contact:	**Name:**	Kathy Schwarting				
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	Title:	Project Director				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$298,687

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Ehrhardt Pharmacy	Bamberg	SC	Pharmacy
	Lee's Inlet Apothecary & Gifts	Georgetown	SC	Pharmacy
	Giant Discount Pharmacy	Orangeburg	SC	Pharmacy
	R&J Drugs	Orangeburg	SC	Pharmacy
	Medical Ministries, Inc.	Bamberg	SC	Nonprofit Org.
	Bethel AME Church	Dorchester	SC	Faith-based Org.
	Good Hope AME Church	Orangeburg	SC	Faith-based Org.
	Edisto Fork United Methodist Church	Orangeburg	SC	Faith-based Org.
	Pine Hill Indian Community Development Initiative	Orangeburg	SC	Community Center

Counties the project serves:		
	Bamberg County, SC	Georgetown County, SC
	Dorchester County, SC	Orangeburg County, SC

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children	☐

			(Middle/high school ~13-17 years)	
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Telehealth
	Secondary Focus Area:	Chronic Disease

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	To achieve efficiencies; expand access to, coordinate, and improve the quality of essential health care services; and strengthen the rural health care system as a whole in each target community.
	Objective	Improve access and quality of health care in rural areas through sustainable health care programs created as a result of network collaboration.
	Objective	Prepare network for the transition to value-based payment and population health management.
	Objective	Demonstrate improved health outcomes and community impact.
	Objective	Promote the sustainability of network through the creation of diverse products and services.
	Objective	Utilize evidence-based models in the delivery of health care services.

Project Description:

The goal of this project is to achieve efficiencies; expand access to, coordinate, and improve the quality of essential health care services; and strengthen the rural health care system as a whole in each target community. The service area covers four rural counties in South Carolina –Bamberg, Dorchester, Georgetown, and Orangeburg. The project will meet the health care needs of the rural underserved population in the rural South Carolina communities of Murrells Inlet, North, Orangeburg, Neeses, St. George, Cope, and Ehrhardt.

The South Carolina Virtual Access Telehealth Network (SC VATN) will expand the existing Palmetto Care Connections (PCC) rural health network by adding rural, independent pharmacies, Medical Ministries, Inc., Pine Hill Indian Community Development Initiative, and health care providers to the telehealth network services. The purpose of the project is to expand access to care in the target communities by integrating the functions of network members, staff, and the board of directors to improve population health as well as individual health outcomes. The network consists of 15 members with separate EIN numbers. Four of the members are rural, independent pharmacies, one is a faith based organization that operates three rural clinics, one is a tribal affiliated community organization, one is a federally qualified health center, one is a private rural care provider, one is a community health center, two are state schools of medicine, one is a health care insurer, one is a hospital system, one is a hospital association and one is the SC Office of Rural Health.

Network project activities include: implementing telehealth services; specialty and primary care integration; improving coordination of services; implementing Health Information Technology/Exchange; and implementing programs to increase primary care workforce in rural communities. Expected outcomes of the project include an improvement in quality of life amongst chronic disease patients, an improvement in blood pressure control amongst hypertension patients, an improvement in HbA1c in diabetes patients, and an improvement in knowledge and/or skills amongst pharmacists and providers

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Evidence Based/ Promising Practice Model Being Used or Adapted:

The program will include chronic disease self-management education (CDSME). CDSME is an evidence-based model proven to work in a broad range of populations and conditions. It is a six-week course, meeting once weekly for 2.5 hours, which will be led by either a Certified Diabetes Educator (CDE) from FHC or by a trained pharmacist at a partner pharmacy. While it is expected that the majority of participants will have diabetes and/or hypertension, CDSME is applicable to other chronic diseases with high prevalence rates in the communities including chronic lung disease.

SC VATN will also use Project ECHO® (Extension for Community Health Care Outcomes). Project ECHO was originally designed to improve care and outcomes for Hepatitis C patients, a chronic disease. According to the Agency for Health Care Research and Quality, Project Echo is "an innovative and widely applicable model to provide treatment for patients with chronic, common and complex diseases who do not have direct access to specialty health care providers." MUSC is a local provider of Project ECHO and will connect Bamberg Family Practice and FHC to their project in support of the network. Project ECHO is designed to extend specialty care to rural patients utilizing videoconferencing for area providers to offer:

•Direct support from specialists to primary care providers (PCPs) on patient cases
•Increased knowledge for PCPs through shared case-based learning and mentorship
•Assistance with patient treatment plan development and monitoring

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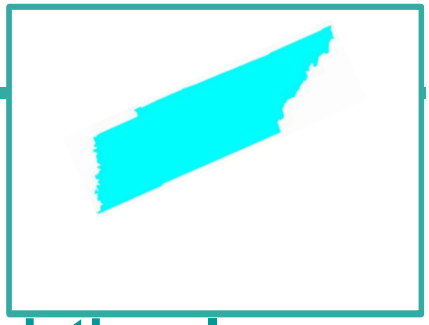
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303



Tennessee

Paris-Henry County Health Care Foundation, Inc.

Grant Number:	D06RH37518					
Organization Type:	Nonprofit Organization (other than a network nonprofit)					
Grantee Organization:	**Project Name:**	West Tennessee Delta Network Telehealth Project				
	Address:	301 Tyson Ave.				
	City:	Paris	**State:**	Tennessee	**Zip code:**	38242
	Tel #:	731-644-8266				
	Website:	http://www.hcmc-tn.org/Foundation/default.aspx				
Primary Contact:	**Name:**	Rachel Matlock				
	Title:	Network Director				
	Tel #:	731-644-8300				
	Email:	rlmatlock@hcmc-tn.org				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Henry County Medical Center	Henry	TN	Hospital
	Hardeman County Community Health Center	Hardeman	TN	FQHC
	Hardin County Regional Health Center d/b/a/ Lifespan Health, Inc.	Hardin	TN	FQHC

Counties the project serves:			
	Henry County, TN	Hardin County, TN	
	Benton County, TN	Wayne County, TN	
	Weakley County, TN	Chester County, TN	
	Gibson County, TN	McNairy County, TN	
	Carroll County, TN	Hardeman County, TN	
	Haywood County, TN	Decatur County, TN	
	Henderson County, TN		

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☒
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☒
	Infants and toddlers (up to 3 years)	☒	School-age children (Middle/high school ~13-17 years)	☒

	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Telehealth	
	Secondary Focus Area:	Chronic Disease	
	Other Focus Area:	Behavioral Health/Mental Health - General	☐ Primary ☒ Secondary

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Hire Network staff and establish committees, grant administration and operational framework.
	Goal	Develop and adopt a 5-year strategic plan to guide Network's telehealth program development.
	Goal	Complete service and business agreements, vendor selection, data & evaluation plans, and training.
	Goal	Implement hardware and software installation and complete "Go-live" for Network and participants.
	Goal	Provide and monitor Network telehealth services at all sites moving forward.
	Goal	Continue to manage and develop the Telehealth Network Project under the active direction of the Board with support from committee, staff, consultants and input from external community stakeholders and patients.
	Goal	Implement hardware and software installation and complete "Go-live" for year 3 project site.
	Goal	Provide and monitor Network telehealth services at all sites on an ongoing basis.
	Goal	Continue to manage, develop and monitor the Telehealth Network Project.

Project Description:

West Tennessee Delta Network Telehealth Project will increase the organizational and technology capacity of the Network to expand access to telehealth behavioral, and obesity-related primary and specialty health services for rural residents of West Tennessee. The West Tennessee region served by this project includes 13 rural counties which lie between the Tennessee and Mississippi Rivers in the western third of the state, bordered by Kentucky on the north, and Mississippi on the south. All but two counties have populations below 30,000. A majority of residents in the region live in communities with populations of less than 10,000. The target population is adults, children and families at risk for obesity and/or obesity-related chronic conditions and/or that have behavioral health conditions.

The West Tennessee Delta Network (Network)is a formally organized network established in 2018. The Network grew out of the West Tennessee Delta Consortium, a group of more than 30 healthcare and nonprofit agencies that have worked together since 2010.Through a Rural Health Network Planning Grant, ,the Network members established a formal organizational structure, mission, bylaws and self-governing board in 2018. Paris & Henry County Healthcare Foundation (PHCHF) and three Network healthcare providers are co-applicants: Henry County Medical Center, a rural public hospital chartered in Henry County; Hardeman County Community Health Center, Federally Qualified Health Center(FQHC); Hardin County Regional Health Center d/b/a Lifespan Health, Inc., also a FQHC.

The project will address needs identified by health providers, stakeholders and residents of the region for improved access to behavioral health, obesity and related chronic disease health services through expansion of telehealth technology. This includes expanding access to primary care, specialty and behavioral health services for school-based health clinics; primary and specialty care follow-up for adults and children at Project Partner sites; and for behavioral telehealth, nutritional, and chronic disease management services and education. Currently there is no telehealth network in West Tennessee, and this project aims to address that gap. Project outcomes will include significantly improved access to healthcare services and improved quality of services. Project Partners expect a 20% increase in telehealth encounters, a 10% increase in telehealth referrals, a 20% increase in family members who can remotely participate in telehealth visits of their children, and a 20% decrease in travel miles for patients.

Evidence Based/ Promising Practice Model Being Used or Adapted:						
Evidence-based services that already offered by HCMC, HCCHC and Lifespan Health will continue to be used and will be expanded through telehealth. These include: •BMI screening and follow up for children with high BMIs •Nutritional and exercise counseling for children with high BMIs •Motivational Interviewing (MI) for children and adults provided by Licensed Clinical Social Workers trained in MI •Blood Pressure (BP) screening/medication management for patients with high BP •Diabetic screening and medication management •Depression Screening with counseling (such as Cognitive Behavioral Therapy) and medication management •Nutritional Counseling for Adults with obesity, diabetes or other chronic conditions •Stanford University Chronic Disease Self-Management Programs (CDSMP): Living Well with Chronic Conditions, and Take Charge of Your Diabetes.						
Project Officer (PO):	**Name:**	Chinyere Amaefule				
	Tel #:	301-594-4417				
	Email:	camaefule@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA):	**Name:**	Coleman Tanner				
	Tel #:	404-413-0314				
	Email:	ctanner18@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Kentucky

Purchase District Health Department, Inc.

Grant Number:	D06RH37519					
Organization Type:	Public Health Department					
Grantee Organization:	**Project Name:**	Using Community Health Workers to Reduce Hospital Readmissions and the Impact of Value-Based Care on Rural Health Care Systems				
	Address:	916 Kentucky Ave.				
	City:	Paducah	**State:**	Kentucky	**Zip code:**	42003
	Tel #:	270-444-9625, Ext. 191				
	Website:	http://www.purchasehealth.org/				
Primary Contact:	**Name:**	Kaitlyn Krolikowski				
	Title:	Network Director				
	Tel #:	270-444-9625 x 161				
	Email:	kkrolikowski@purchasehealth.org				
Secondary Contact:	**Name:**	Kaylene Cornell				
	Title:	Project Director				
	Tel #:	270-444-9625, Ext. 180				
	Email:	kaylenes.cornell@ky.gov				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Purchase Area Health Connections Network	McCracken	KY	Network Org.
	Jackson Purchase Medical Center	Graves	KY	Hospital
	Marshall County Hospital	Marshall	KY	Hospital

Counties the project serves:	
	Ballard County, KY
	Calloway County, KY
	Carlisle County, KY
	Fulton County, KY
	Graves County, KY
	Hickman County, KY
	Marshall County, KY
	McCracken County, KY

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐

	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☐	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Community Health Workers
	Secondary Focus Area:	Alternative Payment Models

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Continue to strengthen the rural health care Network by further developing sustainability and collaboration.
	Objective	Complete HRSA deliverables (five-year strategic plan, evaluation plan, marketing plan, business model, final sustainability plan.
	Objective	Expand the network to include other partners to increase coordination of care and access to service through resource directory.
	Objective	By June 30, 2023 increase coordination of care and access to services and improve data compatibility among the hospitals HER and data systems to allow for health information exchange.
	Objective	By June 30, 2021, identify an initial list of policies and trends in healthcare that Network members believe have an impact on rural health care, including value-based care models.
	Objective	By December 31, 2022, complete training of Network members on value-based care models, and other identified training needs focusing on models implemented in rural areas including expanded CHW training through the development of webinars.
	Objective	By June 30, 2023, provide a report to the Network on value-based care including a potential implementation strategy for the Network.
	Objective	By June 30, 2021 identify barriers due to COVID-19 for the network.
	Goal	Reduce hospital readmission rates in the rural target service area.
	Objective	Year 1: At least 50 at-risk patients referred to PAHC for CHW expansion; receive follow up phone calls/home visit in 72-hours.
	Objective	Year 1:Reduce readmission rates among those served by the pilot by at least 2%.
	Objective	Year 1-3: Seventy percent of patients/family/caregivers report increased confidence and understanding of patient care and condition.
	Objective	Year 2: At least 250 at-risk patients referred to PAHC; receive follow up phone calls/home visit in 72-hours.
	Objective	Year 2: Reduce readmission rates among those served by 5%.
	Objective	Year 3: At least 500 at-risk patients referred to PAHC
	Objective	Year 3: Reduce readmission among those served by 10%
	Objective	By June 30, 2023 CHW program protocols integrated into at least one of the partner hospitals.
	Objective	By June 30, 2021 identify barriers and effects on program utilization and hospital readmissions due to COVID-19 and telehealth.
	Objective	By Dec. 31, 2021 develop education for clients on accessing telehealth.

Project Description:

Purchase District Health Department is the fiscal agent on behalf of the Purchase Area Health Connections Network (PAHC) for the project "Using Community Health Workers to Reduce Hospital Readmissions." Grant funding supports PAHC, a rural health Network in western Kentucky with an eight-county service area, for three purposes: 1) to continue to strengthen the Network and its members; 2) to better understand value-based care and its impact on rural health care systems; and 3) to improve population health and reduce hospital readmissions by developing a joint system of transitional care.

Kentucky ranks 50thin the nation for avoidable readmissions, and the western Purchase District of the state is characterized by high rates of poverty, provider shortages, and barriers to accessing care. PAHC will train Community Health Workers (CHWs) to collaborate with two new member hospitals to meet with patients about to be discharged to home and develop a post-discharge plan. Following best practices and evidence-based models, the CHWs will engage the patients in a series of follow up in-home visits and phone calls 30-90 days following discharge. These visits and calls will assist and empower recently discharged patients to better understand and take ownership of their health once they return home.

Network members previously designed the program, tested it with a pilot group, and refined it using a continuous quality improvement approach. Now, it is expanding to new hospitals, specifically Jackson Purchase Medical Center and Marshall County Hospital, collecting data from the replication to test the effectiveness of the model in reducing readmissions, especially among those patients at the highest risk of readmission. This approach will improve Network member collaboration while strategically addressing some of the social determinants of health faced by area residents.

This replication effort will provide the opportunity to compare outcomes from patients in the expanded area with prior results. The Network will also compare hospital readmission rates at the two new hospitals with the previously served hospitals to determine the effectiveness of the program. The intention is to submit the program's results for consideration as a promising practice or evidence-based practice.

Additionally, the Network will work with a consultant to help all Network members to understand the impact of value-based care on each individual Network member, community systems of care, and potential impact on Network members that are not presently participating in these cost containment strategies.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The intention is to submit this program's results for consideration as a promising practice or evidence-based practice. Evidence-Based/Promising Practices followed will include:

- "Community Health Coaches for Successful CareTransitions";
- "MI-Connect Community Health Worker Program";
- "Abbeville County's Community Paramedicine Program";
- CHW's Evidence-Based Toolkit, provided by the Rural Health Information Hub.

Project Officer (PO):	**Name:**	Katy Lloyd				
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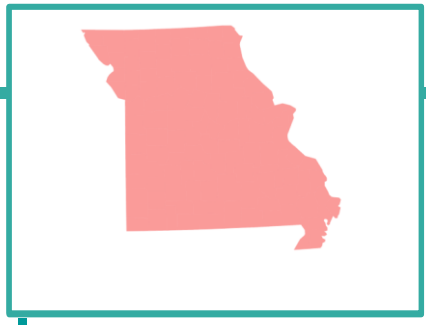
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303



Missouri

Randolph County Caring Community, Inc.

Grant Number:	D06RH37520					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	Innovative Strategies				
	Address:	101 W Coates St., Ste. 201				
	City:	Moberly	**State:**	Missouri	**Zip code:**	65270
	Tel #:	660-263-7173				
	Website:	https://randolphcaringcommunity.org				
Primary Contact:	**Name:**	Brian K Williams				
	Title:	Executive Director				
	Tel #:	660-263-7173				
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Secondary Contact:	**Name:**	Tela Saunders				
	Title:	Project Director				
	Tel #:	660-651-3532				
	Email:	telasaunders@rcccpmo.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Randolph County Caring Community Partnership RCCCP	Randolph	MO	Nonprofit Network Org.
	Randolph County Health Dept	Randolph	MO	Public Health Dept.
	Monroe County Health Dept.	Monroe	MO	Public Health Dept.
	Schultz Psychological Services	Cole	MO	Psychologist
	Compass Health	Chanton	MO	FQHC
	Sam's Health Mart	Randolph	MO	Pharmacy
	Timberlake Christian Counseling	Randolph	MO	Nonprofit Org./Mental Health
	Lighthouse Counseling Services	Randolph	MO	Nonprofit Org./Mental Health
	Olive Tree Counseling Services	Randolph	MO	Nonprofit Org./Mental Health
	Crossroads Counseling Services	Howard	MO	Nonprofit Org./Mental Health
	Randolph County Ambulance	Randolph	MO	Emergency Medical Services

Counties the project serves:		
	Chariton County, MO	Howard County, MO
	Randolph County, MO	Monroe County, MO

Target population served:	Population	Yes	Population	Yes
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:		
	Primary Focus Area:	Community Health Workers
	Secondary Focus Area:	Behavioral Health/Mental Health - General

Project goals & objectives:	Goal/ Objective	Description
	Goal	Increase the capacity of the Rural Mental Health Network (RMHN) to transition from an evolving into a mature network.
	Objective	Strengthen governance infrastructure.
	Objective	Enhance management performance processes.
	Objective	Expand network membership to be inclusive of diverse partners and providers.
	Objective	Provide formal engagement process for new network members.
	Goal	Expand existing Care Coordination model through integration of a Collaborative Care model.
	Objective	Evaluate the effectiveness of the integration of the Collaborative Care model.
	Objective	Strengthen the capacity of clinical service providers to implement the Collaborative Care model.
	Objective	Include Community Health Workers as members of the Collaborative Care model.
	Objective	Document patient outcomes from services received through the Collaborative Care model.
	Goal	Maximize limited rural health resources through collaboration and coordination
	Objective	Review and update current list of health and social health resources in targeted area.
	Objective	Identify and comprise list of new health and social health providers.
	Objective	Cultivate new partnership and relationship opportunities.
	Objective	Align resources and needs effectively.
	Goal	Enhance network sustainability.
	Objective	Identify sustainable network components and outcomes.
	Objective	Develop dashboard of program outcomes for dissemination among key stakeholders.
	Objective	Review strategic plan and identify priorities for sustainability.
	Objective	Identify public and private sector partners for financial support.

Project Description:

Innovative Strategies primary/overarching purpose is to integrate the existing and rural-relevant CHW Care Coordination model with the clinically driven Collaborative Care Team model, a practice of integrated care that operationalizes the principles of the Chronic Care Model, to improve access to evidence based mental health treatments for primary care patients.

The target population to be served by the project resides in a service area comprised of the adjoining/adjacent rural Northeast Missouri counties of Randolph, Monroe, Chariton, and Howard, populated by 51,632 residents located throughout a large expanse of 2,397 square miles. The Target Population that will benefit from increased access to services and resources through

Innovative Strategies' Care Models is comprised of residents over the age of 18 and their affected family and community members with the following characteristics and disparities: unemployed; uninsured; history of mental illness; acute and chronic pain; chronic illness; history of substance abuse; lack of social support networks and connections.

The purpose of the Rural Mental Health Network (RMHN) is to provide integrated mental health and primary healthcare services in the Northeast Missouri region. Total number/facility/entity type of network members: 11 key rural health network members representing mental health, primary healthcare, behavioral health, pharmacy, emergency medical transportation, and community-based services.

Project activities/services include: Building on RCCCP's established RMHN framework, Innovative Strategies will increase access to mental health and related services and resources by expanding existing client-centered Care Coordination Model that effectively utilizes Community Health Workers (CHW) to assist clients in navigating and accessing essential clinical services and community-based resources with a Collaborative Care Team model engaging multiple clinical providers and CHWs.

Expected outcomes of the project include:

- Improve access and quality of health care in rural areas through sustainable health care programs created as a result of network collaboration;
- Prepare rural health networks for the transition to value-based payment and population health management;
- Demonstrate improved health outcomes and community impact;
- Promote the sustainability of rural health networks through the creation of diverse products and services;
- Utilize and/or adapt an evidence-based or promising practice model(s) in the delivery of health care services.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Innovative Strategies project will integrate the rural-relevant, evidence-based CHW model of Collaborative Care into the Care Coordination model that will establish, strengthen, coordinate, and sustain a system of mental health services and resources within this needful, rural, targeted service area, in order to expand and improve access.

Project Officer (PO):	**Name:**	Chinyere Amaefule				
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	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA):	**Name:**	Eric Baumgartner				
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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Georgia

Rural Health Works, Inc.

Grant Number:	D06RH37521					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	Southeast Georgia Obesity Prevention Network				
	Address:	504 Maple Dr., Ste. B				
	City:	Vidalia	**State:**	Georgia	**Zip code:**	30474
	Tel #:	478-254-5210				
	Website:	www.chwg.org				
Primary Contact:	**Name:**	Fred Ammons				
	Title:	CEO				
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Secondary Contact:	**Name:**	Ursula Spece				
	Title:	Project Director				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$299,986
	Jul 2021 to Jun 2022	$299,945
	Jul 2022 to Jun 2023	$299,989

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Meadows Regional Medical Center	Toombs	GA	Hospital
	Southeast Regional Primary Care Corporation (SRPCC)	Toombs	GA	Physician Practice
	Montgomery County Schools,	Montgomery	GA	School District
	Toombs County Schools,	Toombs	GA	School District
	Treutlen County Schools	Treutlen	GA	School District
	Wheeler County Schools	Wheeler	GA	School District
	Vidalia City Schools	Toombs	GA	School District
	Toombs County Family Connection	Toombs	GA	Nonprofit Org.
	TriCounty Family Connection	Montgomery	GA	Nonprofit Org.

Counties the project serves:		
	Montgomery County GA	Treutlen County, GA
	Toombs County, GA	Wheeler County, GA

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☐	Pre-school children (3-4 years)	☒
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☐	School-age children (elementary ~ 5-12 years)	☒
	Infants and toddlers (up to 3 years)	☐	School-age children	☒

			(Middle/high school ~13-17 years)	
	Latinos	☒	Uninsured	☒
	Native Americans	☐	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	School-based Health	
	Secondary Focus Area:	Chronic Disease	
	Other Focus Area:	Obesity Prevention	☒ Secondary

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Prepare the region to implement a cohesive multipronged solution to improve access to and utilization of effective obesity prevention and treatment.
	Objective	Enhance the network's autonomy, self-sufficiency, governance, and viability.
	Objective	Develop a comprehensive network communications plan to guide messaging to internal and external stakeholders.
	Objective	Improve the quality of obesity care in the network catchment area by assisting medical providers develop technical capacity.
	Objective	Strengthen the internal capacity of school systems in the network catchment area to incorporate nutrition and physical activity programming into school culture.
	Objective	Develop and pilot an afterschool family centric education, counseling, and behavioral modification program.
	Objective	Investigate and advocate for built environment changes that enhance resident's ability to effectuate lifestyle changes.
	Objective	Augment medical interventions by the establishment of a peer health champion coaching program.

Project Description:

The goal of this Southeast Obesity Prevention Network project is to prepare the region to implement a cohesive multipronged solution to improve access to and utilization of effective obesity prevention and treatment. Southeast Georgia Obesity Prevention Network was formed to create a cohesive regional plan to improve access to effective obesity prevention interventions in the region. The members include one healthcare non-profit charity, a public safety-net regional hospital, an integrated physician group, five school systems, and two family connection collaboratives.

Developed over the course of a year-long community wide needs assessment and strategic planning process, the goal of preparing the region to implement a cohesive multipronged solution to improve access to and utilization of effective obesity prevention and treatment will be achieved by accomplishing the following distinct objectives:
(1) enhancing the network's autonomy, self-sufficiency, governance, and viability;
(2) developing a comprehensive network communications plan to guide messaging to internal and external stakeholder;
(3) improving the quality of obesity care in the network catchment area by assisting medical providers develop technical capacity;
(4) strengthen the internal capacity of school systems in the network catchment area to incorporate nutrition and physical activity programming into school culture;
(5) develop and pilot an afterschool family centric education, counseling, and behavioral modification program,
(6) investigate and advocate for built environment changes that enhance resident's ability to effectuate lifestyle changes, and
(7) augment medical interventions by the establishment of a peer health champion coaching program.

The proposed project will achieve efficiencies through provider collaboration and coordination, expand access to health care services by tackling environmental and cultural barriers, and improve the quality of health care services by providing providers and their staff with the necessary tools to effectively manage the population.

Further, the long-term impact of the project –a nimble and adaptive provider community, a healthier population, and a collaborative community – will result in the transformation and strengthening of the entire rural health care system.

Evidence Based/ Promising Practice Model Being Used or Adapted:						
Because childhood and adult obesity is such a complex issue, solving this epidemic will take the commitment of a variety of community stakeholders. Accordingly, although this Network was founded primarily by medical providers, the vision for this Network is to be modeled on the Collective Impact Model for rural health networks and coalitions. In addition, the Network will consult existing health network organizations such as the Community Health Center Network and the National Cooperative of Health Networks.						
Project Officer (PO):	**Name:**	Robyn Williams				
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	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA):	**Name:**	Coleman Tanner				
	Tel #:	404-413-0314				
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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Wisconsin

Rural Wisconsin Health Cooperative

Grant Number:	D06RH37522					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	RWHC Care Coordination Project				
	Address:	880 Independence Ln.				
	City:	Sauk City	**State:**	Wisconsin	**Zip code:**	53583
	Tel #:	608-644-3237				
	Website:	www.rwhc.com				
Primary Contact:	**Name:**	Louis A Wenzlow				
	Title:	Project Director				
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Secondary Contact:	**Name:**	Cheryl DeVault				
	Title:	Project Manager				
	Tel #:					
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$299,985
	Jul 2021 to Jun 2022	$299,994
	Jul 2022 to Jun 2023	$299,997

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Black River Memorial Hospital	Jackson	WI	Hospital
	Crossing Rivers Health	Crawford	WI	Hospital
	Cumberland Healthcare	Barron	WI	Hospital
	Divine Savior Healthcare	Columbia	WI	Hospital
	Door County Medical Center	Door	WI	Hospital
	Fort HealthCare	Jefferson	WI	Hospital
	Memorial Hospital Lafayette County	Lafayette	WI	Hospital
	Mile Bluff Medical Center	Juneau	WI	Hospital
	Richland Hospital	Richland	WI	Hospital
	Sauk Prairie Healthcare	Sauk	WI	Hospital
	Southwest Health	Grany	WI	Hospital
	St. Clare-SSM Baraboo	Sauk	WI	Hospital
	St. Croix Regional Medical Center	St. Croix	WI	Hospital
	ThedaCare Medical Center-Berlin	Green Lake	WI	Hospital
	ThedaCare Medical Center-Shawano	Shawano	WI	Hospital
	Upland Hills Health	Iowa	WI	Hospital
	Western Wisconsin Health	St. Croix	WI	Hospital

Counties the project serves:		
	Adams County, WI	Lafayette County, WI
	Barron County, WI	Marquette County, WI

	Burnett County, WI	Menominee County, WI
	Columbia County, WI	Polk County, WI
	Crawford County, WI	Richland County, WI
	Door County, WI	Sauk County, WI
	Grant County, WI	Shawano County, WI
	Green County, WI	St. Croix County, WI
	Lake County, WI	Waupaca County, WI
	Iowa County, WI	Waushara, County, WI
	Jackson County, WI	Winnebago County, WI
	Jefferson County, WI	
	Juneau County, WI	
	Kewaunee County, WI	

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:			
	Primary Focus Area:	Care Coordination	
	Secondary Focus Area:	Chronic Disease	
	Other Focus Area:	Advanced Care Planning	☐ Primary ☒ Secondary

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Expand the RWHC quality data analytics portal to new participants and new measures in order to enable project, clinic, and practitioner evaluation.
	Objective	Network participants will extract quality data from their EHRs and submit a QRDA1 file to Physician Compass in order to incorporate the specified quality measures into the RWHC project evaluation portal.
	Objective	RWHC will onboard ED visit and hospital discharge/readmission data from the Wisconsin Hospital Association Information Center (WHAIC) to the evaluation portal for all network participants. Summary of Care exchange data will also be collected from participant organizations.
	Goal	Finalize best practice tools/protocols to facilitate effective care coordination service implementation.
	Objective	Update the Rural Wisconsin Chronic Disease Toolkit to include care coordination service best practices for CCM, TCM, BHI, CoCM, IPPE, AWV, and ACP.
	Objective	Determine the role of WISHIN's PatientPing cross-organizational notification service for network member interventions.
	Objective	Finalize the Rural Caregiver Toolkit for Healthcare Organizations and plan for its implementation.
	Goal	Plan, test, implement, and expand the selected interventions that will lead to increased care coordination services in the target population.

	Objective	Conduct testing of the selected interventions using appropriate measures to determine their effectiveness.
	Objective	Refine and fully implement the selected interventions in order to achieve the expected outcomes improvements.
	Objective	Develop and execute plan for quality project expansions to new measures and new participants.

Project Description:

The Rural Wisconsin Care Coordination Project is a collaborative effort by the Rural Wisconsin Health Cooperative (RWHC) and seventeen rural Wisconsin healthcare organizations to improve outcomes and reduce costs associated with chronic disease management by implementing care coordination services in rural Wisconsin primary care settings. The Wisconsin Statewide Health Information (WISHIN), the Wisconsin Collaborative for Healthcare Quality (WCHQ), Physician Compass (a Quality Clinical Data Registry), and the American Association of Retired Persons (AARP) will be assisting in the effort.

The RWHC Care Coordination Project has the primary goal of increasing the utilization of care coordination services (such as Chronic Care Management, Transitional Care Management, Advanced Care Planning, General Behavioral Health Integration, and others) in order for participants to improve on a variety of NQF quality measures and reduce target population ED Visit and 30-day readmission rates.

The service area includes the Wisconsin counties served by the project participants. The total population of the service area is approximately 960,000 people. The project's target population are people in the service area with a chronic disease. The target population is approximately 40% of the total population, or 384,000 people.

The purpose of the RWHC Care Coordination Project is for network members to use shared resources/staff and lessons learned from each other's experience to implement care coordination services that will improve the outcomes of their target population. The participants are seventeen rural Wisconsin hospitals (both PPS hospitals and CAHs), which collectively operate forty-nine rural primary care clinics with over two hundred primary care providers.

Project activities will include:
(1) participants submitting QRDA1 files to a Qualified Clinical Data Registry (QCDR) in order for the network to track the trajectory of five project-related NQF/MIPS quality measures;
(2) participants and network staff developing best practice tools and protocols that will facilitate effective care coordination service implementation;
(3) the implementation of a currently in development Rural Family Caregiver Toolkit, and;
(4) the planning, testing, and implementation of care coordination services that the participants have selected from the following list:
•Chronic Care Management (CCM)
•Transitional Care Management (TCM)•General Behavioral Health Integration (BHI)
•Psychiatric Collaborative Care Model (CoCM)
•Initial Preventive Physical Examination (IPPE)
•Annual Wellness Visit (AWV)
•Advanced Care Planning (ACP).

Expected outcomes for the target population include improved blood pressure and HbA1C control; increased preventative services (including pneumococcal vaccination and breast cancer screening); reduced cost associated with ED visits and 30-day hospital readmissions; and increased family caregiver referrals to Wisconsin Aging and Disability Resource Centers (ADRCs).

Evidence Based/ Promising Practice Model Being Used or Adapted:

This project will deliver best practice tools for effective care coordination service implementation by:

Partnering with the Wisconsin Collaborative for Healthcare Quality (WCHQ), the Network will update the current Rural Wisconsin Chronic Disease Toolkit to include a new section with strategies to support the implementation of a variety of care coordination

services (CCM, TCM, ACP, AWV, IPPE, BHI, and CoCM). Each participant will select and begin planning to test and implement one or more of these care coordination services.

Partnering with the Wisconsin Statewide Health Information Network (WISHIN), the Network will evaluate PatientPing, a cross-organizational patient transition notification platform, in supporting the selected care coordination interventions.

Partnering with AARP, the Network will distribute the Rural Caregiver Toolkit to assist in the integration of family caregivers in supporting coordination of care services. This toolkit is currently in development and should be completed by the project start date. RWHC has been collaborating with AARP on this toolkit in order to help rural healthcare organizations provide patients and caregivers with Advance Directive handouts and community resource guides, which will support the requirements of Chronic Care Management, Transitional Care Management, and Advance Care Planning services.

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South Dakota

Sacred Heart Health Services

Grant Number:	D06RH37523					
Organization Type:	Hospital					
Grantee Organization:	**Project Name:**	Upper Midwest Palliative Care Education Network				
	Address:	501 Summit St.				
	City:	Yankton	**State:**	South Dakota	**Zip code:**	57078
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	Website:	https://www.avera.org/locations/sacred-heart/				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	South Dakota State University	Brookings	SD	Academic/University
	Mount Marty College	Yankton	SD	Academic/College
	Presentation College	Brown	SD	Academic/College

Counties the project serves:		
	Brookings County, SD	Yankton County, SD
	Brown County, SD	

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☐	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:		
	Primary Focus Area:	Workforce Development
	Secondary Focus Area:	Care Coordination

	Other Focus Area:	Palliative Care	☒ Secondary

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Increase knowledge of palliative care among students in healthcare professions, providers, patients and their family members, as well as communities across South Dakota and create a palliative care education model that can consistently be replicated by health care organizations and institutions of higher education throughout the state.
	Objective	Establish a sustainable and collaborative healthcare network by December 1, 2020
	Objective	Develop, deliver, and disseminate a curriculum to be used by area institutions of higher education by August 1, 2021.
	Objective	Design and provide continuing education opportunities for existing staff in healthcare facilities across South Dakota by June 30, 2021 and ongoing throughout the project period.
	Objective	Educate and engage community members (including patients and family members) on the topic of palliative care throughout the state of South Dakota by Dec. 31, 2020 and ongoing throughout the project period.
	Objective	Evaluate the effectiveness of network activities at yearly intervals and by June 30, 2023.

Project Description:

The goal of the Upper Midwest Palliative Care Education Network is to increase knowledge of palliative care among students in healthcare professions, providers, patients and their family members, as well as communities across South Dakota and create a palliative care education model that can consistently be replicated by health care organizations and institutions of higher education throughout the state. The overall target population includes students enrolled in nursing and other healthcare-related courses, current healthcare professionals, and community members and families of palliative care patients. The secondary target population includes palliative care patients throughout rural South Dakota.

Vision
The Upper Midwest Palliative Care Education Network envisions a state where all individuals have access to and receive necessary care to manage their illnesses.
Mission
The Upper Midwest Palliative Care Education Network's mission is to improve access to quality palliative care for all South Dakotans by advocating for community-based resources and greater awareness.
Strategic Purpose Statement
The Upper Midwest Palliative Care Education Network serves patients throughout rural South Dakota by increasing knowledge of palliative care among students in healthcare professional programs, healthcare professionals, patients, families, and communities through a statewide partnership with healthcare facilities, educational institutions, and the community.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The Upper Midwest Palliative Care Education Network intends to explore evidence-based practices or models during the grant performance period to determine if an existing model could be partially or fully implemented in South Dakota. The Center to Advance Palliative Care (CAPC), a supporter of Avera Sacred Heart Hospital's proposal, has a variety of evidence-based modes and information that can be utilized. CAPC previously partnered with Avera Sacred Heart Hospital on the HRSA Rural Health Network Development Planning Program planning grant awarded in 2018, which involved a year of planning and assessment to further assess the perception of palliative care among patients, providers, and family members and explore possible solutions to address the uneven access to palliative care.

A promising model, the End-of-Life Nursing Education Consortium (ELNEC) project, is a national education initiative to improve palliative care and is a partnership between the American Association of Colleges of Nursing (AACN) and City of Hope, a comprehensive cancer center based in Duarte, Calif. The project provides undergraduate and graduate nursing faculty, continuing

education providers, staff development educators, specialty nurses in pediatrics, oncology, critical care and geriatrics, and other nurses with training in palliative care so they can teach this essential information to nursing students, practicing nurses, and other healthcare professionals.						
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Oregon

Sky Lakes Medical Center Foundation, Inc.

Grant Number:	D06RH37524					
Organization Type:	Hospital					
Grantee Organization:	**Project Name:**	Healthy Klamath Network for Expanded Diabetes Management				
	Address:	2865 Daggett Ave.				
	City:	Klamath Falls	**State:**	Oregon	**Zip code:**	97601
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Sky Lakes Medical Center	Klamath	OR	Hospital
	Klamath County Public Health	Klamath	OR	Public Health Dept.
	Cascade Health Alliance	Klamath	OR	Managed Care Org.
	Klamath Health Partnership	Klamath	OR	FQHC

Counties the project serves:	Klamath County, OR			
Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐
Focus Areas:	**Primary Focus Area:**	Community Health Workers		

	Secondary Focus Area:	Chronic Disease
Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Strengthen an existing rural health care network to improve diabetes-related outcomes among residents in Klamath County, OR.
	Objective	A formalized partnership exists between Healthy Klamath Network members by September 2020. (Legislative Aims 2 & 3)
	Objective	A communication system is created to increase coordination of resources by December 2020. (Legislative Aims 1, 2, & 3)
	Objective	A Healthy Klamath Sustainability Plan has been developed by September 2021. (Legislative Aim 3)
	Objective	Healthy Klamath partners are sharing data by December 2020. (Legislative Aim 1)
	Objective	A Healthy Equity Strategic Plan for improving equitable interventions is adopted by December 2021. (Legislative Aim 1 & 3)
	Objective	Referrals for care management from primary care providers increases by 10% by July 31, 2021. (Legislative Aim 2)
	Objective	A second community-based DPP program that is culturally relevant to Klamath County residents is available July 2021. (Legislative Aim 2)
	Objective	The number of patients diagnosed with pre-diabetes who are enrolled in a DPP program increases by 5% by September 2021. (Legislative Aim 2)
	Objective	Increased patient participation in prevention screenings, exams, and dietary/nutrition counseling to help achieve glycemic & blood pressure control by July 2022. (Legislative Aim 2)
	Objective	Innovative alternative payment and delivery models are in place by October 2023. (Legislative Aims 1, 2, & 3)

Project Description:

The target population that will be served by this project are community members living in rural Oregon and California that experience social, economic, and physical barriers to successfully managing and/or preventing diabetes. Specifically, the interventions will focus on patients with Medicare that are diagnosed with diabetes that have an HbA1c greater than 9.0,with additional focus on patients with a primary language of Spanish. In addition to network development activities, the Healthy Klamath Network will be working on targeted Diabetes Management Program using evidence-based models for Community Health Workers (CHW) that are culturally appropriate for the target population. This target population was selected due to the disproportionate number of patients with diabetes in poor control, in addition to their lack of clinical oversight and unique patient demographics. Further, by expanding the footprint of the CDC's Diabetes Prevention Program (DPP), the Network will also focus on patients at high risk for developing diabetes.

The outcomes expected from the project include:
1) Improve the quality, coordination, and cost of health care services in the target community by strengthening an existing rural health care network;
2) Increase community/patient access to health care services by expanding the footprint of current DPP initiatives (particularly to Spanish-speaking populations);
3) increase the network of referrals and patient engagement in the community by utilizing Community Health Workers; and
4) Improve overall health outcomes for the target population (i.e., patients at-risk of developing diabetes as well as those with poorly managed diabetes.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The goal of the Healthy Klamath Expanded Network for Diabetes Management is to improve the overall health and well-being of people in the community. The Network is built upon several evidence-based models including the IMPaCT program from Penn Center for Community Health Workers1, the Center for Disease Control's (CDC) proven Promotora de Salud model, and components of other self-management and community health worker models identified in the Rural Information Hub (RHIhub) Rural

Community Health Worker Toolkit. The combination of these approaches has helped identify and engage with the most disconnected and at-risk members of the community. Replicability is a vital part of this program and is one of the many reasons for choosing well-established evidence-based models for implementation. The evidence-based models to be deployed by the Network are all well recognized, reputable models that have a proven track-record of successful replication across the country and world. By utilizing these well-established models, Healthy Klamath: Expanded Network for Diabetes Management will be positioned to replicate locally, regionally, and beyond. The IMPaCT model will be primary utilized. However, due to the unique target population elements will be combined to best meet the needs of the community. For example, key components of the Promotora de Salud model will be tied in to support the Spanish speaking community and other important templates and guides will be pulled from the Rural Community Health Worker Toolkit as needed.

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Kentucky

St. Claire Medical Center, Inc.

Grant Number:	D06RH37525					
Organization Type:	Hospital					
Grantee Organization:	**Project Name:**	Provider Resources and Outreach Through Education and Clinical Training (PROTECT)				
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	Website:	https://www.st-claire.org				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Northeast Kentucky Area Health Education Center	Rowan	KY	AHEC
	Clark County Health Department	Clark	KY	Public Health Dept.
	Comprehend, Inc.		KY	Nonprofit Org./Mental Health
	Tri-State Primary Care	Boyd	KY	Medical Group Practice
	Kentucky Rural Healthcare Information Organization	Franklin	KY	Nonprofit Org./Health Information
	Gateway District Health Department	Bath	KY	Public Health Dept.
	Pathways, Inc.	Rowan	KY	Nonprofit Org./Mental Health
	Achieving Recovery Together	Clark	KY	Recovery Org.

Counties the project serves:		
	Bath County, KY	Mason County, KY
	Carter County, KY	Menifee County, KY
	Clark County, KY	Montgomery County, KY
	Elliott County, KY	Morgan County, KY
	Fleming County, KY	Nicholas County, KY
	Greenup County, KY	Powell County, KY

	Lawrence County, KY		Robertson County, KY	
	Lewis County, KY		Rowan County, KY	
	Magoffin County, KY		Wolfe County, KY	
Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☒
	Latinos	☒	Uninsured	☒
	Native Americans	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Behavioral Health/Mental Health - Substance Use Disorder	
	Secondary Focus Area:	Workforce Development	
	Other Focus Area:	Youth Opioid Prevention Education	☒ Secondary

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	To expand MAT and related opioid use disorder services in northeastern Kentucky by addressing gaps in rural primary care provider training and support.
	Objective	Establish a training program for MAT certification and continuing education for rural providers in 18 counties by August 2020 through June 30, 2023.
	Objective	Create an MAT provider mentorship program for providers that obtained the waiver to provide services under our other grant programs but have indicated they do not yet feel confident enough to begin providing services, as well as for other providers interested in obtaining the waiver by October 2020 through June 30, 2023.
	Objective	Track the community impact by monitoring the number of providers receiving training, number of providers receiving mentoring services, number of providers using MAT, and number of patients receiving MAT from these providers from August 2020 through June 30, 2023.
	Goal	Offer Hepatitis C training and support to rural primary care providers in collaboration with the Kentucky Rural Health Association/University of Louisville's Kentucky Hepatitis Academic Mentorship Program (KHAMP) beginning November 2020-June 30, 2023.
	Objective	Coordinate with KRHA/University of Louisville to offer KHAMP trainings and provide mentorship for primary care providers across the region from August 2020 through June 30, 2023.
	Objective	Track community impact by monitoring the number of providers that receive training and academic mentorship and the number of patients receiving Hepatitis C Virus (HCV) services from August 2020 through June 30, 2023.
	Goal	To increase education to rural youth about drug misuse prevention from September 1, 2020,to June 30, 2023.
	Objective	Review Generation Rx curriculum (developed by The Ohio State University and the Cardinal Health Foundation) and training schedule by October 1, 2020
	Objective	Establish partnerships with schools across the region by October 2020 and on-going throughout the three-year project period.
	Objective	Deliver prevention education at least one time in each of the 18 service area counties from October 1, 2020-June 30, 2023.
	Objective	Track number of youth that receive education and assess knowledge using pre-post test method from October 1, 2020-June 30, 2023.

Project Description:

Kentucky has one of the top 10 highest rates of drug overdose mortality in the nation. High rates of drug use have resulted in a 50% increase in HIV cases and KY now has the highest Hepatitis C infection rate in the nation. Critical shortages of primary care providers and substance use services have created a gap in the healthcare system.

This Coalition is a formal network of seven health care and social service organizations –representing 18 counties –focused on building a community-based approach to addressing the opioid crisis.

Project Activities include the establishment of a model regional training resource center using three evidence-based strategies including 1) Continuing Medical Education; 2) Mentoring; and 3) Youth prevention education. The proposed project will focus on increasing access to Medication-Assisted Treatment (MAT), an evidence-based response for treating persons diagnosed with substance use disorder/opioid use disorder (SUD/OUD). MAT delivered in the primary care setting is more accessible and patients are more likely to enter treatment if they can do so in their home community.

Expected Outcomes are increased access to SUD/OUD services as a result of increases in the number of MAT providers, enhanced access to Hepatitis C treatment, and a stronger health care system based on a community-focused response toward prevention and treatment of SUD/OUD.

Evidence Based/ Promising Practice Model Being Used or Adapted:

To facilitate the success of this demonstration project during which the Coalition will establish a model training resource center, there are three key evidence-based practices that will guide our activities: 1) continuing medical education; 2) mentorship; and 3) youth prevention education.

1.Continuing Medical Education: Continuing medical education(CME) refers to a specific form of continuing education that helps those in the medical field maintain competence and learn about new and developing areas that may improve patient outcomes. There is scholarly support for our strategy of using accredited educational activities. A 2015 meta-analysis in the Journal of Continuing Education in the Health Professions found that "[continuing medical education] does improve physician performance and patient health outcomes" and that activities "focused on outcomes that are considered important by physicians lead to more positive outcomes."

2.Mentorship: Supporting primary care practitioners in the provision of MAT services is increasingly recognized as the highest standard of care, especially in rural communities such as the project service area where treatment options are limited and transportation barriers reduce access to other providers across the state. The mentorship model will work to rapidly increase the number of providers who are confident in their provision of MAT services. In a review of a national program that provides similar mentoring and educational outreach to primary care practitioners, it was found that supportive programming like this addresses the needs of patients with opioid use disorder and other co-occurring psychiatric and medical disorders.

3.Prevention Education-Generation Rx: The strategy for addressing youth drug abuse prevention will be the Generation Rx curriculum developed by the College of Pharmacy at The Ohio State University and the Cardinal Health Foundation. Research indicates the following are important evidence-based quality criteria for youth prevention education in schools: "interactive delivery methods are superior; the "social influence model" is the best we have; focus on norms, commitment not to use, and intentions not to use; adding community interventions increases effects; the use of peer-leaders is better; and adding life skills to programs may strengthen effects."

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Florida

St. Johns River Rural Health Network, Inc.

Grant Number:	D06RH37526					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	Putnam County Care Connect (PC3)				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Health Planning Council of Northeast Florida, Inc. (HPCNEF)	Putnam	FL	Nonprofit Org.
	SMA Healthcare (SMA)	Putnam	FL	Nonprofit Org./Mental health

Counties the project serves:	Putnam County, FL

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:		
	Primary Focus Area:	Telehealth
	Secondary Focus Area:	Behavioral Health/Mental Health - General

Project goals & objectives:	Goal/ Objective	Description
	Goal	Integrated health networks will focus on integrating health care services and health care delivery of services to achieve efficiencies and improve rural health care services.
	Objective	Improve coordination of services by creating a centralized care connect portal through HPCNEF website for Putnam County Care Connect (PC3).
	Goal	Integrated health networks will collaborate to expand access to and improve the quality of essential health care services by focusing on projects and network activities related to the evolving health care environment.
	Objective	Implementing resource management, telehealth service, and sustainability-focused data portal.
	Goal	Networks are encouraged to improve population health by implementing promising practice, evidence-informed and/or evidenced-based approaches to address health disparities and enhance population health in their communities.
	Objective	Implementing innovative and alternative payment and delivery models.

Project Description:

The project service area is Putnam County, Florida, an 827 square mile area. Network Partners include a non-profit, St. Johns River Rural Health Network (SJRRHN), serving as the lead applicant in partnership with two non-profit agencies: Health Planning Council of Northeast Florida, Inc. (HPCNEF) and SMA Healthcare (SMA),and will address the challenges in providing access to behavioral health services in Putnam County.

The PC3 project is composed of three distinct but interrelated components: an online, real-time virtual meeting space to provide coordination for providers and access to resources for consumers, an easily accessible telehealth service for medical, behavioral and psychosocial services, and an online central repository for evidence-based approach assessment.

Proposed activities and expected outcomes include:

Legislative Aim #1: Achieve efficiencies
Goal: Integrated health networks will focus on integrating health care services and health care delivery of services to achieve efficiencies and improve rural health care services.

The project Putnam County Care Connect (PC3) proposes to address Legislative Aim 1 by creating a virtual meeting space provided by the contracted services of Cureo. This website plug-in will allow for the efficient coordination of consumer services. CareClix contracted services will create a telehealth service within the HPCNEF website allowing consumers to complete medical, behavioral health and psychosocial support services. EK3 Technologies will create a population health data portal to track the improvements in rural population health and the data needed for community health project sustainability.

Legislative Aim #2: Coordinate and expand access to behavioral health services
Goal: Integrated health networks will collaborate to expand access to and improve the quality of essential health care services by focusing on projects and network activities related to the evolving health care environment.

The virtual meeting space created in the HPCNEF website through the use of Cureo's "plug-in" application allows for high volume management of the many complex moving parts in the behavioral health community. Cureo allows connected organizations to continue to provide quality and essential behavioral health services by identifying and coordinating the best resources for consumers without duplication of efforts and multiple frustrating phone calls. CareClix telehealth services allow for stress free appointments for consumers struggling with a transportation barrier. EK3 data portal will allow organizations to utilize the most current data to sustain their projects.

Legislative Aim #3: Strengthen the rural health care system as a whole.

Goal: Networks are encouraged to improve population health by implementing promising practice, evidence-informed and/or evidenced-based approaches to address health disparities and enhance population health in their communities.

The EK3 data portal within the HPCNEF website will provide a centralized repository for organizations to assess evidence-based approaches for implementation within their organizations. The use of Cureo will provide communications for training in topics such as trauma-informed care and research on topics such as the National Culturally and Linguistically Appropriate Service (CLAS) Standards. The use of a telehealth platform will address disparities related to geographic location, provider shortages and lack of access to needed care.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The EK3 data portal within the HPCNEF website will provide a centralized repository for organizations to assess evidence-based approaches for implementation within their organizations. This network and the project will rely on EBPs including National Culturally and Linguistically Appropriate Service (CLAS) Standards.

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Technical Assistance (TA):	**Name:**	Ann Abdella				
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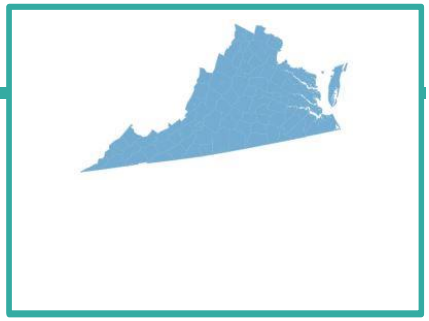
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303



Virginia

Strength in Peers, Inc.

Grant Number:	D06RH37527					
Organization Type:	Nonprofit Organization (other than a network nonprofit)					
Grantee Organization:	**Project Name:**	Virginia Peer Outreach Network: The Side by Side Recovery Project				
	Address:	9560 S Congress St.				
	City:	New Market	**State:**	Virginia	**Zip code:**	22844
	Tel #:	540-325-5869				
	Website:	www.strengthinpeers.org				
Primary Contact:	**Name:**	Lisa N Fadley				
	Title:	Executive Director				
	Tel #:	540-325-5869				
	Email:	nicky@strengthinpeers.org				
Secondary Contact:	**Name:**	Ragan McManus				
	Title:	Director of Operations and Network Director				
	Tel #:	540-217-0869				
	Email:	ragan@strengthinpeers.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Harrisonburg Center for Relational Health	Harrisonburg	VA	Behavioral Health Service Provider
	University of Virginia Medical Center	Charlottesville	VA	Academic/Hospital/Behavioral Health Service Provider
	On Our Own Charlottesville	Charlottesville	VA	Nonprofit Org./Behavioral Health

Counties the project serves:		
	Louisa County, VA	Shenandoah County, VA
	Page County, VA	

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☐	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Behavioral Health/Mental Health - Substance Use Disorder
	Secondary Focus Area:	Telehealth

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Develop a treatment program tailored to the needs of the most vulnerable and high need populations—particularly individuals who have histories of homelessness and incarceration—that includes outreach, peer support, telecounseling, and telepsychiatry.
	Objective	Establish the program policies and procedures regarding eligibility, intake, releases of information, data reporting, safety, crisis response, referrals, scheduling, and discharge by November 30, 2020. Review and update policies and procedures as needed.
	Objective	Hire and/or train program staff who will provide direct services, supervision, and administrative support by December 31, 2020.
	Objective	Conduct outreach to at least 200 individuals from the target population by June 30, 2023.
	Objective	Vet at least 100 individuals for potential enrollment in the program based on their motivation to engage in services by June 30, 2023
	Objective	Enroll at least 75 individuals in the program and provide at least two types of services to each by June 30, 2023.
	Objective	Maintain active engagement and successfully graduate a minimum of 70 percent of program participants through June 30, 2023.
	Goal	Develop the infrastructure for recovery community organizations (RCOs) to receive Medicaid reimbursement for peer support services provided as part of a clinical treatment plan.
	Objective	Develop a business plan for the program and formal agreements between UVA Medical Center and RCOs to bill Medicaid for peer support services and reimburse RCOs a negotiated proportion of the funds by December 31, 2021
	Objective	Provide Peer Support Specialists clinical oversight and direct supervision through June 30, 2023.
	Objective	Provide Peer Support Specialists and their supervisors training and continuing education to maintain their certifications through June 30, 2023
	Goal	To develop a system for providers to collaborate on participant cases and improve their capacity to serve individuals with high needs.
	Objective	Develop an ECHO project and provide network members 12 educational sessions and opportunities to present complex participant cases for recommendations from a panel of subject-matter experts by June 30, 2023.

Project Description:

The goal of the Side by Side Recovery Project is to improve the quality, accessibility and sustainability of substance abuse and mental health services for underserved populations that face barriers to accessing treatment facilities in rural Virginia. The project targets adults with substance abuse and mental health challenges, with a focus on high need individuals who have significant histories of homelessness and incarceration. The project will serve Louisa, Page and Shenandoah Counties in Virginia.

The mission of the Virginia Peer Outreach Network is to develop partnerships among clinical substance abuse and mental health treatment providers and recovery community organizations (RCOs) to improve the quality, accessibility and sustainability of services for vulnerable, high-need and hard-to-reach populations in Virginia. Network members include one clinical provider, the University of Virginia Medical Center, and two RCOs--Strength In Peers and On Our Own Charlottesville.

Activities of the project will include a substance abuse and mental health treatment program composed of a multi-disciplinary, collaborative treatment team. Peer Support Specialists employed by rural RCOs will conduct outreach; recruit participants; provide peer recovery support; and help participants to navigate community services. Counselors employed by HCRH and psychiatrists

employed by UVA Medical Center will provide assessments, therapy, and medication management to participants via telemedicine. Through this partnership, the Network will develop a gateway for RCOs to access Medicaid reimbursement for peer support services. The Network also will develop an ECHO telementoring program to give rural providers opportunities to learn from subject matter experts how to better care for high need individuals.

In the short-term, the project will increase outreach to high need populations that are not engaged in other treatment; increase access to and utilization of substance abuse and mental health services among the target population; and improve recovery indicators among participants including substance use, mental health, housing, employment, and recidivism. In the long-term, the project will develop the capacity of the Network to provide a viable pathway for RCOs to partner with clinical providers as part of multi-disciplinary teams and access Medicaid reimbursement for peer support services. The Network anticipates that it will expand over time to include more RCOs that seek to implement the program and develop Medicaid reimbursement as a source of sustainable revenue.

Evidence Based/ Promising Practice Model Being Used or Adapted:

At the heart of this project is the evidence-based consumer operated services model. Extensive evidence shows that peer support services provided by consumer operated organizations facilitate recovery and reduce health care costs.1Strength In Peers, On Our Own Charlottesville and other RCOs are consumer operated meaning that their governance body, administrative leadership, and staff are made up of behavioral health consumers and services are provided by peer workers. All Peer Support Specialists in this project will be trained under the Virginia Department of Behavioral Health and Developmental Disabilities program and certified under the Virginia Board of Certification. Additionally, Peer Support Specialists will receive ongoing professional development in evidence-based practices, including cultural sensitivity, trauma-informed care, ethics, and motivational interviewing.

Additionally, the project will implement the evidence-based Project ECHO model. ECHO is a telementoring project that resembles virtual grand rounds and links specialist teams at an academic hub with providers in local communities. Specialists in working with high need populations will be recruited from both clinical organizations and RCOs. Participants will join monthly teleconference meetings during which they will present challenging cases to the specialist teams and receive support and recommendations for treatment and service provision.

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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Wisconsin

Thedacare Medical Center - Shawano, Inc.

Grant Number:	D06RH37528					
Organization Type:	Hospital					
Grantee Organization:	**Project Name:**	Expansion of Rural Behavioral Health				
	Address:	100 County Road B				
	City:	Shawano	**State:**	Wisconsin	**Zip code:**	54166
	Tel #:	920-205-8880				
	Website:	www.thedacare.org				
Primary Contact:	**Name:**	Julie A Meyer				
	Title:	Network Director				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$299,597
	Jul 2021 to Jun 2022	$298,097
	Jul 2022 to Jun 2023	$292,097

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Shawano County Department of Human Services	Shawano	WI	Public Health Dept.
	LaClinica Family Health	Waushara	WI	Family Health Clinic
	Menominee Tribal Clinic	Menominee	WI	Tribal Clinic
	ThedaCare Medical Center-Waupaca	Shawano	WI	Hospital

Counties the project serves:	Shawano County, WI	Waupaca County, WI

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Behavioral Health/Mental Health - Substance Use Disorder

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	The overarching goal of this project is to meet the unmet behavioral health need through integrative approaches with creation of a network with emphasis on the rural footprint of Wisconsin within the ThedaCare service area.
	Objective	Develop infrastructure to support Medication Assisted Treatment Prescribing.
	Objective	Expand and Extend Collaborative Care.
	Objective	Expand and Extend Medication Assisted Treatment.
	Objective	Develop the infrastructure for opioid stewardship within ThedaCare to support rural clinic settings.
	Objective	Facilitate collaboration of Network Partners.

Project Description:

The purpose of the project is to meet the unmet behavioral health need through integrative approaches, with emphasis on the rural footprint of Wisconsin within the ThedaCare service area. The functions of the network will be combined to address improved efficiencies, expansion of access, coordination, and improvement of the quality of health care services, and strengthening the rural health care system as a whole.

The data demonstrates, and the communities self-identify, as needing additional behavioral and mental health support.

Activities and services to be provided in the project include:
–Expand and Extend Collaborative Care: Spread of Behavioral Health Collaboration Managers in Primary Care Clinics, utilizing the Collaborative Care model out of the University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center;.
–Medication Assisted Treatment: Development of the infrastructure to support MAT providers and patients through training, EHR workflows, patient panel tracking for regulatory purposes, availability of SUD treatment, provider-to-provider support, and integrated coordination and intervention support;
–Extend Substance Use Disorder Treatment to Rural Settings: Spread of SUD providers in the rural clinical setting;
–Ambulatory Pharmacy: Develop the infrastructure for opioid stewardship within ThedaCare to support rural clinic settings.

Expected Outcomes of the project are a decrease in numbers of: emergency department utilizations, opioid overdoses, patients chronically prescribed opioids, transfers to urban areas for ongoing SUD treatment as well as a reduction in depression and anxiety as measured by PHQ 9 and GAD 7 scores.

Evidence Based/ Promising Practice Model Being Used or Adapted:

These best practices will be utilized during the project:

- Ambulatory Integration of the Medical and Social (AIMS) model;
- The Matrix model of outpatient stimulant abuse treatment; and
- Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings.

Project Officer (PO):	**Name:**	Robyn Williams				
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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Colorado

Tri-County Health Network

Grant Number:	D06RH37529					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	Using Innovation & Collaboration to Increase Access to Health & Improve Health Outcomes				
	Address:	220 E Colorado Ave.				
	City:	Telluride	**State:**	Colorado	**Zip code:**	81435
	Tel #:	970-708-7096				
	Website:	www.tchnetwork.org				
Primary Contact:	**Name:**	Lynn R Borup				
	Title:	Project Director				
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	Email:	lynn@telluridefoundation.org				
Secondary Contact:	**Name:**	Rasa Kaunelis				
	Title:	Assistant Project Director				
	Tel #:	248-910-9507				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Basin Clinic*	Montrose	CO	Medical Clinic
	River Valley Family Health Center*	Delta	CO	FQHC
	Telluride Medical Center*	San Miguel	CO	Hospital
	Uncompahgre Medical Center*	San Miguel	CO	Medical Clinic
	Pediatric Associates*	Montrose	CO	Medical Clinic
	Mountain Medical Center	Ouray	CO	Medical Clinic
	Montrose Memorial Hospital*	Montrose	CO	Hospital
	Center for Mental Health*	Montrose	CO	Nonprofit Org./Mental Health
	Telluride Foundation*	San Miguel	CO	Nonprofit Org.

Counties the project serves:		
	Montrose County, CO	San Miguel County, CO
	Ouray County, CO	Delta County, CO

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐

	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Behavioral Health/Mental Health - General
	Secondary Focus Area:	Social Determinants of Health

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Improve patient health and wellbeing by increasing access to holistic, person-centered, and team-based evidence-based services.
	Objective	Increase health equity and improve health of high- and rising-risk clients in our region by providing High Fidelity Wraparound Care Coordination (HFWCC) for up to 135 clients by the end of the grant.
	Objective	Treat substance use disorder (SUD) for residents in our region by providing Certified Addiction Counseling (CAC) via teletherapy (TT) to up to 25 community members by the end of the grant.
	Objective	Train up to 50 Spanish speaking community members using the evidence-based Mental Health First Aid (MHFA) or Mental Health First Aid-Youth (MHFAY) training course in Spanish throughout our 4-county region by the end of year 3, to provide Spanish-speaking residents the tools and information necessary to identify, understand, and respond to signs of mental illness or SUD.
	Goal	Increase knowledge and awareness of mental health and wellness and break down stigma around mental health in Delta County.
	Objective	Expand TCHNetwork presence into Delta County by developing or strengthening relationships with up to 5 partners by the end of the grant, as demonstrated by an increase in referrals to HFWCC services and participation in TCHNetwork offered behavioral health training workshops.
	Objective	Train up to 125 staff at clinics, community-based organizations, businesses, and governmental agencies and community members in Delta County using the evidence-based MHFA or MHFAY training course by the end of the grant to provide residents the tools and information necessary to identify, understand, and respond to signs of mental illness or SUD.
	Objective	Replicate the evidence informed safeTALK curriculum in Delta County empowering up to 100 residents by grant end in developing skills to recognize and intervene when another person is considering suicide.
	Objective	Improve mental wellness and increase access to mental health treatment in Delta County by expanding teletherapy (TT) services into the county and providing teletherapy services to up to 50 Delta County community members by the end of the grant.

Project Description:

This project of the Tri-County Health Network (TCHNetwork) launches a comprehensive set of innovative solutions to address the unique healthcare needs of a four-county rural region, with a focus on addressing behavioral health and social determinants of health outside the clinical walls to improve population health and overall community wellbeing. TCHNetwork's proposed program targets the 86,100 people living in the rural 4-county region of San Miguel, Ouray, Montrose, and Delta counties in southwestern Colorado.

The project requires a Network approach to be successful. TCHNetwork's 9 members include 8 medical providers: Basin Clinic, River Valley Family Health Center, Telluride Medical Center, Uncompahgre Medical Center, Pediatric Associates, Mountain Medical Center, Montrose Memorial Hospital, and Center for Mental Health; and the Telluride Foundation, a community foundation. The Network members are each meaningful collaborators, bringing unique expertise to the Network. They are united around the common goal of providing quality health care to patients and improving the health of each community by the pursuit of excellence in patient care.

Network members' patients need assistance navigating different systems outside of their clinics. The clinics are actively identifying patient social determinant of health needs. However, clinical staff struggle to navigate and connect with organizations outside of the Network who can provide the intensive support needed by patients to prioritize, navigate systems, and address those needs. Substance use disorder treatment options continue to lack in the region, despite an increasing need for services. A proactive approach is needed to build a coordinated system of support to address substance use disorder before the need reaches a crisis level. The need for increased mental health treatment in the county has consistently been identified in community health needs assessments for the past 10+ years.

TCHNetwork's program uses a holistic, systems-level approach to improve population health. Specific initiatives include: adapting High Fidelity Wraparound to provide care coordination to high- and rising-risk adults, launching substance use treatment teletherapy services throughout the region, offering Mental Health First Aid and Youth Mental Health First Aid training workshops in Spanish in the 4 counties and in English in Delta County, offering the SafeTALK suicide prevention program in Delta County, and expanding mental health teletherapy in Delta County. Anticipated outcomes include improved quality and coordination of care in the region, increased efficiencies, increased access to evidence-based and evidence-informed services, expanded access to healthcare services, increased health equity and improved population health.

Evidence Based/ Promising Practice Model Being Used or Adapted:

These best practices will be utilized in the implementation of this program:

1) High Fidelity Wraparound is a team-based case management model traditionally used with youth with serious or complex emotional, behavioral, and mental health needs. The goals of wraparound are to help youth get their needs met, learn new skills to manage their lives, and develop the skills to navigate crises after wraparound. In order for wraparound to be more effective than traditional case management, it must be implemented with fidelity to the 10 core principles—client voice and choice (intentionally elicit and prioritize the voice of the client), team-based (the team must be committed to the client and the client must agree to have all team members at the table), natural supports (the team encourages full participation of the client's interpersonal and community relationships), collaboration (the team works together, shares responsibility, and outlines commitments in plan), community-based (the process promotes client integration into home and community life), culturally competent (the process demonstrates respect of and builds upon the culture of the client), individualized (the plan and process is customized for the client), strengths-based (the process identifies, builds upon, and enhances the knowledge, skills, and assets of the client), unconditional (the team works together until the team agrees that formal wraparound is no longer needed), outcome-based (the goals and strategies in the plan are measurable and change as needed).
2) Teletherapy, or offering mental health treatment or substance use disorder treatment services using tele-video technology, is an evidence-informed method to increase access to behavioral healthcare services in rural regions. Research has found that all patients, including those with complex mental health concerns, can benefit from teletherapy to address behavioral health issues.
3) Mental Health First Aid (MHFA) and MHFA for Youth (MHFAY) are both 8-hour courses that teach graduates how to assist someone experiencing a mental health or substance use-related crisis by empowering graduates to: recognize the risk factors and warning signs for mental health and addiction concerns, offer help in crisis and non-crisis situations, and know where to refer someone for help. Group activities and role playing help participants more effectively apply the skills learned when in real-life situations. Both programs provide an overview of common mental health challenges, including anxiety, depression, substance abuse and disorders in which psychosis may occur, and introduce a 5-step action plan specialized to help those living with a mental health condition in crisis and non-crisis situations.
4) SafeTALK is a 4-hour course that teaches participants to recognize when someone is experiencing suicidal ideation, intervene, and connect the person experiencing suicidal ideation to life-affirming community resources. SafeTALK is

	designed to help participants recognize the societal beliefs that cause caring people to miss, dismiss, or avoid intervening when someone is experiencing suicidal ideation and to practice actions to move past these barriers in a graduated fashion. The "TALK" in SafeTALK stands for those practice actions—Tell, Ask, Listen, and Keep safe.					
Project Officer (PO):	**Name:**	Robyn Williams				
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Technical Assistance (TA):	**Name:**	Ann Abdella				
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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

New Mexico

Union County Health and Wellness Network, Inc.

Grant Number:	D06RH37530					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	Aces 4 Hearts				
	Address:	4 1/2 Main St.				
	City:	Clayton	**State:**	New Mexico	**Zip code:**	88415
	Tel #:	575-779-7746				
	Website:					
Primary Contact:	**Name:**	Kristen Christy				
	Title:	Project Director				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$299,848
	Jul 2021 to Jun 2022	$299,799
	Jul 2022 to Jun 2023	$299,579

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Clayton Health Systems	Union	NM	Health System/CAH/RHC
	Miners' Colfax Medical Center (MCMC),	Colfax	NM	Health System/CAH/RHC
	Valle del Sol of New Mexico, LLC	Union	NM	Nonprofit Org./Mental Health
	Noesis Integrative Health (Noesis)	Colfax	NM	Nonprofit Org./Mental Health
	Golden Spread Rural/Frontier Coalition,	Union	NM	Nonprofit Org./SDOH
	Regional Agency Intervention Network (RAIN)	Colfax	NM	Nonprofit Organization

Counties the project serves:	Union County, NM	Colfax County, NM

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Community Health Workers
	Secondary Focus Area:	Chronic Disease

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Engage people to action
	Objective	Promote community-wide the risks associated with CVD and type 2 diabetes, plus healthy behaviors for reducing those risks.
	Objective	Help HUB clients overcome individual access barriers.
	Objective	Respond to system access barriers and gaps in service availability.
	Goal	Support people in achieving health goals.
	Objective	Support comprehensive health and address disparities by developing/implementing a Pathways Community HUB model for care coordination.
	Objective	Help adults with or at risk for type 2 diabetes or CVD build personal efficacy through evidence-based evaluation.
	Goal	Make a lasting impact.
	Objective	Ensure program success.
	Objective	Ensure program sustainability.

Project Description:

This project of the Union County Network /NEN-NM, a 501(c)(3) vertical rural health network, will strengthen the regional health care system's capacity to more effectively, efficiently and sustainably address chronic disease and ameliorate disparities. The northeast region of New Mexico (Union and Colfax counties) experiences high rates of chronic disease. Cardiovascular disease is the leading cause of death in both counties. Rates for diabetes mellitus (type 2 diabetes), which has been closely associated with CVD, also are high. Risky behaviors, long distances to care, socio-cultural factors and other disparities pose an additional burden on people's ability to live healthy, long lives.

The program, ACES 4HEARTS, initially targets adults with or at-risk for developing type 2 diabetes and/or cardiovascular disease. It works within four main areas: A) Awareness and Access C) Care Coordination E) Evidence-based Education and S) Success and Sustainability.

A) Awareness and Access: Promote community-wide awareness of risks associated with CVD and type 2 diabetes, plus healthy behaviors and available services for reducing those risks, by conducting community outreach campaigns, delivering screening events at health fairs, and training our partners to screen and refer at-risk community members to Community Health Workers (CHWs). Then, CHWs enroll eligible community members into the HUB and help them to overcome individual access barriers, such as lack of insurance or transportation, and the consortium responds to any identified gaps in services needed to address clients' needs.

C) Care Coordination: Through the Pathways Community HUB model, use CHWs to assess and address clients' unmet medical, behavioral-health, social-service, employment, and/or educational needs (including the need for health education) through tailored "pathways," which match individuals to community resources that can address these needs. CHWs then confirm and track clients' connection to these resources, as well as their progress toward health outcomes.

E) Fill a meaningful gap in service availability by working with public health to deliver chronic-disease self-management education to HUB clients and other at-risk community members.

S) Promote program success and sustainability through strong administrative, evaluation, and communication and coordination systems, plus a robust and diversified Business & Funding Plan.

The program improves the quality of essential health services by focusing together on value and outcomes, rather than discrete services. It also helps fill meaningful gaps in the service system and strengthens the rural healthcare system as a whole by establishing sustainable systems that provide more comprehensive, coordinated and culturally responsive care.

Evidence Based/ Promising Practice Model Being Used or Adapted:						
The Pathways Community HUB model is nationally recognized by the Agency for Healthcare Research and Quality for creating an infrastructure that connects health care organizations and trained community health workers (CHWs) with clients that have unmet health and social needs. The HUB model employs culturally competent community health workers (CHWs) to identify people with health and social risk factors, connect them with community resources, and track progress toward addressing those risk factors. The HUB is the organizational infrastructure that supports CHW-led care coordination, and each pathway represents a risk factor.						
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	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Iowa

Unity Healthcare

Grant Number:	D06RH37531					
Organization Type:	Nonprofit Organization (other than a network nonprofit)					
Grantee Organization:	**Project Name:**	Fueling the Future of Muscatine County (Fueling the Future)				
	Address:	1518 Mulberry Ave.				
	City:	Muscatine	**State:**	Iowa	**Zip code:**	52761
	Tel #:	563-264-9134				
	Website:	www.unitypoint.org/muscatine				
Primary Contact:	**Name:**	Christy Roby Williams				
	Title:	Project Director				
	Tel #:	563-264-9134				
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	Title:	Operations Manager				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jul 2021	$300,000
	Jul 2021 to Jul 2022	$300,000
	Jul 2022 to Jul 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Trinity Muscatine Public Health	Muscatine	IA	Public Health
	Muscatine County Schools	Muscatine	IA	School District
	Muscatine Community College	Muscatine	IA	Academic/Comm. College
	Muscatine Center for Social Action	Muscatine	IA	Nonprofit Org.
	City of Muscatine	Muscatine	IA	Local Government
	Community Foundation	Muscatine	IA	Nonprofit Org./Foundation
	Aligned Impact Muscatine	Muscatine	IA	Nonprofit Org.

Counties the project serves:	Muscatine County, IA	

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☐	School-age children (elementary ~ 5-12 years)	☒
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☒
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐

	Other:	☐	Other:	☐
Focus Areas:	**Primary Focus Area:**	Social Determinants of Health		
	Secondary Focus Area:	Care Coordination		
	Other Focus Area:		☐ Primary ☐ Secondary	

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	Formalize the Fueling the Future Rural Health Network
	Goal	Address emergent crisis of elementary school children by offering upskill training to caregivers.
	Goal	Reduce barriers to employment success through a continuum of social determinant of health supports.

Project Description:

The purpose of Fueling the Future is to address the rural healthcare needs of low-income, vulnerable populations using a three-prong approach of (1) emergent crisis stabilization, (2) reducing social determinants of health barriers, and (3) formalizing an existing rural health network to meet the health needs of the county.

The target population is elementary school-aged children who are receiving weekend backpack food subsidies to curb hunger. Poverty is considered a key driver of health status; lack of educational attainment and poverty creates barriers to access, including health services, healthy foods, and other necessities that contribute to poor health outcomes. Fueling the Future starts by engaging the custodial parents ("caregivers") of elementary children in an intensive "earn while you learn" upskill training program in high demand jobs (welding, certified nursing assistants, CNC machining). Once enrolled, the family is then assessed to determine SDOH barriers, and a plan is created based on prioritizing the urgency of care. The final prong is formalizing the Muscatine County health care providers into a rural health network that can readily respond to the evolving health care environment and resident needs.

The Fueling the Future Rural Health Network Board is currently comprised of eight members. Representation includes mental health and substance abuse service providers, the community hospital/emergency services, the community school district, the community college, and community-based organizations. Additional members will be invited as barriers are identified, and rural health needs determined.

Fueling the Future of Muscatine County expects to serve 120 households (approximately 300 individuals). Expected outcomes include a high-functioning network board capable of rapid response to the health needs of the county, successful/ongoing employment of over 100 caregivers, and the potential for 250 individuals -with a high percentage being children-having their health stabilized and a re-structured economic pathway created

Evidence Based/ Promising Practice Model Being Used or Adapted:

Social Needs Screening Toolkit from Health Leads, INC., will be utilized by the Economic Navigator with a caregiver of each household to assess current social determinant needs and urgencies that households may be experiencing upon initiation of services and throughout care navigation. This screening model was developed by Health Leads, who has over 20 years of experience addressing social determinants of needs or, as they like to call them, "essential needs."

The essential social needs domains identified in this screening tool include food insecurity, housing instability, utility needs, financial resource strain, transportation challenges, exposure to violence, socio-demographic information, childcare, education, employment, health behaviors, social isolation and supports, and behavioral/mental health. See Table 1(following page)for domains and examples.

These domains are based on the findings of the most common social needs impacting the health of patients today as identified by the Institute of Medicine, Centers for Medicare and Medicaid Services. They are in alignment with Health Leads' two decades of experience and field research with proven validity. The Social Needs Screening Toolkit shares the latest research on how to effectively screen patients for social needs.

Care Coordination-The Economic Navigator is delivering comprehensive care coordination and navigation service to all individuals residing within each household. To establish a framework for this position, the Economic Navigator will be required to complete the Clinical Health Coaching Training Program provided through the Iowa Chronic Care Consortium. This program is designed for organizations that seek to improve health outcomes with the people they serve through self-management support and patient-centered care. According to the Iowa Chronic Consortium, individuals living with chronic conditions drive 80% of the total cost of healthcare today. Improved health behaviors, more patient engagement, and increased levels of self-care are providing to reduce the progression of conditions, ER visits, and hospitalizations. The program includes standardized resources that support the guided care process and patient defined goal setting. Population health strategies are utilized to identify, stratify, select interventions, track, and measure outcomes. The Economic Navigator will also learn effective communication strategies to support and improve health literacy.						
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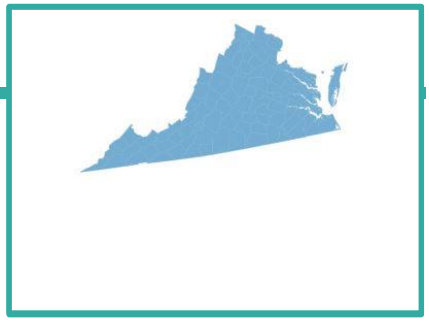
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303



Virginia

Virginia Rural Health Association

Grant Number:	D06RH37532					
Organization Type:	Nonprofit Organization (other than a network nonprofit)					
Grantee Organization:	**Project Name:**	Behavioral Health for Virginia Rural Health Clinics				
	Address:	200 Memorial Dr.				
	City:	Luray	**State:**	Virginia	**Zip code:**	22835
	Tel #:	540-231-7923				
	Website:	www.vrha.org				
Primary Contact:	**Name:**	Beth O'Connor				
	Title:	Project Director				
	Tel #:	540-231-7923				
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Secondary Contact:	**Name:**	Sherri Blair				
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	Email:	sblair@vrha.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jul 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Carilion Clinic (3 sites)	Giles, Lexington City	VA	Rural Health Clinic
	Family Care of Chilhowie	Smythe	VA	Rural Health Clinic
	Patrick County Family Practice	Patrick	VA	Rural Health Clinic
	Ballad Health (3 sites)	Russell, Washington, Wise	VA	Rural Health Clinic
	Bath Community Physicians Group (3 sites)	Bath, Covington City	VA	Rural Health Clinic
	Clinch Valley Physicians	Tazewell	VA	Rural Health Clinic
	Olde Towne Medical & Dental Center	Williamsburg City	VA	Rural Health Clinic
	Tri-State Rural Health Clinic	Buchanon	VA	Rural Health Clinic
	Valley Health (15 sites)	Rappahannock, Page, Shenandoah, Louisa, Warren	VA	Rural Health Clinic

Counties the project serves:		
	Bath County, VA	Page County, VA
	Buchanan County, VA	Patrick County, VA
	Covington City, VA	Pittsylvania County, VA
	Giles County, VA	Rappahannock County, VA

	Grayson County, VA	Shenandoah County, VA
	James City County, VA	Smyth County, VA
	Lancaster County, VA	Tazewell County, VA
	Lee County, VA	Warren County, VA
	Lexington City, VA	Washington County, VA
	Middlesex County, VA	Wise County, VA
	Northumberland County, VA	

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☐	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:		
	Primary Focus Area:	Behavioral Health/Mental Health - General
	Secondary Focus Area:	Telehealth

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	The goal of the project is to position Virginia's Rural Health Clinics to be leaders in improving population health among RHC communities with a focus on behavioral health.
	Objective	By June 30, 2023, VRHCC will provide Virginia's Rural Health Clinics with educational opportunities to optimize RHC practice management.
	Objective	By June 30, 2023, VRHCC will provide Virginia's Rural Health Clinics with technical assistance and educational opportunities to increase access to behavioral health services.

Project Description:

The goal of this project is to position Virginia's Rural Health Clinics to be leaders in improving population health in RHC communities with a focus on behavioral health. The project intends to serve the 527,251 people who live in the counties served by Virginia's Rural Health Clinics.

The Virginia Rural Health Clinic Coalition is comprised of 28 Rural Health Clinics distributed over 22 counties. The project will move the Rural Health Clinics toward the stated goal through two objectives:
Objective #1: By June 30, 2023, VRHCC will provide Virginia's Rural Health Clinics with educational opportunities to optimize RHC practice management.
Objective #2: By June 30, 2023, VRHCC will provide Virginia's Rural Health Clinics with technical assistance and educational opportunities to increase access to behavioral health service.

The objectives will be met through providing behavioral health awareness training to RHC staff, hosting educational forums for healthcare clinicians, providing opportunities for RHC staff to learn management best practices, and assisting RHCs in developing telehealth service programs. This will include Mental Health First Aid, Prescription Drug Abuse Forums, High Risk Patient Education, Hepatitis C Screening and Treatment, and Telehealth implementation. The coalition will also engage in strategic planning, evaluation, and sustainability planning to ensure the long-term success of the network.

Project activities are designed to move Virginia's Rural Health Clinics toward the following long-term outcomes: (1) Virginia's Rural Health Clinics have increased potential for long-term viability that ensures they can continue to serve the health needs of rural residents; (2) Virginia's Rural Health Clinics are prepared to adapt to upcoming changes in payment system reform and participate in quality improvement programs, and; (3) Virginia's Rural Health Clinics integrate mental health and substance abuse services into primary care.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The Virginia Hepatitis C Education and Patient Connection (HEPC) is an adaptation of the Kentucky's Hepatitis C Elimination Plan (KHAMP) developed by the Kentucky Rural Health Association. The program goals are to:• Expand access to hepatitis C specialty training to primary care and addiction care providers by recruiting providers from FQHCs, hospitals, and rural community clinics in high-risk settings • Remove barriers to care for patients with hepatitis C infection• Establish a provider network trained by hepatitis C experts who can completed the hepatitis C care continuum: Screen; Diagnose; Evaluate; Treat or Refer; Cure.

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	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Minnesota

Well Being Development

Grant Number:	D06RH37533					
Organization Type:	Nonprofit Organization (other than a network nonprofit)					
Grantee Organization:	**Project Name:**	Northern St Louis County Behavioral Health Network				
	Address:	41 E Camp St				
	City:	Ely	**State:**	Minnesota	**Zip code:**	55731
	Tel #:	218-235-6104				
	Website:	www.wellbeingdevelopment.org				
Primary Contact:	**Name:**	Kap Wilkes				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$299,797
	Jul 2021 to Jun 2022	$299,894
	Jul 2022 to Jun 2023	$299,243

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Ely Bloomenson Community Hospital (EBCH)	St. Louis County	MN	Hospital
	Essentia Health -Ely Clinic (EHEC)	St. Louis County	MN	Clinic
	Range Mental Health Center (RMHC)	St. Louis County	MN	Nonprofit Org./Mental Health
	Ely Community Health Center (ECHC)	St. Louis County	MN	FQHC
	Ely Community Resource (ECR)	St. Louis County	MN	Nonprofit Org./Youth
	NHS-Northstar Specialized Services (NHS-NSS	St. Louis County	MN	Nonprofit Org./Mental Health Services
	St Louis County Public Health and Human Services	St. Louis County	MN	Public Health Dept.

Counties the project serves:	St. Louis County, MN	

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☒

	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☒
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Behavioral Health/Mental Health - General
	Secondary Focus Area:	School-based Health

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	To expand evidence-based screening and intervention strategies in the Ely area to reduce trauma and build resilience across the age spectrum.
	Objective	Increase behavioral health literacy through community education, skill building, and stigma reduction campaigns.
	Objective	Intervene to increase safety, including self-harm, harm by others, and harming others.
	Objective	Develop and pilot implementation of behavioral health curriculum (including literacy and skill building) in the public-school system..
	Objective	Build capacity of the hub and spoke care facilitation program to offer one-on-one education and access to resources regarding trauma and resilience.
	Goal	To develop behavioral health community network in Virginia, MN, based on lessons learned in the Ely project.
	Objective	Expand and formalize an informal network that is problem-solving intra- and interorganizational issues impacting successful behavioral health interventions in a second rural community in Northern SLC.
	Objective	Adapt urban model for crisis response transportation in rural area.
	Objective	Identify successful Ely initiatives that will complement Virginia project
	Goal	To successfully manage the grant-funded project, expanding programming in the Ely area and adapting the Ely BHN model to another rural community.
	Objective	Facilitate the Ely BHN Governance Group, managing, growing, and sustaining the network
	Objective	Manage the HRSA network development grant.
	Objective	Coordinate and manage Fiscal Sponsor arrangement
	Objective	Ensure sustainability of project through strategic planning.
	Objective	Use results of process and outcome evaluation for program development and dissemination.
	Objective	Conduct workforce recruitment and retention activities..

Project Description:

The goal of this project is to improve health outcomes of residents in Northern St. Louis County, MN by reducing the prevalence and impact of adverse childhood experiences and increasing resilience across the age spectrum.

Well Being Development, the applicant organization that successfully guided creation of the Ely Behavioral Health Network (BHN) with support of 2015 and 2016 HRSA Network Planning grants and a 2017-2020 Network Development grant, plans to further develop and expand the network and behavioral health services in Minnesota's Northern St Louis County. The Ely BHN serves a community of ~12,000, to provide collaborative care to identify and address overall behavioral health and recovery needs for rural Northern St. Louis County. Ely BHN is a vertical network comprised of a Community Representative and 8 organizations: 2 clinics (a free clinic serving people who are under and uninsured and the local primary care clinic that serves many of the individuals targeted by this project), a critical access hospital, community mental health center, a nonprofit mental health recovery program, youth services nonprofit, and 2 new partners integrated to better achieve project goals: a for-profit behavioral health recovery program and the county Public Health and Human Services.

To address regional health disparities and challenges, including the region's rural nature, lower median income than the state and nation, its older population, and health disparities and challenges, the Ely BHN has identified 3 goals to guide its Development Project:
1)to expand evidence-based screening and intervention strategies in the Ely area to reduce trauma and build resilience across the age spectrum;
2) to develop behavioral health community network in Virginia, MN, based on lessons learned in the Ely project; and
3)to successfully manage the grant-funded project, expanding the Ely model to another community.

Activities employed to achieve changes in behavioral health outcomes include: growing the Ely BHN; expanding the network to the neighboring community of Virginia, MN (with a surrounding service area population of ~18,000); and developing and integrating trauma informed and skill building programs in health care, care coordination, school, and community organization settings.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The Ely BHN has consistently sought evidence-based practices to increase opportunities for success that this proposal will build on: rural health networks, integration of behavioral health and primary care, care facilitation, awareness and stigma reduction campaigns, screening, the crisis response plan, and telehealth. Additional evidence-based strategies include: behavioral health literacy and workforce development.
1.Rural Health Networks hold the promise of improving health outcomes through collaboration, The Ely BHN was created to improve outcomes of people with behavioral health issues in rural NE Iron Range. Because BHN is a vertical network, it has the capacity to create and implement a program that collaborates care across the spectrum of services a consumer and their family might need.
2.Integration of Behavioral Health and Primary Care. Integration of behavioral health and primary care in EHEC occurred over the past seven years and it is moving to a new phase, with the addition of physicians with a waiver to provide medication assisted treatment (MAT) to persons with OUD and the increased focus on better serving patients with SUD and their families
3.Care Facilitation. Care facilitation ensures that people at risk who are identified through the screening process receive appropriate assessment, referral, interventions, and follow-up.
4.Awareness and Stigma Reduction Campaign and Behavioral Health Literacy for youth and adults. The Ely BHN has developed a stigma reduction program in the Ely area, focusing primarily on mental health issues and community campaigns such as the "Make it OK" campaign.
5.Screening. Tools to be employed include: Screening, Brief Intervention and Referral to Treatment (SBIRT), which employs the Alcohol Use Disorders Identification Test (AUDIT) for screening or the Drug Abuse Screening Test (DAST);xl PHQ2 and 9 screening for depression and The Columbia Suicide Severity Screening.
6.Building on The Crisis Response Plan: Adapting CAHOOTS for Virginia, MN. (Cahoots (Crisis Assistance Helping Out On The Streets). The adapted model would complement the existing crisis response team; an EMT and behavioral health specialist would have access to a van, which could allow the team to talk with an individual in any setting and then transport the individual to other services such as the hospital, if needed.
7.Telehealth. Telehealth provides the avenue for increased access to health care for chronic diseases, including psychiatric consultation, counseling for people with depression, consultation for OUD treatment, and other behavioral health issues.
8.WorkforceDevelopment. Workforce (teachers, other school staff; health care staff in primary care clinics, hospitals; care facilitators) will be offered training for evidence-based training: Screening, Brief Intervention and Referral to Treatment (SBIRT),WRAP, and Motivational Interviewing.

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New York

Westchester-ellenville Hospital, Inc.

Grant Number:	D06RH37534					
Organization Type:	Hospital					
Grantee Organization:	**Project Name:**	Family Wellness Program				
	Address:	10 Healthy Way				
	City:	Ellenville	**State:**	New York	**Zip code:**	12428
	Tel #:	845-647-6400, Ext. 326				
	Website:	www.ellenvilleregional.org				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$268,394
	Jul 2021 to Jun 2022	$270,803
	Jul 2022 to Jun 2023	$274,382

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	The Institute	Ulster	NY	FQHC
	Ulster County Department of Health and Mental Health	Ulster	NY	Public Health Dept.
	Cornell Cooperative Extension	Ulster	NY	Nonprofit Org.
	Planned Parenthood of the Mid-Hudson Valley	Duchess	NY	Nonprofit Org.

Counties the project serves:	Ulster County, NY	

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☐	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☒
	Elderly (65+)	☐	School-age children (elementary ~ 5-12 years)	☒
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☒
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Community Health Workers
	Secondary Focus Area:	Chronic Disease

Project goals & objectives:	**Goal/ Objective**	**Description**
	Goal	To increase the availability of sustainable programs offered locally, designed to address the social determinants of health, and meet the needs of Wawarsing families; thereby increasing the capacity of the ERRHN Network.
	Objective	During year one conduct a needs analysis to identify to the barriers and social determinants of health impacting local families ability to achieve good health locally.
	Objective	During year one, following the needs assessment, conduct a gap analysis to identify gaps in service providers to meet the needs of families based on the identified barriers.
	Objective	During years two and three, identify and recruit agencies capable of filling needs gaps, in a sustainable way.
	Goal	Use evidence-based community outreach and clinical improvement strategies to reduce the obesity rate amongst a cohort of at-risk members of the Wawarsing community.
	Objective	During all three funding years continue the Ellenville Regional Rural Health Network, to lead the Family Wellness program.
	Objective	Over the 36-month project period, enroll 90 community Families in this comprehensive obesity reduction program, comprising both community-based activities and clinical supports.
	Objective	Over the 12-month project period, engage an additional 300 unduplicated individuals in ongoing community programming and education, resulting in improved knowledge and behavior regarding obesity reduction and health.
	Objective	Hold at least two Expanded Food Education and Nutrition Program (EFNEP) each year, attended by no less than 60 unduplicated families over the over the 36-month grant period.
	Objective	Hold a family gardening education class each year, attended by no less than 60 unduplicated individuals over the over the 36-month grant period.
	Objective	By year 1, quarter 1, launch an Ellenville Regional Rural Health Network YouTube Channel.
	Objective	By Year 1,quarter 3, launch a Healthy Restaurant Initiative to improve healthy meal options on the children's menu.
	Objective	By year 3, leverage the combined strengths of the Consortium partners to achieve permanent, demonstrable improvements in clinical service delivery and availability of community resources that support population health.
	Goal	Use evidence-based community outreach and clinical improvement strategies to reduce the teen pregnancy rate amongst at-risk members of the Wawarsing community.
	Objective	Over the 36-month project period, engage at least 100 unduplicated adolescences in sexual education programing.
	Objective	Over the 36-month project period, engage at least 100 unduplicated adolescents in sexual education programming.

Project Description:

The Westchester-Ellenville Hospital, a rural critical access hospital (dba Ellenville Regional Hospital/ERH), together with several community partners, is implementing a Family Wellness Program in the rural, medically underserved Town of Wawarsing and Village of Ellenville. The target populations for the proposed project include families with children age 5-13, and adolescence ages 13-19, who reside in the target communities.

The Ellenville Regional Rural Health Network, a network founded through a partnership between ERH, the

Institute, and the Ulster County Department of Health and Mental Health (UCDOHMH) in 2017, will serve as the consortium for the proposed project. Through collaborative efforts, consortium partners will implement a series of programs designed to reduce childhood obesity by improving family lifestyle and health behaviors, with a secondary focus on reducing teen pregnancy.

The overarching goal of the program is to increase the availability of sustainable programs designed to reduce childhood obesity and teen pregnancy that are offered in Wawarsing. By recruiting providers to expand service offerings into Wawarsing that already have sustainable funding mechanism, with coordinated execution through the Ellenville Regional Rural Health Network (ERRHN) Cohort, the network will build capacity and improve population health in the community.

Through targeted outreach, ERRHN will utilize the evidence-based Community Health Worker (CHW) model to identify and recruit a cohort of at least 90 at risk families, to track across the three-year grant period. Expected outcomes of the project include self-reported improvements to family dietary habits and physical activity behaviors, self-reported increases in teen sexual health knowledge, decreases in overweight/obesity in the cohort, and an increase in the number of sustainable programs being offered in Wawarsing.

Additionally, this project seeks to build the infrastructure of the ERRHN through projects including a Community Health Assessment, creation of a 3-year Strategic Plan, creation of a detailed Communication Plan, improved usage of social media, and defining the structure of the Network.

Evidence Based/ Promising Practice Model Being Used or Adapted:

ERRHN will utilize a number of evidence-based practices for the proposed project, including the Community Health Worker - Health Educator Model. To date, ERRHN has had success implementing the CHW model to address cardiovascular risk amount the adult population, and feel strongly this model will replicate well with local families. ERRHN and the project partners will host evidence-based programs such as the Great Garden Detective Adventure, the Be Proud! Be Responsible! Program, Teen Life Skills program, Peer Education Program, and the Expanded Food Education and Nutrition Program (EFNEP). Additionally, evidence-based tools such as the CDC Heart Age Calculator, and the Program Sustainability Assessment Tool (PSAT), will be used to implement the proposed work plan. The evidence based PRAPARE document is also used during intake assessments for cohort families. Additionally, network staff regularly consult with the ERH Librarian to identify relevant articles for literature analysis to identify relevant evidence based and emerging practices to share with Network Leadership for future consideration.

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Minnesota

Wilderness Health, Inc.

Grant Number:	D06RH37535					
Organization Type:	Nonprofit Network Organization					
Grantee Organization:	**Project Name:**	Wilderness Health Telehealth Program				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$269,215
	Jul 2021 to Jun 2022	$269,308
	Jul 2022 to Jun 2023	$233,244

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Bigfork Valley Hospital	Itasca	MN	Hospital
	Community Memorial Hospital	Carlton	MN	Hospital
	Cook Hospital	Cook	MN	Hospital
	Ely Bloomenson Community Hospital	St. Louis	MN	Hospital
	Fairview Range Hospital	St. Louis	MN	Hospital
	Grand Itasca	Itasca	MN	Hospital
	Lake View Hospital	Lake	MN	Hospital
	Mercy Hospital	Carlton	MN	Hospital
	North Shore Health	Cook	MN	Hospital
	Rainy Lake Medical Center	Koochiching County	MN	Hospital
	St. Luke's	St. Louis	MN	Hospital

Counties the project serves:		
	Carlton County, MN	Ashland County, WI
	Cook County, MN	Bayfield County, WI
	Itasca County, MN	Douglas County, WI
	Koochiching County, MN	Lake County, MN
	Pine County, MN	St. Louis County, MN

Target population served:	Population	Yes	Population	Yes
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:		
	Primary Focus Area:	Telehealth
	Secondary Focus Area:	Behavioral Health/Mental Health - General

Project goals & objectives:	Goal/ Objective	Description
	Goal	To develop the capacity and Infrastructure to integrate tele-behavioral health.
	Objective	Conduct needs assessment.
	Objective	Pilot project implementation plan.
	Objective	Develop and implement marketing and promotion plan.
	Objective	Develop and implement training and education plan
	Objective	Develop financial sustainability strategies..
	Objective	Launch telehealth program .
	Objective	Monitor and evaluate telehealth program.

Project Description:

Wilderness Health was formed as a non-profit, tax-exempt entity of originally 9, now 11, independent health care systems, in Minnesota in 2013. Many of these health systems are located in the most remote parts of the state with large distances between facilities; 8 of which are critical access hospitals. The purpose of WH is to advance patient and community health outcomes, improve the patient experience and lower the costs of providing health care services by working together to provide services more effectively and efficiently.

This project is the development of a telehealth program. Wilderness Health has identified the need to leverage technology as one of its strategic initiatives and this project will build the capacity and infrastructure to provide telehealth services, including the addition of dedicated staff, equipment, and training. It will support all of the legislative aims of Achieving Efficiencies, Expanding Access to Care and Strengthening the Rural Health Care System.

Successful implementation will enable our members to provide increased access to necessary care starting with critical mental health services, where the wait to see a provider can be several months. This program will allow patients who live in remote areas to access care without having to travel long distances to seek help. The addition of telehealth services will also benefit primary care providers by pairing them with specialists for consults on patients as well as medication management assistance. The anticipated outcomes of the proposed telehealth program include: increasing the ability to recruit providers and staff, increasing access to mental health resources, increasing the ability to provide services locally, reducing patient barriers to care, and ultimately, improving patient health outcomes. Telehealth offers the opportunity to maximize the productivity of providers and to increase access to services in the region.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Project is utilizing best practices and evidenced informed practices from a variety of models to design the telehealth program to the needed parameters and condition. Specifically, Wilderness is adopting a blend of resources including the implementation roadmaps from the MN state roadmap for e-health and the California Telehealth Resource Center, in addition to the telehealth toolkits form the Great Plains Telehealth Resource & Assistance Center and through the Rural Health Innovations. Due to the size of these documents we have provided the links below: MN e-health Roadmap:

https://www.health.state.mn.us/facilities/ehealth/roadmap/docs/ehlth_roadmap_final.pdfRural Health Innovation Hub toolkits: https://www.ruralhealthinfo.org/toolkits/telehealth/2/specific-populations/behavioral-health) .						
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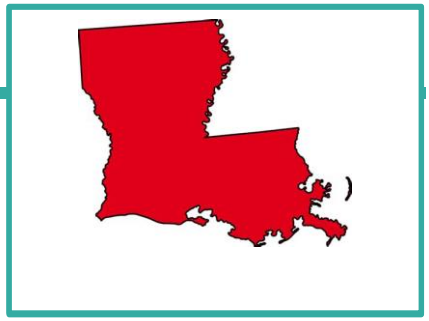

Louisiana

Winn Community Health Center

Grant Number:	D06RH37536					
Organization Type:	FQHC					
Grantee Organization:	**Project Name:**	"Caring Friends"				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Jul 2020 to Jun 2021	$300,000
	Jul 2021 to Jun 2022	$300,000
	Jul 2022 to Jun 2023	$300,000

Network Members:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Winn Parish Medical Center	Winn	LA	Hospital
	Winn Parish School Board	Winn	LA	School District
	Louisiana Primary Care Association	Winn	LA	Nonprofit Org.

Counties the project serves:	Winn Parish, LA	

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18-64 years)	☒	Pre-school children (3-4 years)	☐
	African Americans	☒	Pacific Islanders	☐
	Caucasians	☒	Pregnant Women	☒
	Elderly (65+)	☒	School-age children (elementary ~ 5-12 years)	☐
	Infants and toddlers (up to 3 years)	☐	School-age children (Middle/high school ~13-17 years)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Other:	☐	Other:	☐

Focus Areas:	**Primary Focus Area:**	Chronic Disease
	Secondary Focus Area:	Care Coordination

Project goals & objectives:	Goal/ Objective	Description
	Goal	Improve Health Outcomes for Patients with Chronic Disease in Winn Parish.
	Objective	Implement a community-based chronic care model for service area ("Caring Friends") by 09/20.
	Objective	Implement national evidence based clinical pharmacist program by 10/20. (Team Based Care - Pharmacy Integration/ Intervention)
	Objective	Implement Health Coaching program by 10/20. (Patient education and assistance).
	Objective	Develop a 5-year strategic plan by 7/21.
	Objective	Develop a final assessment report by 08/22.
	Objective	Develop a final sustainability plan by 05/23.
	Objective	Complete three years of annual grant reporting by 10/23

Project Description:

Winn Community Health Center is the fiscal agent for this project on behalf of Cen-LA Healthcare Improvement Partnership (CHIP). CHIP is an association of health care providers, whose principal purpose is providing coordinated healthcare services for the uninsured, underinsured and underserved in central Louisiana. The service area for the project will encompass the Winn Parish area.

CHIP will address the growing burden of chronic disease in the area as well as positioning health care providers for the pay for performance environment through its Caring Friends program. The proposed project focuses on patients of all ages diagnosed with diabetes, hypertension, congestive heart failure, a behavioral health diagnosis or a combination of any three. The long-term, overarching goals are to improve quality of life for those with chronic disease, decrease the number of work days missed due to chronic disease complication in rural Louisiana, and reduce disease burden.

This will be done by implementing an evidenced-based program based on "The Asheville Project," that incorporates a clinical pharmacist (CP) into the care team. CPs provide multiple services including managing medications, responding to consultations, writing medication-related policies and procedures, contributing to continuous quality improvement initiatives, assisting patients who could not afford their medications, educating staff and providers, and counseling patients. By focusing on clinical tasks associated with medication management, CPs allow physicians to spend more time to perform the diagnostic and procedural responsibilities that are unique to medicine. Also included is an evidence-based health coaching component which had been proven to engage patients in self-management of health conditions and encourage health behavior change.

Project activities are expected to lead to the following short-term outcomes: increased awareness of chronic disease management; utilization of an evidence-based clinical pharmacist model; and an increase in identifying at risk chronic disease patients. The development of strategic and sustainability plans will support the continuation of all outcomes. After the short-term outcome changes in capacity, knowledge and processes take place, then the expected medium outcomes will be in changed behaviors, access and health outcomes. Examples of medium outcomes include: an established program of chronic disease care coordination in rural areas; reduction of complications in targeted patients with COPD, CHF and diabetes; increased use of clinical pharmacist services within the community; reduced unmet need for both patients and the community; and meeting or exceeding goals for clinical outcome and care coordination measures for the targeted patients. Also the trained staff and embedded processes should lead to an established and sustainable program with measurable results. The major expected long-term outcomes or impact of the program include better quality of life, less works hours missed due to chronic disease complications and reduced disease burden. In addition, policy changes regarding reimbursement for health coaching and clinical pharmacist services will be pursued at the payer and state levels.

Evidence Based/ Promising Practice Model Being Used or Adapted:

In the 1990s, the City of Asheville, North Carolina partnered with pharmacists to provide medication therapy management services for employees with diabetes in what came to be known as The Asheville Project. Patients saw their pharmacists monthly to focus on effective self-management, adherence strategies, basic nutritional concepts, and prevention of diabetes complications. Results demonstrated statistically significant decreases in hemoglobin A1c and LDL, improvements in HDL, decreased sick days, and decreased total health care costs compared to baseline. The Ten City Challenge replicated the Asheville Project, and demonstrated that quality metrics for blood pressure, lipid panels, and hemoglobin A1c improved, and vaccinations and eye exams increased.

Moreover, the interventions made by the pharmacists decreased health care costs by $1,079 per patient. Medication management is now an integral component of pharmacy education and practice across the nation.

Patients in rural communities, such as in Winn Parish, Louisiana, have less access to both primary and specialty care, including clinical pharmacy services. Significant health disparities exist in rural communities compared to their urban counterparts, including increased rates of tobacco abuse, chronic illness, and poverty. Access to health care services is limited and is expected to worsen due to the primary care physician shortage and the aging population. It is important to ensure that patients in rural communities have access to comprehensive medication management provided by pharmacists in a team environment, and that health care transformation is scalable to rural America. Current legislation in Congress seeks to recognize pharmacists as providers under the Social Security Act to increase patient access to clinical services in rural and underserved areas, and to create a reimbursement model that parallels nurse practitioners and physician assistants. This legislation would not change the scope of pharmacy practice, but would establish a financially sustainable business model for incorporating pharmacists into team-based care.

Primary care physicians, whose average panel is 2,500 patients, do not have enough time in a patient visit to diagnose acute problems, manage chronic illnesses, and implement prevention guidelines while still maintaining a positive relationship with their patients. In the average non-team based care practice, a physician spends 10.6 hours per day managing and documenting encounters. Incorporating a CP onto the primary care team improves the efficiency of the physician. The CP is not a physician extender, but rather a valuable team member with expertise in pharmacotherapy that is more extensive than the training and skills of most physicians, thus enhancing the care for the patient and allowing more time for other services unique to medicine.

Also considered as a strategy for this project is “Health Coaching for Patients with Chronic Illness,” a model presented in the Journal for the American Academy of Family Practice in 2010. Health coaching can be defined as helping patients gain the knowledge, skills, tools and confidence to become active participants in their care so that they can reach their self-identified health goals. Health coaching encompasses five principal roles: 1) providing self-management support, 2) bridging the gap between clinician and patient, 3) helping patients navigate the health care system, 4) offering emotional support and 5) serving as a continuity figure.

Both programs will be integrated within WCHC’s current PCMH model of care utilized within its primary clinics. Workflow and processes will model the current Medicare Chronic Case Management program.

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