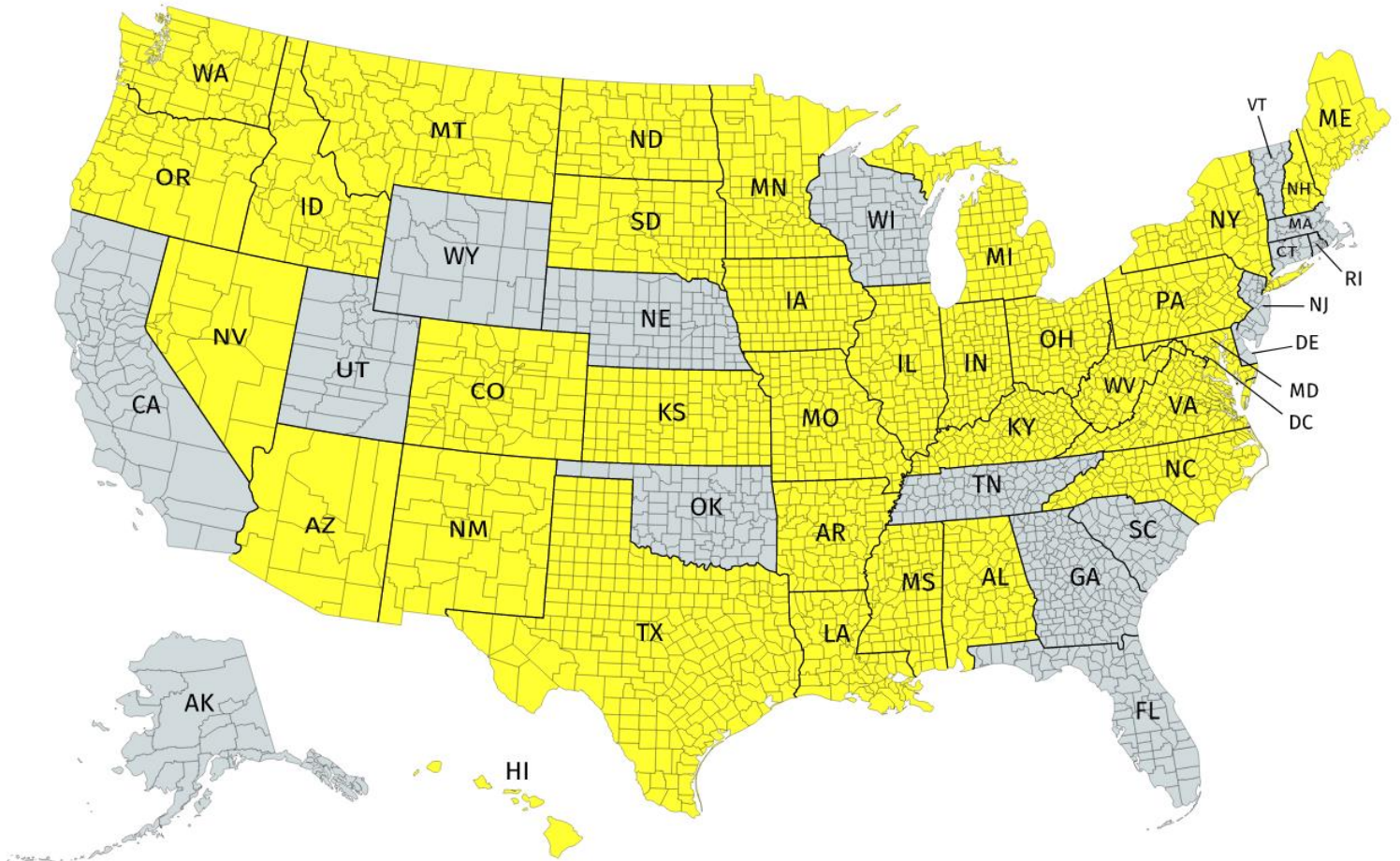


SOURCEBOOK 2018-2021



Highlighted states indicate locations of grant organizations

July 22, 2021

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

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Introduction

The Rural Health Care Services Outreach Program is authorized by Section 330A of the Public Health Service Act (42 U.S.C. 254c(e)) and administered by the Health Resources and Services Administration's (HRSA's) Federal Office of Rural Health Policy (FORHP) Community-Based Division. The program expands and improves health services for rural residents through grant funding that supports projects using community-based models to effectively enhance health care outreach and service delivery in rural communities.

This *Sourcebook* provides contact and project summary information for each of the Rural Health Care Services Outreach Program's 59 projects funded during the program's 2018-2021 funding cycle. Following the introduction, a summary of key project impacts, and cohort snapshot, the reader will find profiles for each of the 59 funded projects. The reader may search grantee information by state, organization type, and program focus area using tables found in the appendices.

Summary of Key Project Impacts

Funding met a broad range of health care needs, including but not limited to health promotion and disease prevention, expanding oral and behavioral health services, case management, and care coordination. These projects address the needs of a wide range of population groups such as low-income populations, the elderly, pregnant women, infants, adolescents, rural minority populations, and rural populations with special health care needs.

The emphasis of this grant program is on service delivery through collaboration, adoption of an evidence-based or promising practice model, demonstration of health outcomes, replicability, and sustainability. Common models implemented by projects include community health workers, peer recovery support, patient navigation, chronic disease self-management, Chronic Care Model, telehealth, and primary care medical homes. Outreach projects tailor these models to meet their community's needs.

Projects also implemented outcome-oriented approaches to enhance and sustain the delivery of effective health care in rural communities by tracking specific health indicators that demonstrate the impact of projects on the health outcomes of the rural communities served. These projects have demonstrated improved health status through increased access to care and improved clinical measures and health behaviors.

A specialized track of 12 Health Improvement Special Project (HISP) grantees focused on addressing cardiovascular disease (CVD) risk within a subset. Activities implemented by the HISP grantees included, but were not limited to, care coordination, case management, tobacco

cessation, and biometric screenings. To describe the long-term outcomes of the HISPs, participants reported data using the Centers for Disease Control and Prevention (CDC) Heart Age Calculator. The HISP grantees demonstrated reduced cardiovascular risk because of the activities supported by the Outreach Program.

The onset of the coronavirus, COVID-19, during the last year of the funding cycle for grant project implementation presented unprecedented challenges. Grantees overcame these challenges through innovative solutions such as telehealth, virtual classes and meetings, and new partnerships to serve the community. Many of these innovations will continue after the pandemic to increase access to quality health care and community services.

Authorized under Section 330A of the Public Health Service Act, the Small Healthcare Provider Quality Improvement Program provides support for the planning and implementation of evidenced-based quality-improvement activities in the rural primary care setting in order to improve the quality and delivery of rural primary care services and patient health outcomes.

Targeted Outcomes

Targeted Measures

Grantees targeted a range of outcomes during the three-year grant period. Their initiatives aimed to improve access to and quality of health care and demonstrate improved health outcomes and community impact.

Common Outcomes:

- ❖ Increased access to clinical and behavioral health services
- ❖ Decreased avoidable emergency department and hospital admissions
- ❖ Increased connection to community resources
- ❖ Increased insurance enrollment
- ❖ Increased healthy behaviors (e.g., fruit and vegetable intake, physical activity)
- ❖ Improved clinical measures (e.g., blood pressure, hemoglobin A1c, body mass index)
- ❖ Improved youth oral health (e.g., fewer cavities and decay)
- ❖ Increased workforce capacity through training and professional development
- ❖ Built strategic new partnerships and strengthened existing relationships



A subset of 12 Health Improvement Special Project (HISP) grantees focused on addressing cardiovascular disease (CVD) risk within a population subset. The overarching goal of the HISP is to demonstrate changes to cardiovascular risk because of the activities supported by the Outreach Program. These grantees made improvements in the 11 funded states.

Common HISP Outcomes:

- ❖ Decreased cardiovascular disease risk as demonstrated by the implementation of the CDC Heart Age Calculator
- ❖ Decreases in body mass index, blood pressure, A1c, and cholesterol
- ❖ Reduced heart age
- ❖ Improved medication adherence
- ❖ Decreased rates of smoking
- ❖ Increased knowledge of health factors that contribute to cardiovascular disease
- ❖ Improved healthy behaviors (increased fruit and vegetable intake, increased physical activity, decreased sedentary time)



Type of Outreach Grantee

Organization Name	Regular Outreach Track	HISP Track
Adams County Public Hospital District 2		✓
District Health Department 10		✓
Greater Meridian Health Clinic Inc.		✓
Lake Cumberland District Health Department		✓
Mariposa Community Health Center Inc.		✓
North Central Iowa Mental Health Center		✓
Pennyroyal Healthcare Service Inc.		✓
Rural Alabama Prevention Center		✓
Stephenson County Health Department		✓
Tri-County Health Network		✓
Westchester-Ellenville Hospital Inc.		✓
Williamson Health and Wellness Center		✓
ARcare	✓	
Arkansas Rural Health Partnership	✓	
Aroostook County Action Program	✓	
Bay Rivers Telehealth Alliance	✓	
Bi-State Primary Care Association Inc.	✓	
Butler Healthcare Providers	✓	
CentraCare Health System	✓	
City County Health District	✓	
Community Care of West Virginia Inc.	✓	
Delta Health Alliance Inc.	✓	
El Centro Family Health	✓	
Family Health Services Corp.	✓	
Firsthealth of the Carolinas Inc.	✓	
Garrett County Memorial Hospital	✓	
Harbor Beach Community Hospital Inc.	✓	
Health Care Partners Foundation Inc.	✓	
Healthy Communities Coalition of Lyon and Storey Counties	✓	
Hopewell Health Centers Inc.	✓	
Indiana Rural Health Association	✓	
Innis Community Health Center Inc.	✓	
Inspire Development Centers	✓	
Lana'i Community Health Center	✓	
Mary Imogene Bassett Hospital	✓	

Organization Name	Regular Outreach Track	HISP Track
Mercer, County of	✓	
Mid-Valley Healthcare Inc.	✓	
Miners' Colfax Medical Center	✓	
Mississippi Headwaters Area Dental Health Center	✓	
Missouri Bootheel Regional Consortium Inc.	✓	
Monroe County Hospital	✓	
Mountain Comprehensive Care Center Inc.	✓	
North Country Health Consortium	✓	
Northeast Oregon Network	✓	
Ohio University	✓	
Peacehealth	✓	
Plainview Foundation for Rural Health Advancement Inc.	✓	
Regional Health Care Clinic Inc.	✓	
Rehoboth McKinley Christian Health Care Services Inc.	✓	
Richland Medical Center Inc.	✓	
Rural Health Access Corp.	✓	
Southwest District Health	✓	
Spokane Tribal Network	✓	
St. John's Lutheran Hospital Inc.	✓	
Strength in Peers Inc.	✓	
Summit Medical Fitness Center	✓	
University of South Dakota	✓	
Valley Heights School District 498	✓	
Yakima Valley Farm Workers Clinic	✓	
Total	47	12

Grantee Profiles

The following section contains contact information and brief descriptions of the 59 Rural Health Care Services Outreach Program grantees funded during the 2018-2021 grant period. These descriptions include project goals, services, and activities for project implementation, including evidence-based or promising practice utilized, key outcomes and impacts, lessons learned, and considerations for other communities.

Organization Name

Adams County Public Hospital District 2

Organization Information**Grant Number**

D04RH31628

Organization Type

Other: Public Hospital District

Organization Website**Address**

903 S. Adams St.

City

Ritzville

State

Washington

ZIP Code

99169

Primary Contact Information for Project**Name**

Corey Fedie

Phone

509-659-5402

Emailcfedie@earh.org**Focus Area(s)**

	Behavioral/Mental Health	Oral Health
	Cancer Care Management	Pediatric Care
✓	Cardiovascular Disease (CVD) Care Management	Pharmacy Assistance
	Case Management	Primary Care Services
✓	Chronic Disease Management	Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention	School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management	Specialty Care Services
✓	Community-based Care Coordination	Substance Abuse Treatment and/or Education
	Diabetes Care Management	Telehealth/Telemedicine
	Health Education/Promotion and Disease Prevention	Transitions of Care
	Health Improvement Special Project (HISP)	Women's Health
	Health Screenings	Other:
	HIV/AIDS	Other:
	Maternal and Child Health	Other:

Area(s) Served

The public hospital districts making up the Grand Columbia Health Alliance are in Adams, Grant, and southwest Lincoln counties.

Target Population(s)/Need Addressed

This grant project focused on the cohort of patients aged 30-74 at risk of developing cardiovascular disease (CVD). The communities comprising the Grand Columbia Health Alliance (GCHA) experienced shortages of primary care and specialty providers and identified a need for primary care and medical cardiology services. The communities also faced population, demographic, and socioeconomic challenges, including higher levels of poverty, higher percentages of chronic illnesses, and geographic barriers. They experienced higher rates of the leading controllable risk factors for CVD, including high blood pressure, diabetes, unhealthy diet and physical inactivity, and obesity.

Consortium/Network Partners

The GCHA Consortium members participating in this grant included five rural public hospital districts (PHDs) and the hospitals and clinics they operated. The districts included Grant County PHD3, Columbia Basin Hospital; Adams County PHD2, East Adams Rural Healthcare; Lincoln County PHD1, Odessa Memorial Healthcare; and Grant County PHD1, Samaritan Healthcare.

Project Goals

The GCHA grant program was designed to develop and utilize standardized care delivery and data-monitoring processes across the GCHA communities with the following specific and overarching goal: to prevent cardiovascular disease and improve quality of life for patients in the GCHA communities through prevention, detection, and treatment of risk factors for heart attack and stroke. The GCHA embedded selected evidence-based models into the primary care practices within the collective service areas to implement the following objectives designed to meet this project goal:

1. Develop a GCHA-level quality-assurance/quality-improvement program to ensure standardization, implementation, and evaluation of evidence-based models for cardiovascular disease prevention across the GCHA communities.
2. Identify and monitor cardiovascular disease risk for a cohort of patients aged 30-74 with no prior cardiovascular event.
3. Develop a comprehensive system of care collaboration across the alliance communities that provides coaching, training, and support to primary care providers and staff.
4. Address the social determinants of health, behaviors, and clinical indicators placing patients at risk of developing cardiovascular disease through deployment of community health workers.

Evidence-Based Model(s)/Promising Practice(s)

Because of the identified shortage of primary care providers and cardiologists in the community, the grant adapted the widely recognized evidence-based Collaborative Care Model (currently used in behavioral health) and focused on the cohort of patients aged 30-74 at risk of developing CVD. The collaborative care model included:

1. Care coordination and care management;
2. Regular, proactive monitoring and treatment to target using validated clinical rating scales; and
3. Regular, systematic psychiatric caseload reviews and consultation for patients who do not show clinical improvement.

The Collaborative Care Model was combined with elements of the Chronic Care Model and evidence-based community health worker model to ensure that the social determinants of health, health behaviors, and clinical indicators that lead to CVD were identified and addressed in a comprehensive manner.

Services and Activities

The GCHA Outreach Program included:

1. A GCHA-level quality-assurance/quality-improvement program to ensure standardization, implementation, and evaluation of evidence-based models for cardiovascular disease prevention across the GCHA communities.
2. Recruitment, enrollment, and monitoring of patients 30-74 with cardiovascular disease risk with no prior cardiovascular event into the outreach/care coordination program.
3. A comprehensive system of care collaboration across the alliance communities that provides coaching, training, and support to primary care providers and staff.
4. Deployment of community health workers to address the social determinants of health, behaviors, and clinical indicators placing patients at risk of developing cardiovascular disease.
5. Assessment and reporting on project progress and outcomes and monitoring patients over the three-year grant period and modifying the program as necessary.

Outcomes

Adams County's Outreach Program activities began in spring 2018. The project had significant success and had more than 300 community residents aged 35-70 at risk of cardiac disease enrolled. Through robust data collection and reporting, Adams County documented improvements related to nutrition and smoking, body mass index (BMI) and blood pressure, and improvements as measured by the CDC Heart Age Calculator. Adams County also heard many patient stories noting the benefits beyond what was "measured," including reduced feelings of isolation and loneliness, enhanced sense of safety, connection with other community resources, and improved patient and family satisfaction, to name a few.

1. Recruited and provided care to over 300 at-risk patients.
2. Improved outcomes including:
 - a. Lowered BMI
 - b. Reduced heart age
 - c. Improved Rate Your Plate scores
 - d. Lowered hemoglobin (Hgb) A1c
 - e. Improved medication adherence
3. Increased billed revenue by nearly \$200,000

Sustained Impacts

The Outreach Program grant has demonstrated the value of care coordination and community health workers for select patient populations. The program demonstrated that at certain enrollment volumes, the activities are sustainable through billable fees. Finally, ARCare's care coordinators and community health workers have valued the opportunity to meet regularly and to share best practices and learnings.

The program also demonstrated a need for expansion of the program beyond just the focus target population of this grant project, with providers identifying a need to expand the program to all ages, all conditions, and to specifically target at-risk obstetrician patients.

Lessons Learned and Considerations for Program Replication

Adams County learned it is very challenging for care coordinators in the smaller-volume hospitals (carrying out multiple responsibilities, in several areas of the hospital) to not get "pulled away" on higher-priority issues. Adams County also learned that without dedicated care coordination support, community health worker (CHW) staff could not be as effective in providing the community outreach, home visits, and monitoring components of the program. In turn, the amount CHWs were able to bill Medicare for services provided falls far short of covering even direct expenses. Adams County also found the need to remotely monitor a subset of the patients in the program and identified a significant number of additional patients and conditions that would greatly benefit from care coordination, CHW support, and home monitoring. Based on these findings, key considerations for program replication included the need for regionalization in the smallest rural clinics to ensure enough volumes to support the program, the importance of dedicated care coordination and community health worker staff, and the addition of remote patient monitoring.

Organization Name		ARcare	
Organization Information			
Grant Number		Organization Type	
D04RH31629		Federally Qualified Health Center (FQHC)	
Organization Website			
www.arcare.net			
Address		City	State
117 S. 2nd St.		Augusta	Arkansas
			ZIP Code
			72006
Primary Contact Information for Project			
Name		Phone	Email
Christy Campbell		870-347-2534	christy.campbell@arcare.net
Focus Area(s)			
<input checked="" type="checkbox"/>	Behavioral/Mental Health		Oral Health
<input type="checkbox"/>	Cancer Care Management		Pediatric Care
<input type="checkbox"/>	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
<input type="checkbox"/>	Case Management		Primary Care Services
<input type="checkbox"/>	Chronic Disease Management		Population Health
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
<input type="checkbox"/>	Community-based Care Coordination	<input checked="" type="checkbox"/>	Substance Abuse Treatment and/or Education
<input type="checkbox"/>	Diabetes Care Management		Telehealth/Telemedicine
<input type="checkbox"/>	Health Education/Promotion and Disease Prevention		Transitions of Care
<input type="checkbox"/>	Health Improvement Special Project (HISP)		Women's Health
<input type="checkbox"/>	Health Screenings		Other:
<input type="checkbox"/>	HIV/AIDS		Other:
<input type="checkbox"/>	Maternal and Child Health		Other:
Area(s) Served			
Independence, Izard, and White counties in Arkansas.			
Target Population(s)/Need Addressed			
The target population was adults in Independence, Izard, and White counties in Arkansas with a mental health or substance use disorder (SUD) diagnosis. The need addressed by this project was to increase access to behavioral and mental health and SUD services for rural Arkansans.			

Consortium/Network Partners

The Integrated Healthcare Consortium partners included ARcare, lead applicant, Federally Qualified Health Center; Stanley Pharmacy, pharmacy partner; and Mid-South Health Systems, community mental health center partner.

Project Goals

The goals of the Integrated Healthcare Consortium were:

1. Increased access to integrated health care services within the proposed service area;
2. Increased access to medication-assisted treatment (MAT) services to address the opioid epidemic in the service area; and
3. A finalized strategic plan for the consortium.

Evidence-Based Model(s)/Promising Practice(s)

The evidence-based models that were used in this project included Comprehensive Opioid Response with Twelve Steps (COR-12), Motivational Interviewing, cognitive behavioral therapy, and MAT. In addition, peer support services were also implemented to complement these services and engage the patients outside the clinic setting.

Services and Activities

Services and activities implemented through this project included adding mental health, MAT and peer support services utilizing the COR-12 model, Motivational Interviewing, and cognitive behavioral therapy in clinic settings within the project service area; annual depression screening of adults aged 19 years and older; provider and community education on SUD prevention and treatment services; continued education with Hazelden Betty Ford Foundation; Narcan education and distribution to eligible patients and first responders; newly developed partnerships with White County District and Drug Court and 100 Families/Alternative Sentencing (a collaborative effort of government agencies, nonprofits, and the business community working together to provide needed services to incarcerated individuals prior to and after their release); and a finalized a three-year strategic plan. In addition, project staff added a primary care focus to the initial screening, which led to other health-related positive detections such as HIV and hepatitis C, resulting in appropriate linkage to care for the patients.

Outcomes

1. Eighty-eight individuals enrolled in the 100 Families program. (The program had just started when COVID-19 hit; patients must complete 16 visits before graduating, and the program is still in implementation).
2. One hundred eighty-eight individuals enrolled in MAT program, and 101 are currently active and successfully participating in the program
3. Added mental health and MAT peer support at one additional site (Batesville); took on additional clients after the community health clinic in White County closed.
4. Four providers have obtained Drug Abuse Treatment Act waivers.
5. Ten providers and project staff have received SUD-specific training conducted by Hazelden Betty Ford Foundation.
6. One recovery coach obtained peer support specialist certification from the Arkansas Department of Behavioral Health Services.

Sustained Impacts

Sustained impacts included increased capacity; improved knowledge among providers, patients, and community; and improved service models. Since the implementation of this project in 2018, consortium members along with other community partners, state agencies, and local organizations continued to see the demand for these programs in other areas of the state, especially when the coronavirus pandemic became a reality. ARcare has expanded these services to nine of the FQHC clinic sites throughout ARcare's three-state service area. Implementation of tele-behavioral health is another way the consortium has made an impact, especially during the last year of the project. Although it is not ideal and not preferred by the provider, there were a few MAT visits that were conducted via telehealth during the pandemic. This service delivery model has also allowed members of the consortium to provide mental health services via telehealth in school systems, residential treatment centers, and homeless shelters. Behavioral health care coordination by the recovery coach was also a sustainable impact for this project.

Lessons Learned and Considerations for Program Replication

There have been many lessons learned over the course of the three-year project. Provider buy-in (prescriber and licensed clinical social worker (LCSW)) is key. If they do not believe in the program and what they are doing, then the program will not work — the patients will feel it. The integrated care team seems to work best — prescriber, LCSW, recovery coach, and behavioral health coordinator. The team should meet daily to discuss staffing and program needs for the upcoming day, any challenges on the horizon, any call-ins or reschedules to be made, and so on. It is important for the team to understand that patients will relapse. Have a relapse plan ready. Do not terminate them from the program. Work the relapse plan and help patients get back on track. Do your best to have your team hired and trained before you schedule the first patient.

Organization Name		Arkansas Rural Health Partnership	
Organization Information			
Grant Number		Organization Type	
D04RH31630		Nonprofit Organization	
Organization Website			
https://www.arruralhealth.org/			
Address		City	State
1969 Lake Hall Rd.		Lake Village	Arkansas
			ZIP Code
			71653
Primary Contact Information for Project			
Name		Phone	Email
Mellie Bridewell		870-265-6553	melliebridewell@arruralhealth.org
Focus Area(s)			
✓	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management	✓	Telehealth/Telemedicine
✓	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings		Other:
	HIV/AIDS		Other:
	Maternal and Child Health		Other:
Area(s) Served			
Arkansas Rural Health Partnership's (ARHP's) Mental Health Outreach project served 18 South Arkansas counties: Arkansas, Ashley, Bradley, Calhoun, Chicot, Cleveland, Columbia, Dallas, Desha, Drew, Jefferson, Lonoke, Lincoln, Monroe, Ouachita, Phillips, Prairie, and Union.			
Target Population(s)/Need Addressed			
The target populations included:			
1. Youth and adults (aged 12-64) at risk of developing or diagnosed with a mental or behavioral health issue in the southeast Arkansas Delta.			
2. The health care providers and teachers that treat and teach these individuals.			

Consortium/Network Partners

The project consortium consisted of the ARHP and its 16 member organizations, including Ashley County Medical Center, Baptist Health-Stuttgart, Bradley County Medical Center, Chicot Memorial Medical Center, Dallas County Medical Center, Delta Memorial Hospital, DeWitt Hospital and Nursing Home, Drew Memorial Health Systems, Helena Regional Medical Center, Jefferson Regional Medical Center, Magnolia Regional Medical Center, Mainline Health Systems (FQHC), McGehee Hospital, Medical Center of South Arkansas, Mid Delta Health System (FQHC), and Ouachita County Medical Center.

Project Goals

The overarching goal of the ARHP mental health outreach project was to reduce morbidity and mortality due to mental or behavioral health conditions in rural South Arkansas by building regional infrastructure and involvement, increasing public awareness of mental health, and providing outreach initiatives to community members, front-line responders, and health care providers.

Evidence-Based Model(s)/Promising Practice(s)

The evidenced-based model implemented through project activities included:

1. Mental Health First Aid (MHFA), which was chosen as an early intervention program with demonstrated success in improving population-level behavioral health in rural communities. This was accomplished by training individuals to recognize the signs and symptoms of behavioral health issues and assist individuals in need of care to access needed resources and mental health services. This model was selected based on the fact that the mental health infrastructure (both mental health providers and available services) is extremely limited in the service area.
2. Madison Outreach and Services through Telehealth (MOST) Network, which was selected for its telemedicine counseling component produced through a collaborative partner effort. This model was adapted by partnering with an academic university to provide support for health care providers and their patients in rural clinical and emergency departments.

Services and Activities

Services and activities of the project included:

1. Establishing a regional behavioral task force to address additional, ongoing, and emerging policy, infrastructure, and funding needs related to mental health service delivery in the service area;
2. Conducting a public awareness campaign to promote early detection of mental and behavioral health issues;
3. Increasing preventive and early intervention mental health services by training front line responders in MHFA — adult and youth; and
4. Working with an in-state university psychiatric institute to provide training and telehealth support, including assessment tools and review, medication reconciliation, and referral guidance, to primary care and emergency department providers throughout the region.

Outcomes

The outcomes of the project included:

1. The project provided MHFA (adult and youth) training to 314 front-line responders in rural South Arkansas.
2. The project continued to provide available mental health telehealth and distance learning support to health care providers in 14 hospitals, two FQHCs, and 84 clinics throughout rural south Arkansas.
3. The project provided mental health assessments or counseling to 35 patients in Year 2.
4. Throughout the project period, the ARHP Behavioral Health Task Force increased capacity to include 25 member organizations/representatives and continues to meet bimonthly.
5. The project provided certification training for five MHFA instructors (adult, youth, and teen).
6. The project promoted mental health awareness and access to navigation through billboards throughout the service area.
7. The project allowed ARHP to expand its efforts to obtain additional grant funding to (1) support training high school teachers in all school districts throughout the service area and (2) become the only organization in the state of Arkansas to receive funding for a pilot project for teen MHFA.
8. Sustained all activities.

Sustained Impacts

The sustained impacts of the project include:

1. ARHP will sustain in-house MHFA trainers who will continue to provide MHFA training to front line responders, teachers, parents, church leaders, and so on upon completion of this project, both throughout the service area and state of Arkansas.
2. ARHP will continue to partner with University of Arkansas for Medical Sciences (UAMS) Psychiatric Research Institute to support mental health resources for health care providers in rural health clinics and emergency departments throughout the service area. ARHP and UAMS have partnered together to secure funding needed to support these initiatives.
3. The ARHP Behavioral Task Force has a strategic plan that will continue to move forward through applying for additional funding to support mental health service infrastructure in the region and allow organizations to work together to secure funding needed to support growth and mental health awareness.
4. ARHP population health specialists have been trained in MHFA and will assist with mental health navigation to support mental health patients, their providers, and their families for access to care.

Lessons Learned and Considerations for Program Replication

Lessons learned:

1. Negative impact due to the lack of mental health care providers affected the ability of providing mental health assessments through a rural, local partner.
2. Health care providers in the service area lacked the knowledge of how to assess their patients for mental health and had no resources for assistance; therefore, the project had to take a step back to address this deficit.

Considerations:

1. Finding a strong academic partner to provide education and support for rural providers is extremely effective and nonthreatening to rural providers; providers proved to be receptive to this idea prior to accepting counseling support.
2. MHFA training has become extremely effective on the virtual platform, allows participants ongoing participation, and is an effective program for teachers and students in rural school settings.
3. Developing a strong, inclusive task force allows rural organizations to understand the capacity of each member and leverage each other to create strong and sustained projects.

Organization Name Aroostook County Action Program

Organization Information

Grant Number	Organization Type
D04RH31769	Nonprofit Organization

Organization Website

www.acap-me.org

Address	City	State	ZIP Code
771 Main St.	Presque Isle	Maine	04769

Primary Contact Information for Project

Name	Phone	Email
Jamie Chandler	207-554-4102	jchandler@acap-me.org

Focus Area(s)

Behavioral/Mental Health	Oral Health
Cancer Care Management	Pediatric Care
Cardiovascular Disease (CVD) Care Management	Pharmacy Assistance
Case Management	Primary Care Services
Chronic Disease Management	Population Health
Chronic Obstructive Pulmonary Disease (COPD) Prevention	School Based Care Coordination
Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management	Specialty Care Services
Community-based Care Coordination	Substance Abuse Treatment and/or Education
✓ Diabetes Care Management	✓ Telehealth/Telemedicine
✓ Health Education/Promotion and Disease Prevention	Transitions of Care
Health Improvement Special Project (HISP)	Women’s Health
✓ Health Screenings	Other:
HIV/AIDS	Other:
Maternal and Child Health	Other:

Area(s) Served

Aroostook County, Maine; Washington County, Maine; Penobscot County, Maine; and Franklin County, N.Y.

Target Population(s)/Need Addressed

American Indians suffer disproportionately from diabetes. Rural tribal health care facilities are faced with many challenges. Among these issues are a high prevalence of prediabetes and diabetes, limited financial resources, and a need to provide quality medical care, including screening for diabetes, patient education toward self-management and control, and timely diagnosis and treatment of prediabetes and diabetes and many of its common complications. Our project aimed to provide an efficacious and cost-effective program to deliver systematic, routine, high-quality diagnostic screenings, self-management education, and retinal examinations to all diabetes patients in six tribal communities.

Consortium/Network Partners

The consortium consisted of five Maine tribes located across very rural parts of Maine — two tribes located in Aroostook County (Micmac and Maliseet), two Passamaquoddy tribes in Washington County, and the Penobscot Nation in Penobscot County — and the Saint Regis Mohawk Tribe, located in Akwesasne of Franklin County, N.Y.

Project Goals

The goals of the project included:

1. Reducing the incidence of diabetic retinopathy via a mobile configuration of the Indian Health Service (IHS) Joslin Vision Network (JVN) telehealth platform;
2. Increasing glucose screenings to expand the identification of prediabetes and diabetes;
3. Providing lifestyle education classes to prevent the diagnosis of diabetes in high-risk individuals
4. Improving HgA1c in those with known diabetes via insulin pump opportunities and education (for clinically appropriate insulin-dependent patients with diabetes).

The ultimate goal of the project is Healthy People 2020 Objective V-5.2, reduce visual impairment due to diabetic retinopathy, and objective D-5.1, reduce the proportion of people with diabetes with an A1c value greater than 9%.

Evidence-Based Model(s)/Promising Practice(s)

The consortium implements the JVN telemedicine technology. The IHS JVN has a well-documented history of success through peer-reviewed literature and 100,000 retinal exams performed using JVN telemedicine technology.

The introduction of the insulin pump was an evidence-based option for clients with insulin-dependent diabetes. In a systematic review of 74 studies, the insulin pump has been found to provide better glycemic control and quality of life compared to daily insulin injection.

The National Diabetes Prevention Program (National DPP) is an evidence-based strategy adopted during the grant cycle.

Services and Activities

All tribal communities participated in community-level glucose screenings. Retinal imaging through IHS JVN was offered at each tribal clinic at a minimum of two times per year, with the duration of imaging days proportional to each clinic's diabetic caseload (or as requested by the participating health clinics). Five out of six tribes received training for the National DPP. Insulin pump therapy was implemented at three tribal health clinics (Saint Regis, Micmac, and Penobscot) with Maliseet also just beginning to request services.

Outcomes

Our outcomes varied by year and were greatly impacted by the coronavirus.

1. During 2018 and 2019, all tribal communities participated in community glucose screenings at health fairs. IHS JVN retinopathy services were offered at each tribal clinic a minimum of two times per year, with the duration of imaging days proportional to each clinic's diabetic caseload (or as requested by the participating health clinics). Individual patient imaging sessions were each 15-30 minutes in length. The IHS JVN ophthalmologists analyzed the retinal photos via telemedicine and then sent diagnostic consultation reports back to the primary care physicians at each respective health clinic. In 2019, 288 patients were screened.
2. In 2018, five out of six tribes received training for the National DPP. In 2019, the diabetes prevention program was in progress (or completed) at five out of six tribal sites. (Penobscot, Saint Regis, Township, and Pleasant Point had all completed activities.)
3. By March 2020, insulin pump therapy was in effect at three tribes (Saint Regis, Micmac, and Penobscot) with Maliseet also just beginning to request services. All activities came to a halt in March 2020 when the extent and ramification of the pandemic became fully realized. All tribes entered into a state of emergency. Diabetes Zoom classes were in effect at one tribal nation by December 2020, and two others were in the process of starting them by March 2021.

Sustained Impacts

One of the most beneficial sustained impacts of the program has been the success of the intertribal partnerships and proof that collaboration is indeed a great asset to all communities involved. The Maine tribal health directors have long worked together before the start of the consortium for health promotion and disease prevention but had never engaged in a cost-sharing program that relied on the sharing of common personnel, equipment, and assets. The tribal health centers all positively attest that the IHS JVN program, among other components of the project, is viable and effective in delivering systematic, routine, quality retinal examinations to diabetes patients. All tribes that have offered the JVN program have had increased eye examination rates and improved diabetes health outcomes based on the tribal Indian Health Service's Diabetes Care and Outcomes Audit Report.

Lessons Learned and Considerations for Program Replication

Most clinics that used the JVN program also expanded its uses to provide direct diabetes or nutrition education, HgA1c and blood glucose interpretations, individual case management, and referrals. In this multitier approach to health care, each tribal health clinic has found the program to be a boon to their diabetes program and has been highly effectively in helping patients to reach all the standards of care for diabetes management, not just eye examinations.

The National DPP proved not to be very successful through tribal communities. Zoom classes, although in their infancy in our project right now, seem to hold more promise and better participation rates.

Organization Name		Bay Rivers Telehealth Alliance	
Organization Information			
Grant Number		Organization Type	
D04RH31770		Nonprofit Organization	
Organization Website			
www.bayriverstelehealth.org			
Address		City	State
618 Hospital Rd.		Tappahannock	Virginia
			ZIP Code
			22560
Primary Contact Information for Project			
Name		Phone	Email
Donna Dittman Hale		804-443-6286	execdirector@bayriverstelehealth.org
Focus Area(s)			
✓	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
✓	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
✓	Case Management	✓	Primary Care Services
✓	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
✓	Diabetes Care Management	✓	Telehealth/Telemedicine
✓	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings		Other:
	HIV/AIDS		Other:
	Maternal and Child Health		Other:
Area(s) Served			
Bay Rivers Telehealth Alliance's (BRTA's) Bridges to Cardiovascular Population Health project served a rural population in the Northern Neck and Middle Peninsula of Virginia, encompassing 1,447 square miles with a population of 78,653; Westmoreland, Northumberland, Essex, Middlesex, Lancaster, and King and Queen counties.			
Target Population(s)/Need Addressed			
Approximately 500 rural, high-risk patients with congestive heart failure (CHF) or a dual diagnosis of CHF and diabetes in Westmoreland, Northumberland, Essex, Middlesex, Lancaster, and King and Queen counties of Virginia, were served through their primary care physician practices in home and community settings.			

Consortium/Network Partners

The network partners engaged in this project were Bay Aging, Middle Peninsula/Northern Neck Community Services Board, Riverside Health System, including the Riverside Center for Excellence in Aging and Lifelong Health, and the Riverside Medical Group.

Project Goals

Overarching goal: To increase access to health care services for patients with congestive heart failure and Diabetes who reside in rural communities of Virginia's Middle Peninsula and Northern Neck in order to intervene earlier in the disease progression to improve health outcomes, reduce morbidity and mortality, activate patient self-care, and improve patient satisfaction.

Goal 1: Expand access to services for patients with congestive heart failure and diabetes who are at high risk of hospitalization including remote home/patient monitoring (RPM), virtual health coaching, and nurse care management.

Goal 2: Expand BRTA capacity (or scope) to include remote telemonitoring for Medicare, Medicaid, and dual-eligible patients who are considered at risk for hospitalization or readmission.

Goal 3: Educate, engage, and activate enrolled patients to proactively manage their chronic health conditions.

Goal 4: Develop and incorporate a behavioral health screening and intervention component for enrolled patients.

Goal 5: Monitor health care access, quality, and cost to ensure program effectiveness and efficiency to demonstrate impact and identify the resources required to ensure its continuation.

Evidence-Based Model(s)/Promising Practice(s)

Adaptations of the Essentia Health Heart and Vascular Center model of care (RPM for long-term CHF), Healthy IDEAS (behavioral health coaching for depression and anxiety), and the Centers for Disease Control and Prevention-recognized diabetes education program, the Coleman Care Transitions Intervention, and the Stanford Model for chronic disease self-management education.

Services and Activities

This project implemented the following activities (by network partner organization):

1. Riverside Health System (RHS);
2. Remote patient monitoring using RPM equipment, nurse clinicians, and trend reporting;
3. Riverside Medical Group (RMG) — primary care case management, virtual visits, patient enrollment, and community referrals;
4. Riverside Center for Excellence in Aging and Lifelong Health (CEALH) — project evaluation and training services, staff development for the Riverside care coordinators;
5. Bay Aging — Healthy IDEAS community health coaches, home visiting, chronic disease self-management coaching and community-based chronic disease self-management programs transportation, and home-delivered meals; and
6. Middle Peninsula Northern Neck Community Services Board — behavioral health needs, behavioral health supervision and consultations to the Healthy IDEAS coaches, and mental health skills building for chronic mental illness. When needed, patients were referred for additional behavioral health services.

Outcomes

Final outcomes data is not available at this time; however, the following is a summary of some program outcomes based on preliminary results:

1. Higher-risk patients received a more intensive level of patient care management, including RPM, biweekly visits by phone, in-person or virtual visits by health coaches or the nurse care manager, an assessment of behavioral health support needs, referral for behavioral health coaching or counseling as needed, and chronic disease self-management training.
2. Anticipated outcomes include improved health status, reduced hospital admissions and emergency department usage, improved access to health services, reduced cost of care delivery, improved integration and oversight of services with regional providers, and improved patient management of chronic conditions.
3. Interim results in the patient satisfaction survey showed patients were motivated to monitor their health, used monitoring to help them improve their health, and used the technology for them to become more involved with their health care. Every participant said they would recommend remote patient monitoring to others. A smaller group reported they would be willing to pay for remote monitoring if insurance didn't cover it, although some said cost was a major factor. The daily alerts resulted in patients more proactively monitoring their health. Any alerts were followed up by nurses to determine the issue.

Sustained Impacts

The following represent some of the anticipated sustained impacts of the project:

1. Reduced hospital admissions, reduced emergency department usage, improved chronic disease outcomes, improved access to health services, and improved integration and oversight of services and return on investment.
2. Access to remote patient monitoring and care coordination as a tool to enhance primary care practitioner's ability to manage patients with complex chronic conditions.
3. Utilization of community-based services coordinated to address the social determinants of health that impact patient health outcomes, including access to transportation, quality of housing and nutrition, chronic disease self-management knowledge, and mental health self-management skills.

Lessons Learned and Considerations for Program Replication

Continued assessment of measures related to return on investment, patient outcomes, patient and provider satisfaction, and patient activation are anticipated to provide evidence of the efficacy of remote patient monitoring, case management, coaching/chronic disease self-management training, and mental health skills building and behavioral health services. This data can be used to influence decision-makers in private and public spheres to embrace these strategies through policy change, reimbursement support, and funding to reduce patient and financial risk, improve the quality of care outcomes, and reduce health disparities.

Patients were reserved or hesitant early on but then found they liked the monitoring, built trust with monitoring staff, and many expressed they did not want the monitoring to end after 90 days. One barrier that had to be worked through several times was the referral process from care management in the primary care practices to other community-based providers. In terms of replication in other communities, this is feasible as long as there is clear communication among the key departments in the health system between the community and technology partners.

Organization Name		Bi-State Primary Care Association Inc.	
Organization Information			
Grant Number		Organization Type	
D04RH31631		Nonprofit Organization	
Organization Website			
https://www.bistatepca.org/			
Address		City	State
61 Elm St.		Montpelier	Vermont
			ZIP Code
			05602
Primary Contact Information for Project			
Name		Phone	Email
Kate Simmons		802-229-0002	ksimmons@bistatepca.org
Focus Area(s)			
✓	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management	✓	Primary Care Services
	Chronic Disease Management	✓	Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
✓	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings		Other:
	HIV/AIDS		Other:
	Maternal and Child Health		Other:
Area(s) Served			
All of Vermont's rural designated counties or partially rural counties: Franklin, Lamoille, Orleans, Essex, Caledonia, Orange, Washington, Addison, Rutland, Bennington, Windham, and Windsor			
Target Population(s)/Need Addressed			
Bridges to Health serves immigrant farmworkers across rural Vermont with a focus on those who face significant barriers to care, including but not limited to language, cost, and transportation. Utilizing a whole-person approach, Bridges increases access to primary care and mental health services as well as personal well-being activities. Activities center around reducing individual barriers to services, addressing systemic barriers, and engaging farmworkers around emotional health and well-being.			

Consortium/Network Partners

Bi-State Primary Care Association partners with the University of Vermont UVM Extension (university), the Open Door Clinic (free clinic), and Vermont Care Partners (mental health network).

Project Goals

The first goal was to establish relationships between UVM Extension, Open Door Clinic (ODC), and Vermont Care Network to ensure that immigrant farmworkers in Vermont can successfully access mental health care services. Activities centered on staff training, targeted outreach to farmworkers, mental health screenings, and work with mental health agencies to increase access to services. The second goal was to continue work to improve access to primary care services for Vermont immigrant farmworkers by enhancing the Bridges to Health model, strengthening consortium and community partner relationships, and promoting culturally competent, linguistically appropriate health care for farmworkers statewide. The final goal was to leverage community, state, and federal resources to integrate the provision of mental health and primary care services to immigrant farmworkers in Vermont.

Evidence-Based Model(s)/Promising Practice(s)

Bridges to Health utilizes a modified *promotora* or community health worker model to reach the immigrant farmworker target population. This is a promising practice for Vermont, in which bilingual staff of local organizations incorporate health outreach into their existing employment positions. Recruiter/promoter positions created within UVM Extension and an outreach nurse position created at ODC enabled the consortium to utilize staff that is already respected and trusted within the target population, while at the same time maximizing outreach effectiveness and leveraging resources for both projects. This promising practice is being enhanced by integrating a mental health component. The five regional recruiters/promoters in addition to the outreach nurse were trained on mental health within the Latin community, identifying and appropriately responding to mental health needs, Motivational Interviewing techniques, and strategies to address nonclinical mental health needs.

Services and Activities

Outreach staff received Mental Health First Aid and Motivational Interviewing training to increase knowledge and capacity to respond to mental health needs of the target population. Farm outreach incorporated both formal and informal conversations and screenings related to mental health. Referrals and care coordination were provided to participants who screened positive for mental health concerns or self-identified as wanting to engage with mental health professionals. Outreach staff engaged farmworkers in activities to explore and address nonclinical mental health needs. Key mental health access points were supported in completing an accessibility self-assessment and provided recommendations for improvements. Farm outreach included education about access to health services, including primary care, and when necessary, care coordination was provided to reduce barriers to care. Feedback surveys were used to identify and discuss accessibility concerns with individual health entities. As possible, on-farm health screenings were provided. Consortium members met regularly and served as a resource at a local and state level as a voice for immigrant farmworkers impacted by barriers to health care.

Outcomes

1. Direct care provided or improved access to care for an average of 575 unique patients per year.
2. Over 150 farmworkers screened for mental health needs yearly, and over 70 increased knowledge about how to manage nonclinical mental health stressors.
3. Enhanced training, skills, and performance for nine outreach staff and community volunteers.
4. Decreased barriers to health care services including mental health care.
5. Increased knowledge by primary care and mental health care providers in Vermont through recorded training titled Culture: An Integral Part of Mental Health Services (69 views for part 1).
6. Resources and knowledge leveraged to secure additional funding for enhanced work and supplies related to COVID prevention, testing, and vaccine education (\$250,000) as well as food access (\$62,000).

Sustained Impacts

Bridges to Health's work over the past decade, supported in large part through a series of FORHP Outreach Program grants that allowed for an expansion of service area and enhanced focus areas to include mental health outreach, positioned Bridges to Health to serve as a resource and voice for farmworker health within the context of the global health pandemic. The trust built over the years among the farm owner and farmworker populations has proved to be an important component in public health efforts related to COVID and resulted in increased numbers of individuals reaching out seeking support in navigating services. Bridges to Health has been able to leverage resources, knowledge, and relationships to help ensure more equitable access to COVID prevention education and supplies, testing, and access to COVID vaccines. The foundational work of the Outreach Program helped secure additional funding for increased capacity to meet COVID-specific needs and has resulted in a recognition at a state level that Bridges to Health's work is critical to health equity goals put forth by the Vermont Department of Health.

Lessons Learned and Considerations for Program Replication

Creating long-term systemic change within health entities that have limited contact with non-English speakers requires patience. For rural areas with small numbers of limited-English-proficiency individuals spread across large geographic areas, utilizing health promoters that can work across siloed health entities and counties can be an effective way to reach and serve hard-to-reach populations. Coupling the health promoter role with other outreach work that is ongoing can be an efficient use of resources and benefit both Outreach programs (in our case health and education). At the same time, onboarding and training new staff who work only very part time can be challenging. Engaging participants in conversations about personal health and well-being including mental health contributes to enhanced trust and disclosure of health needs. Non-English speakers may, however, be resistant to accessing mental health services due to stigma and are even less likely to do so if an interpreter is required for services. A recent successful opportunity to connect participants to a native Spanish-speaking mental health provider through telehealth has underscored the need to prioritize this access.

Organization Name		Butler Healthcare Providers	
Organization Information			
Grant Number		Organization Type	
D04RH31771		Hospital (non-CAH)	
Organization Website			
https://www.butlerhealthsystem.org/			
Address		City	State
1 Hospital Way		Butler	Pennsylvania
			ZIP Code
			16046
Primary Contact Information for Project			
Name		Phone	Email
Erin Stewart		724-355-2897	erin.stewart@butlerhealthsystem.org
Focus Area(s)			
	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
✓	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
✓	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
✓	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
✓	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	Other:	
	HIV/AIDS	Other:	
	Maternal and Child Health	Other:	
Area(s) Served			
The service area is in western Pennsylvania and encompasses the four rural Pennsylvania counties of Butler, Clarion, Indiana, and Jefferson.			
Target Population(s)/Need Addressed			
The target population are inpatients 45 or older receiving care at one of the partnering hospitals with two or more chronic diseases, including obesity, congestive heart failure, diabetes, ischemic heart disease, chronic obstructive pulmonary disease (COPD), and hypertension.			

Consortium/Network Partners

This project included the following 13 partners: Butler Memorial Hospital, Clarion Hospital, Indiana Regional Medical Center, Butler Medical Providers, Clarion Hospital Employed Physician Practices, Indiana Regional Medical Center Physician Group, Butler County Area Agency on Aging, Clarion County Area on Aging, Aging Services Inc. Indiana County, Jefferson County Area Agency on Aging, Concordia Community Support Services, Visiting Nurse Association of Indiana County, and Clarion Forest Visiting Nurses Association.

Project Goals

The goal of this project was to improve the health and well-being of rural patients living with two or more chronic diseases by maximizing the coordination, communication, and compliance with appropriate health care resources in alignment with the Triple Aim. This project achieved this goal by providing a comprehensive care management program, linkages to social services and community agencies to help reduce barriers to care, and enrolling patients into chronic disease self-management education and lifestyle coaching classes. The consortium leveraged existing clinical resources and expertise in a coordinated manner. The partnership included all services needed to address care coordination by involving hospitals, physician practice groups, home health, community resources, and wellness programs.

Evidence-Based Model(s)/Promising Practice(s)

The primary evidence-based models and approaches implemented under this program included diabetes self-management education and Motivational Interviewing. Additionally, the project employed the Intensive Outpatient Care Program (IOCP), designed for people over the age of 65, and modifying it to be used as a model for those 45-64 years of age.

Services and Activities

This project implemented the following services and activities:

1. A comprehensive care management program that used an adapted version of Intensive Outpatient Care Program (IOCP) and followed patients between care transitions from inpatient care to a predetermined level of self-sufficient home care.
2. Linkages to social services and community agencies to help reduce barriers to care and long-term health, which includes support related to transportation, access to healthy foods, and prescription expenses, and so on.
3. Enrolling patients into chronic disease self-management education and providing lifestyle coaching classes.

For the purposes of this program, self-sufficient home care includes persons who may live in residential programs, independent living, or assisted living. *Self-sufficiency* in this usage refers less to a patients' ability to live alone without a caregiver or assistance and more to their ability to self-manage their chronic diseases.

Outcomes

In the first year of implementation, the focus was to hire resources, provide Motivational Interviewing skills training for staff, and develop protocols and processes for coordination of care within, and across, partners and ancillary care providers.

For inpatients, processes were developed to identify and enroll participants into the program. The program worked in partnership with home health to streamline transitions and create and disseminate patient and provider education. As the enrolled population transitioned through the health care continuum, the program successfully provided patient linkages to community support services and chronic disease self-management education. The lifestyle coaching classes evolved beyond diabetes education and weight management to include heart-healthy lifestyles, plant-based and Mediterranean eating, menu planning, blue zones, and a self-care series.

In Year 2, the program continued to improve due to learnings from Year 1 efforts. The program created clinical pathways that allowed staff to be more experienced and effective with chronic disease management. Heart failure and COPD clinics were developed to support this large chronic disease population after discharge and through transition, providing meaningful support to patients and their families.

In the third year, COVID-19 supported expansion of telehealth efforts. Earlier in the grant, obstacles with telehealth existed mainly due to state regulations, limiting the engagement and enthusiasm around this method of care delivery. With COVID-19, providers gained increasing exposure to and experience with telehealth. Barriers were reduced, promoting the use and convenience of this tool. Through the consortium, the program utilized HIPAA-compliant Zoom technology not only to meet with partners but also to connect patients with their providers and care team.

Sustained Impacts

The collaboration of this program and the blended delivery model created a bond of people with similar interests. In addition to the day-to-day information sharing, a formalized heart failure pathway was created. The pathway will continue long after the federal funding is completed, and there are plans to create additional clinical pathways for other chronic diseases. As a result of the program, the community will continue to see practice changes from increased referrals to diabetes education and lifestyle coaching as the value has been proven and explained to the referring providers. Providers are knowledgeable about the services and the value they add. Communities will continue to see an increased capacity for diabetes education and lifestyle coaching as new services have been added and patients have greater access to education including through use of videoconferencing. Beyond the services and infrastructure, the program has further integrated Motivational Interviewing into provider practice when engaging and educating patients.

Lessons Learned and Considerations for Program Replication

COVID-19 created unique challenges to providing care coordination and lifestyle coaching. A key takeaway is to not underestimate the tech savviness of patients. Many patients adapted well to virtual appointments and this allowed the project to reach a larger service area more efficiently. However, a one-size-fits-all approach does not work for everyone. Programs should consider patient preferences and ability to engage with technology. These valuable lessons showed that the future will be based on hybrid models.

Another takeaway is that strong partnerships are needed to deal with difficult times. The relationships between the care coordination staff, provider offices, and community agencies were paramount in pivoting this program to meet the needs of patients during the pandemic. The program created many lasting effects on the community. The program's legacy will include but certainly is not limited to the change in the way the hospital and community work together to serve patients with chronic diseases in the service area. It is anticipated that Butler Healthcare will continue to network strategically with community partners and share all knowledge.

Organization Name		CentraCare Health System	
Organization Information			
Grant Number		Organization Type	
D04RH31632		Critical Access Hospital (CAH)	
Organization Website			
www.centracare.com			
Address		City	State
50 CentraCare Dr.		Long Prairie	Minnesota
			ZIP Code
			56347
Primary Contact Information for Project			
Name		Phone	Email
Jodi Hillmer		320-732-7224	hillmerj@centracare.com
Focus Area(s)			
Behavioral/Mental Health			Oral Health
Cancer Care Management			Pediatric Care
Cardiovascular Disease (CVD) Care Management			Pharmacy Assistance
Case Management			Primary Care Services
Chronic Disease Management			Population Health
Chronic Obstructive Pulmonary Disease (COPD) Prevention			School Based Care Coordination
Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		✓	Specialty Care Services
Community-based Care Coordination			Substance Abuse Treatment and/or Education
Diabetes Care Management		✓	Telehealth/Telemedicine
Health Education/Promotion and Disease Prevention			Transitions of Care
Health Improvement Special Project (HISP)			Women's Health
Health Screenings			Other:
HIV/AIDS			Other:
Maternal and Child Health			Other:
Area(s) Served			
The counties included in the TEN Initiative are Todd, Lac qui Parle, Douglas, Renville, Swift, Morrison, Aitkin, Wright, and Kandiyohi.			
Target Population(s)/Need Addressed			
The target population for the TEN Initiative included the population of nine counties in Central Minnesota, each with a rural hospital as the focal point for specialty care services. The project also included one urban partner hospital that offers specialty care provider services. The TEN Initiative provided the telehealth equipment needs to improve access to telestroke specialty care for these nine rural hospitals and one telestroke specialty care support provider at St. Cloud Hospital in Stearns County. Stroke specialty care refers to stroke neurologists, neurosurgeons, and physician assistants and nurse practitioners.			

Consortium/Network Partners

The 10 consortium partners include CentraCare–St. Cloud Hospital (non-CAH), CentraCare–Long Prairie (CAH), Madison Hospital (CAH), Alomere Hospital (non-CAH), Renville County Hospital and Clinics (CAH, clinic), Appleton Area Healthcare Services (CAH, clinic), Little Falls Specialty Clinic within CHI St. Gabriel’s Hospital (clinic), Riverwood Healthcare (CAH), CentraCare Monticello (CAH, clinic), and Carris Health–Rice Memorial Hospital (non-CAH).

Project Goals

The overarching goal of the Central Minnesota Telehealth Expansion and Navigation Initiative (TEN Initiative) was to expand medical specialty outreach to rural health care providers and improve patient outcomes through telehealth and patient navigation services in Central Minnesota. This grant was built on the early successes of an initial Rural Health Care Services Outreach (Outreach) award in 2014 that resulted in an effective but limited rural telehealth network in Central Minnesota. The objectives of the grant award were:

1. To expand telestroke services at 10 rural health care provider sites above eight current stroke-care rural provider sites;
2. To expand specialty practices to include neurosurgery follow-up for intracerebral and subarachnoid hemorrhagic strokes to all current and new sites; and
3. To increase nurse navigator services through the Stroke Patient Navigator Program for patients to support their ability to self-manage post-stroke care.

The Stroke Patient Navigator Program is a regional post-stroke and transient ischemic attack (TIA) program that provides patients access to a telestroke/vascular neurology clinic navigator program. The primary goal of this navigation program is to provide better access to care to patients living in rural Minnesota and improve health outcomes for patients recovering from stroke or TIA. The patient navigator program went live in eight sites during the first grant award 2014-2017 and the program had proven results but lacked the resources for expansion, which allowed for opportunity for an expansion grant in 2018.

Evidence-Based Model(s)/Promising Practice(s)

The evidence-based models adopted to meet the community’s needs are telemedicine and patient navigation. Telemedicine and patient navigation have proven effective in many settings, including our targeted, rural population, and are recommended by the American Heart Association and American Stroke Association for improving the lives of anyone residing in rural locations and needing assistance with accessing care. CentraCare’s 2014 Outreach grant award had proven results but lacked the resources for expansion. With the 2018 Outreach award, CentraCare Health was able to build on and expand these services and continue to improve health outcomes for their rural health patients.

Services and Activities

For eligibility in the patient navigator program, the patient must:

1. Reside in an HRSA-determined rural area;
2. Have a diagnosis of a stroke or TIA; and
3. Be discharged from St. Cloud Hospital. The referral for the program came from each consortium partner in the form of a transfer log report, which tracks each phone call request for specialty neurology care from each of the consortium partners.

The patient navigator contacts the patient within five to seven days after hospital discharge to enroll the patient into the program. Upon enrollment, the patient navigator assesses the patient’s disability using the modified Rankin scale, assesses the patient’s situation at home, and reinforces education provided prior to discharge. The patient navigator verifies that new medications were picked up and all medications prescribed are being taken as directed. The patient navigator also verifies all follow-up appointments have been scheduled, including any therapies needed. The patient navigator offers a telehealth option for patients to use their neurology follow-up appointment, and if the patient prefers telehealth, assists with scheduling of the appointment.

Outcomes

1. Goal: Decrease the degree of disability by 50% within three months.
Outcome: As of March 2021, 67% of the patients enrolled for at least three months had no disability documented. The remainder patient population that has been enrolled for at least three months has had a 91% decrease in the degree of disability within three months.
2. Goal: Enroll 80% of the patients with stroke diagnoses into the post-stroke clinic grant program.
Outcome: As of March 2021, we have enrolled 84% of the patients who qualify for the program.
3. Goal: Reduce readmissions among enrolled patients to less than 9%.
Outcome: As of March 2021, among the patients who have completed their follow-up neurological appointment via Telehealth, there was 0% readmissions. Among the patients who did not have telehealth visits, but may have had a follow-up visit via phone, the readmission rate was 17.9%.

Sustained Impacts

All consortium partners have equipment in place to provide telehealth specialist appointments to the rural patient due to the funding of this outreach grant. This grant was an extension of a previous grant to expand successful telehealth services to rural communities throughout central Minnesota, increasing the network from eight sites to 18. The lessons learned from the previous grant helped us set up the network to be successful in the current grant. The workflows that were adopted in the previous grant were enhanced throughout this grant, such as having patients scheduled with their telehealth appointment at the time of their hospital discharge. With the pandemic, many appointments were transitioned to phone to reduce entry to any site.

CentraCare was able to utilize the foundation and networks that have been built through the work of both grants and make the transition to virtual care quicker and more efficient, especially during the time of COVID-19. In the years ahead, it is anticipated that the demand for virtual health care will continue to increase, and CentraCare will be able to continue build on these advancements and continue to provide high-quality care for rural patients.

Lessons Learned and Considerations for Program Replication

Most patients do not need frequent contact after returning home with a stroke. The sustainment plan will be looking at a process where all patients will receive an initial phone call, and if they require more assistance, the patient's home clinic transitional care individuals will become involved. These individuals work closely with the patient's primary care provider in the same clinic and can provide the most individualized care.

Most patients with a stroke in the rural hospitals will be transferred and admitted at St. Cloud, as the tertiary-care hospital for stroke care. Coordination of post-discharge ancillary services, such as speech and physical therapy, does not always flow seamlessly from the hospital to the community level. The patient navigator continues to assist with making sure the patient has appointments scheduled and, if they don't, the patient navigator will assist the patient in determining who to call.

Organization Name	City County Health District		
Organization Information			
Grant Number	Organization Type		
D04RH31772	Health Department		
Organization Website			
https://www.citycountyhealth.org/			
Address	City	State	ZIP Code
415 2nd Ave. NE, Ste. 101	Valley City	North Dakota	58072
Primary Contact Information for Project			
Name	Phone	Email	
Theresa Will	701-845-8518	twill@barnescounty.us	
Focus Area(s)			
Behavioral/Mental Health		Oral Health	
Cancer Care Management		Pediatric Care	
Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance	
Case Management		Primary Care Services	
Chronic Disease Management	✓	Population Health	
Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination	
Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services	
Community-based Care Coordination		Substance Abuse Treatment and/or Education	
Diabetes Care Management		Telehealth/Telemedicine	
✓ Health Education/Promotion and Disease Prevention		Transitions of Care	
Health Improvement Special Project (HISP)		Women's Health	
Health Screenings	✓	Other: Childhood Obesity	
HIV/AIDS		Other:	
Maternal and Child Health		Other:	
Area(s) Served			
Barnes County, N.D.			
Target Population(s)/Need Addressed			
The Barnes On The Move with Healthy Eating and Physical Activity Project (BOTMP) serves youth aged 10-17 in Barnes County by providing physical activity opportunities, proper nutrition education, and healthy food to enhance quality of life in the region.			

Consortium/Network Partners

BOTMP Consortium is a partnership consisting of individuals from the following organizations: Valley City Public Schools (VCPS), Barnes County Extension Services (NDSU Extension), and City-County Health District (CCHD). These organizations are located at the Barnes County seat in Valley City, N.D. All of these organizations share a stake in improving the health outcomes of youth in Barnes County.

Project Goals

The project has four goals. The first goal was to establish a professional structure to efficiently coordinate the project. The second goal was to develop and implement a robust, school and community healthy eating program to help see childhood obesity decrease or minimally level off with use of the Whole School Whole Community Whole Child (WSCC) model. The third goal was to develop and implement a robust, school and community healthy physical activity program using the Comprehensive School Physical Activity Program (CSPAP). The fourth goal was to obtain local data and complete a comprehensive project evaluation and sustainability plan for the BOTMP project.

Evidence-Based Model(s)/Promising Practice(s)

The basis of BOTMP is the WSCC model. The WSCC is a Centers for Disease Control and Prevention–endorsed model that is an expansion and update of the Coordinated School Health (CSH) approach, which incorporates the components of the CSH with the tenets of the whole-child method to strengthen a unified and collaborative approach to learning and health. It emphasizes the relationship between educational attainment and health by putting the child at the center of a system designed to support both. WSCC includes health education, physical education (PE) and physical activity, nutrition environment and services, health services, social and emotional climate, counseling, psychological and social services, physical environment, employee wellness, family engagement, and community engagement.

Services and Activities

1. Physical activity consultants provided several trainings to school staff on CSPAP, PE curriculum development, Active Classroom, Active Recess, and PE COVID-19. Fully stocked mobile kitchen carts have been purchased for all Barnes County schools, which will provide an opportunity for teachers to demonstrate and share healthy recipes with students in the classroom.
2. The BOTMP grant allowed for the continued operation of the Community On the Move program, which seeks to encourage physical activity during the winter months. As a result of COVID-19, we were able to adapt grant funding to provide the foundation necessary to shift to a virtual community program. On the Move now provides Zoom cooking classes and hosts exercise videos from community partners. Day care received equipment and social-distance PE training to ensure that children could still have access to safe physical activity.
3. In cooperation with various community partners, On the Move was able to launch a yearly Let's Walk Valley City! event designed to foster community exercise and engagement. The event has become popular among those in Barnes County and now has community support for continuing for a fourth year.

Outcomes

1. Children aged 10-17, daycare children, and community members have increased physical activity levels.
2. Increased understanding of the value of health and wellness accompanied by implemented policy, system, and environmental changes.
3. Enhanced availability of healthy food choices within the schools and community events.
4. Active classroom and active recess trainings offered to Barnes County schools.
5. New remote opportunities through Community On the Move that are able to be sustained.
6. PE curriculum development training provided to PE staff.
7. Provided Student On the Move, a program in which all the elementary schools in Barnes County participate to get students active and motivated, reaching over 900 students.
8. PE equipment and Interactive Health Technologies Spirit Zone heart rate monitors provided to county schools to provide additional physical activities and data collection.
9. Nutrition Zoom classes are now offered to daycare providers along with healthy baking classes for youth.
10. Fully stocked mobile kitchen carts have been purchased for all five Barnes County schools, which will provide an opportunity for teachers to demonstrate and share healthy recipes with students in the classroom.
11. Ran and sustained Let us Walk Valley City, a community event where approximately 500 participants walk a determined route complete with booths and healthy snacks.
12. Provided additional training opportunities for school staff, including attendance at the Shape America Conference.
13. Three daycares received equipment and social-distance PE training to ensure that children could still have access to safe physical activities during COVID-19.
14. Two hundred students participated in an after-school basketball pilot.

Sustained Impacts

1. One of the largest impacts of the BOTMP grant was the relationship fostered between BOTMP and daycare providers in Barnes County. Several socially distanced and Zoom classes have been held for daycare providers that really influenced the types of snacks offered to children and redefined safe socially distanced physical activity.
2. BOTMP has also led to a change in schools taking a more all-encompassing approach to student health. Now physical activity and nutrition is being tied to mental and behavioral health. For Valley City Public Schools, the Coordinated School Wellness Council was formed with members from both the schools and the BOTMP Consortium. By revitalizing this work group, the decisions for healthier options for students becomes a community opportunity.
3. The mobile kitchen cart project that is implemented in the county schools is now a sustainable project that will be overseen by On the Move. Coordinators will be in place at each school who will work with On the Move to manage and sustain the carts for future use.
4. Above all else, BOTMP has managed to establish itself as a strong local partnership that continues to provide benefit in Barnes County.

Lessons Learned and Considerations for Program Replication

1. One of the largest lessons learned from undertaking the BOTMP grant was the need to be flexible to the environment and needs of the community. When COVID-19 hit, the project faced the challenge of adapting our work plan to focus on remote physical activity and nutrition opportunities. The consortium worked to position itself in a way to provide services and events to the community during a time when in-person gathering was not permitted.
2. For a rural community program to be successful, the working relationships between consortium partners have to be strong and versatile. In addition, the structure of the consortium being decentralized allows for ideas and work structure to be organized according to the needs of individual work projects.
3. Working with community partners is vital to project success. BOTMP has provided oversight and recommendations to our county schools, while still acknowledging that they are the respective heads when it comes to implementing effective health policy. This has cultivated a relationship in which the schools see the BOTMP Consortium as local consultants or partners to improve health outcomes of our youth.

Organization Name		Community Care of West Virginia Inc.	
Organization Information			
Grant Number		Organization Type	
D04RH31773		Federally Qualified Health Center (FQHC)	
Organization Website			
www.ccvv.org			
Address		City	State
78 Queens Alley Rd.		Rock Cave	West Virginia
			ZIP Code
			26234
Primary Contact Information for Project			
Name		Phone	Email
Kristi Walker		304-881-1190	kristi.walker@ccvv.org
Focus Area(s)			
<input checked="" type="checkbox"/>	Behavioral/Mental Health		Oral Health
<input type="checkbox"/>	Cancer Care Management		Pediatric Care
<input type="checkbox"/>	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
<input type="checkbox"/>	Case Management		Primary Care Services
<input type="checkbox"/>	Chronic Disease Management		Population Health
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
<input type="checkbox"/>	Community-based Care Coordination		Substance Abuse Treatment and/or Education
<input type="checkbox"/>	Diabetes Care Management		Telehealth/Telemedicine
<input type="checkbox"/>	Health Education/Promotion and Disease Prevention		Transitions of Care
<input type="checkbox"/>	Health Improvement Special Project (HISP)		Women's Health
<input type="checkbox"/>	Health Screenings	Other:	
<input type="checkbox"/>	HIV/AIDS	Other:	
<input type="checkbox"/>	Maternal and Child Health	Other:	
Area(s) Served			
Clay, Lewis, and Upshur counties in West Virginia			
Target Population(s)/Need Addressed			
<p>This project targets teachers and elementary school-age children by implementing the PAX Good Behavior Game (GBG) in all elementary schools in the three-county area. By using the PAX GBG, this project will be able to teach children coping skills and identify children that need tier 2 and 3 services from a behavioral health provider. Evidence also shows that the PAX GBG will improve teacher satisfaction, which will have a positive impact on their mental health.</p>			

Consortium/Network Partners

Community Care of West Virginia (CCWV), Paxis Institute, Clay County School System, Upshur County School System, and Lewis County School System.

Project Goals

The goal of this project was to better serve the behavioral health needs of the children in Upshur Lewis and Clay counties in West Virginia by providing them an avenue to learn appropriate coping and behavior management skills and refer children that needed further intervention to an appropriate behavioral health professional.

Evidence-Based Model(s)/Promising Practice(s)

CCWV used the PAX GBG as its evidence-based model.

Services and Activities

CCWV and its partners implemented the PAX GBG in every elementary school in the three-county service area. This involved a strategic planning session with the Paxis Institute, initial teacher training, PAX Partner training, Next Step training, and PAX Tools training. CCWV provided the behavioral health support to the schools for the children that were identified as needing a higher level of intervention.

Outcomes

CCWV is still implementing the program through a no-cost extension due to the COVID-19 pandemic. The preliminary data shows:

Site estimate for implementation to date of teachers using PAX: for one year
Number of first-graders at school, district, tribe or community: 19,675

Hence, **1,692** fewer young people will need any form of special education services, **1,095** more boys will likely graduate from high school, **1,314** more boys will likely enter university, **1,746** more girls will likely graduate from high school, **1,365** more girls will likely enter university, **191** fewer young people will commit and be convicted of serious violent crimes, **1,892** fewer young people will likely develop serious drug addictions, **1,294** fewer young people will likely become regular smokers, **697** fewer young people will likely develop serious alcohol addictions, **954** fewer young women will likely contemplate suicide, and **1,294** fewer young men will likely attempt suicide.

\$256,168,500 — Predicted financial net savings to students, families, schools, communities, state and federal governments

\$23.67 — Estimated cost of PAX GBG materials per child for lifetime protection

\$22.00 — Estimated cost of external training and technical supports per teacher prorated per child's lifetime

\$26.80 — Estimated cost of internal supports for implementation and maintenance by teachers prorated per child's lifetime

Note: The forecasts are based on multiple randomized, longitudinal control trials of the active ingredients of this evidence-based practice. Benefits will vary as consequence of the quality of implementation, training, supports, commitment, and other variables; the predicted impact is greater for first-grade children with higher entering risks for internalizing and externalizing disorders. The cost-savings and lifetime benefits increase if trained teachers use these evidence-based based strategies in succeeding years for new entering cohorts of first-grade children.

Sustained Impacts

The sustained impact of this program is identified above in the preliminary data based on the number of first-graders that have been exposed the PAX GBG. This data is based on projections from proven data trials in the past.

Lessons Learned and Considerations for Program Replication

The pandemic made the limitations of school-focused models clear. The Pax Institute developed programs to address this gap and pushed them out quickly so that the project did not lose too much momentum. However, it was difficult since the children were not in schools. This was a special circumstance that interrupted our program, but moving forward we are planning to refocus on trainings through the summer in order to complete the project. CCWV and its partners have engaged the local colleges and universities to help coordinate training the PAX GBG to education majors. This would allow those teacher candidates to graduate with the skills to manage their classrooms and identify students that need behavioral health intervention. The original plan was to train only K–2 but the project was able to train the entire elementary school staff. In hindsight, the recommendation is to train the lower grade levels first (K–2) and then add a new level as students progress. For example, in Year 2 add third grade, in Year 3 add fourth grade, and so on. It is also recommend working with each school individually so that the implementation is more tailor-fitted to the specific needs of the school.

Organization Name		Delta Health Alliance Inc.	
Organization Information			
Grant Number		Organization Type	
D04RH31774		Nonprofit Organization	
Organization Website			
www.deltahealthalliance.org			
Address		City	State
435 Stoneville Rd.		Leland	Mississippi
			ZIP Code
			38776
Primary Contact Information for Project			
Name		Phone	Email
Michie Duke		662-686-7004	mduke@deltahealthalliance.org
Focus Area(s)			
<input checked="" type="checkbox"/>	Behavioral/Mental Health		Oral Health
<input type="checkbox"/>	Cancer Care Management		Pediatric Care
<input type="checkbox"/>	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
<input checked="" type="checkbox"/>	Case Management		Primary Care Services
<input type="checkbox"/>	Chronic Disease Management		Population Health
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
<input type="checkbox"/>	Community-based Care Coordination	<input checked="" type="checkbox"/>	Substance Abuse Treatment and/or Education
<input type="checkbox"/>	Diabetes Care Management		Telehealth/Telemedicine
<input type="checkbox"/>	Health Education/Promotion and Disease Prevention		Transitions of Care
<input type="checkbox"/>	Health Improvement Special Project (HISP)		Women's Health
<input type="checkbox"/>	Health Screenings		Other:
<input type="checkbox"/>	HIV/AIDS		Other:
<input type="checkbox"/>	Maternal and Child Health		Other:
Area(s) Served			
Washington and Sunflower counties of Mississippi.			
Target Population(s)/Need Addressed			
Targeted population includes 75,135 individuals in rural Sunflower and Washington counties, Mississippi. Nearly three of every four (72.2%) residents are African American, 35% live below the poverty level, 18.2% of adult males report regular binge drinking, 4.9% of adults are at high risk for poor health due to heavy drinking, 24.5% of residents lack basic literacy skills, and among low-income residents, 38.4% report more than seven days of poor mental health.			

Consortium/Network Partners

Delta Health Alliance (community-based health and education), Leland Medical Clinic (primary care clinic) Parkwood Behavioral Health (behavioral health inpatient), and Desoto Family Counseling (behavioral health outpatient).

Project Goals

The Delta Systems of Treatment and Rehabilitation (Delta STAR) Consortium is a collaborative program that provides access to a comprehensive pipeline of services implemented to improve access to and outcomes related to alcohol recovery and treatment in select rural communities in Sunflower and Washington counties. The goals of the program are to:

1. Reduce the number of arrests (recidivism) among participants;
2. Increase the number of different services and supports made available to participants;
3. Increase the percentage of participants that self-report one or more 30-day sobriety milestones;
4. Increase the number of days employed and working (self-reported); and
5. Improve the self-reported quality of life for program participants.

Evidence-Based Model(s)/Promising Practice(s)

The Delta STAR program implemented the following evidence-based or promising practice models: Quality of Life Enjoyment and Satisfaction Questionnaire (Endicott, J, 1993). The Q-LES-Q is a self-report measure designed to enable investigators to easily obtain sensitive measures of the degree of enjoyment and satisfaction experienced by subjects in various areas of daily functioning. The Recovery-Oriented Systems of Care (ROSC) model: This model is designed to establish a person-centered, coordinated network of community-based services for those at risk of alcohol and drug problems. ROSC involves partnering with other disciplines, such as mental health and primary care, to provide a full continuum of care to people in recovery. A cornerstone of this model is that it offers choice by providing a flexible menu of services and supports design to meet each individual's needs.

Services and Activities

The Delta STAR collaborative sought to replicate and build upon the evidence-based ROSC model, which offers choice by providing a flexible menu of evidence-based services and supports to meet the specific needs of individuals with alcohol and drug problems. This cooperative endeavor had two specific aims:

1. To establish a system to help patients and clinicians make better-informed health decisions about how to treat and manage persons who interact with local court systems with a finding of alcohol abuse or addiction; and
2. To improve substance abuse outcomes by engaging patients in selecting specific behavioral health services with regular primary care and supporting behavior change through goal setting. Services offered through the Delta STAR program include but are not limited to case management and patient navigation, career-readiness, and social service supports. The program offers mental and behavioral health counseling and medication management for enrollees.

Outcomes

Program data suggest that enrollees experience higher rates of sobriety and higher rates of employment after sustained participation in Delta STAR. There was also statistically significant improvement for Delta STAR participants on several quality-of-life measures.

Sustained Impacts

During the life of the project, infrastructure surrounding patient navigation and behavioral health services has grown tremendously. Due to this growth, consortium partners will be able to sustain these new services once the grant period concludes. The Delta STAR coordinator will continue to be employed, and the referral mechanisms between primary care and mental and behavioral health services will remain in place. Patients at Leland Medical Center will benefit from the expanded access to these services.

Lessons Learned and Considerations for Program Replication

Lots of the lessons learned were as a result of the COVID-19 pandemic and were related to televisit infrastructure. The Delta STAR program was even more equipped to service patients and participants virtually while ensuring patients were provided the highest level of care necessary. During the COVID-19 public health emergency, rural health clinics benefited from the expansion of access and payment structures that supported telehealth service provision. Delta Health Alliance was able to provide patients with tablets to support access to telehealth services.

Organization Name		District Health Department 10	
Organization Information			
Grant Number		Organization Type	
D04RH31633		Health Department	
Organization Website			
www.dhd10.org			
Address		City	State
521 Cobb St.		Cadillac	Michigan
			ZIP Code
			49601
Primary Contact Information for Project			
Name		Phone	Email
Donna Norkoli		231-876-3841	dnorkoli@dhd10.org
Focus Area(s)			
	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
✓	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
✓	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
✓	Diabetes Care Management		Telehealth/Telemedicine
✓	Health Education/Promotion and Disease Prevention		Transitions of Care
✓	Health Improvement Special Project (HISP)		Women's Health
✓	Health Screenings	Other:	
	HIV/AIDS	Other:	
	Maternal and Child Health	Other:	
Area(s) Served			
This project served Lake and Mecosta counties in Michigan.			
Target Population(s)/Need Addressed			
<p>The Dental Partnering for Heart Health Project served adults aged 30-74 with no history of cardiovascular disease. The target service area included two rural counties within the District Health Department 10 jurisdiction: Mecosta and Lake counties. This project focused on connecting dental health providers, public health providers, and primary care providers to create programs and referral systems to reduce the risk of cardiovascular disease in their patients. The needs of the target population addressed by this project were lack of access to programs to reduce the risk factors of cardiovascular disease (CVD), such as smoking, unhealthy weight, high blood pressure, diabetes, and periodontal disease.</p>			

Consortium/Network Partners

Primary project partners include a consortium comprising the following five partners:

1. District Health Department 10, a 10-county local health department;
2. Baldwin Family Health Care, a federally qualified health center;
3. My Community Dental Centers Big Rapids, a full-service dental center providing affordable care;
4. Spectrum Health Big Rapids Hospital, a local hospital serving Lake and Mecosta counties; and
5. Ferris State University, a university located in Big Rapids.

Project Goals

The goal of the Dental Partnering for Heart Health Project was to reduce rates of cardiovascular disease in two counties in rural northwest Michigan: Mecosta and Lake. The consortium members formed a network to demonstrate changes to cardiovascular risk through implementation of programming designed to increase adults' access to programs designed to reduce cardiovascular disease risk factors and to increase access to preventive dental care. This consortium created community-clinical linkages to refer individuals identified as having a high risk of experiencing a cardiovascular event to primary care services, dental services, and public health prevention services that addressed the identified risk factors for cardiovascular disease.

Evidence-Based Model(s)/Promising Practice(s)

This project adopted the promising practice model described in the Rural Health Information Hub: Oral Health-Primary Care Integration Model. This project adapted the model to include public health as a means of addressing health risk behaviors by increasing preventive programming and services among the low-income residents of Mecosta and Lake counties. This project facilitated patient navigation in the oral health care delivery system to connect with the medical care and prevention systems through collaboration and communication with primary care providers and public health program providers to ensure referrals that will lead to reduced risk of cardiovascular disease. The rationale for selecting this model was determined by the need in the targeted rural counties to increase access to dental care and connect persons receiving dental care to services and programs that impact their overall health and reduce their risk for cardiovascular disease.

Services and Activities

The primary activities implemented by the Dental Partnering for Heart Health Project included conducting heart age screenings of the target population using the Centers for Disease Control and Prevention Heart Age Calculator and providing referrals to appropriate services in each county based on CVD risk factors identified through use of the calculator. The project also created systems change for tobacco cessation in the My Community Dental Centers and the Baldwin Family Health Care dental clinic through assessment of the current tobacco cessation referral system and workflow and making health systems changes to align protocols and practices for treating tobacco use and dependence to the Clinical Practice Guideline for Treating Tobacco Use and Dependence. Referral systems were created between health care providers, dental providers, and public health providers to address blood pressure case management, diabetes case management, weight management, tobacco cessation, and diabetes prevention. A need was identified for a weight-management program, and Spectrum Health Big Rapids Hospital created a program, Fit 4 U, to address this need for our participants.

Outcomes

Outcomes of the Dental Partnering for Heart Health Project include:

1. Reduction of CVD risk as demonstrated by implementation of the CDC Heart Age Calculator;
2. Increased percentage of adults accessing routine preventive dental care;
3. Decreased rates of adult smoking;
4. Increased percentage of participants managing their type 2 diabetes as measured by A1c;
5. Decreased rates of adult overweight and obesity; and
6. Increased percentage of participants controlling blood pressure to less than 140/90.

Sustained Impacts

Multisector systems have been put in place for referrals to tobacco cessation, the Diabetes Prevention Program, weight management, and case management for blood pressure and diabetes.

New programs to address the need for reducing CVD risk factors have been developed and will be sustainable. Baldwin Family Health Care is now implementing classes for diabetes management with a registered nurse case manager. Spectrum Health Big Rapids developed and implemented the Fit 4 U weight-management program and plans to sustain this program after the funding ends.

The tobacco health systems change activities implemented with the dental clinics have led to a partnership with District Health Department 10 to implement health systems changes to align protocols and practices for treating tobacco use and dependence to the Clinical Practice Guideline for Treating Tobacco Use and Dependence.

Lessons Learned and Considerations for Program Replication

One of the major lessons learned through implementation of this project was that with the goal of screening over 500 eligible adults in Year 1, it was very difficult to follow up with, track, and engage this extremely large cohort. The consortium members anticipated that since there were programs in place to refer participants, that participants would take advantage of these free programs. It was more difficult than anticipated to engage people in lifestyle change programs. A smaller cohort of people who engaged with each other for social support might have increased success with enrolling participants in programs, such as tobacco cessation, weight management, Diabetes PATH, and diabetes prevention. This program is being replicated currently in two additional counties, and we are screening a smaller number of eligible adults and focusing more on follow-up and engagement in lifestyle-change programs. Another lesson learned was that utilizing a community health worker to enroll participants in the Community Connections program to screen them for social determinants of health and connect them to needed resources in the community was a valuable addition to the project.

Organization Name	El Centro Family Health		
Organization Information			
Grant Number	Organization Type		
D04RH31775	Federally Qualified Health Center (FQHC)		
Organization Website			
www.ecfh.org			
Address	City	State	ZIP Code
538 N. Paseo de Onate	Espanola	New Mexico	87532
Primary Contact Information for Project			
Name	Phone	Email	
Tracey Garcia	505-747-5922	tracey.garcia@ecfh.org	
Focus Area(s)			
Behavioral/Mental Health		Oral Health	
Cancer Care Management		Pediatric Care	
Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance	
Case Management		Primary Care Services	
Chronic Disease Management		Population Health	
Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination	
Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services	
Community-based Care Coordination		Substance Abuse Treatment and/or Education	
Diabetes Care Management		Telehealth/Telemedicine	
Health Education/Promotion and Disease Prevention		Transitions of Care	
Health Improvement Special Project (HISP)		Women's Health	
Health Screenings	✓	Other:	Peer Recovery Support Services
HIV/AIDS		Other:	
Maternal and Child Health		Other:	
Area(s) Served			
Rio Arriba, San Miguel, Colfax, Harding, Guadalupe, Mora, and Taos counties.			
Target Population(s)/Need Addressed			
<p>The target population for the Semillas de Esperanza program is Hispanic, American Indian, and Mexican community members who face challenges in accessing behavioral health and substance use disorder services. Challenges include cultural-based stigma and discrimination, lack of treatment options that accept their form of payment, and lack of services that are delivered in a culturally appropriate manner. There are also significant geographic and transportation barriers to seeking health care in this highly rural region. All seven counties are designated as Medically Underserved Areas.</p>			

Consortium/Network Partners

El Centro Family Health (community health center), Hoy Recovery (SUD services), Northern New Mexico College (community college), and Rio Arriba County Health and Human Services Department.

Project Goals

The Semillas de Esperanza project utilizes the evidence-based Peer Recovery Support Services model to assist individuals in substance abuse recovery with peer-led one-to-one and group support in an integrated primary care and behavioral health care environment that serves a seven-county rural region in northern New Mexico. The Semillas de Esperanza project supports long-term impacts that will increase sustained substance abuse recovery and reduce drug overdose deaths in a region that includes Rio Arriba County, one of the areas in the nation most affected by the opioid epidemic. This project sought to build and sustain peer recovery support workforce capacity by hiring and training three peer support specialists (PSSs) and placing them in centrally located integrated primary and behavioral health care clinics in Española, Taos, and Las Vegas operated by lead partner applicant El Centro Family Health (ECFH), a Federally Qualified Health Center.

Evidence-Based Model(s)/Promising Practice(s)

The Semillas de Esperanza project serves patients through three PSSs with the goal of supporting patients to achieve improved recovery outcomes as measured by the reduction in substance abuse relapses. Using the Peer Recovery Support Services evidence-based model outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA), the model is suitable for application in a rural region, and adaptations were not necessary, though there were important lessons learned about staffing and supervision outlined in the Implications section below. The goal to provide ongoing professional development for both the PSS and partner substance abuse treatment staff ensured regional consistency of care and included training on three evidence-based care models: Motivational Interviewing, the Matrix Model, and Seeking Safety.

Services and Activities

Semillas de Esperanza had five primary goals:

1. Implement a new peer recovery support program to serve individuals in a seven-county region of Northern New Mexico in substance abuse recovery.
2. Provide ongoing professional development training for PSSs, as well as partner staff to support substance abuse-related care.
3. Promote workforce development by supporting participating patients to consider entry into the peer-led recovery health care field to fill provider gaps in the region.
4. Ensure the project is successful with regular consortium partner engagement, project planning, measurement and assessment, and is easily replicated.

Outcomes

1. El Centro hired three PSSs and stationed one in each of El Centro Family Health's HUB clinics. The PSSs provide peer support services in person and via telehealth on a one-on-one basis with patients struggling with addiction and mental health disorders. PSSs participate in group sessions that include the Matrix Model for substance use disorder (SUD) and Seeking Safety groups, which focus on trauma and SUD. Having PSSs be a part of the individual and group work has led to positive experiences for those participating as they are able to share their firsthand experience and how the skills being taught in group made a positive impact on their recovery.
2. PSSs were provided Matrix training and certification, Motivational Interviewing training and certification, and Seeking Safety series training. All three also received New Mexico Office of Peer Recovery and Engagement (OPRE) PSS Certification training. Each PSS is provided clinical supervision by an independent social worker or counselor as a part of their professional development and support as a peer. ECFH invited our partners to participate in Matrix training, Seeking Safety ongoing series training, and Motivational Interviewing training all hosted by ECFH.
3. ECFH provided educational materials for all partners to distribute at their facilities to any person interested in the field of peer support, substance abuse counseling, or therapy. Education packets included contact information for OPRE and local colleges and guidelines for various certifications and licenses.
4. Consortium partner meetings were held on a quarterly basis. Project progress and information about successes and barriers were presented during each partner meeting. Consortium partner participation started off strong but declined over the past three years.
5. All three of the PSSs are currently certified and are billing for services.

Sustained Impacts

The benefits of peer support are most evident in the integration with medical care when a Medication-Assisted Treatment (MAT) patient has fallen off of their treatment schedule. The medical provider is able to give a warm handoff to the PSS so that a check-in can be conducted. The PSS is then able to get the patient reengaged with behavioral health (BH) and rebuild connections between medical and BH services. PSS provides patients with a direct contact and support when they have medication issues and other challenges. The PSS can work directly with their medical provider to ensure the patients' medical needs are met. Not only do PSSs work with MAT patients but they also give BH providers support for patient check-ins. This is especially important for those who are high-risk and can use the additional assistance in harm reduction. PSSs are also able to help fill in as needed for intakes and BH handoffs. The integration of the PSS is vital in helping patients and providers in assisting with various responsibilities that promote health, growth, and a smooth transition toward a new healthier lifestyle.

Lessons Learned and Considerations for Program Replication

One lesson learned is the importance of selecting consortium partners that are located within the counties we serve in order to get the most support and engagement. Partners are important in the success of a program and selecting partners that have an investment in the community is an important lesson learned from this process.

Another valuable lesson when it comes to recruitment of PSS staff is the importance of finding the right individual and not to rush the process. The reason for this is that a PSS's time in recovery is crucial to their services as a PSS. The role of PSS can be a trigger if the PSS is not in sustained recovery. Frequent check-ins with supervisors are crucial to ensure self-care is taking place and PSSs are not at risk of mental illness-related or substance-related relapses. An open-door policy is important when it comes to the PSS and supervisor relationship. Another lesson is that it was not reasonable to expect a PSS to become a licensed substance abuse associate in a three-year period. The PSS needs time to adjust to their role and before moving into the education piece. When done all at once, this can be overwhelming and set a PSS up for failure.

Organization Name		Family Health Services Corp.	
Organization Information			
Grant Number		Organization Type	
D04RH31634		Federally Qualified Health Center (FQHC)	
Organization Website			
https://www.fhsid.org			
Address		City	State
794 Eastland Dr.		Twin Falls	Idaho
			ZIP Code
			83301
Primary Contact Information for Project			
Name		Phone	Email
Stephanie Atkinson		208-707-6705	satkinson@fhsid.org
Focus Area(s)			
✓	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management	✓	Pharmacy Assistance
	Case Management	✓	Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
✓	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management	✓	Telehealth/Telemedicine
✓	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings		Other:
	HIV/AIDS		Other:
	Maternal and Child Health		Other:
Area(s) Served			
Region 5 Public Health District–South Central Idaho: Blaine, Camas, Cassia, Gooding, Jerome, Lincoln, Minidoka, and Twin Fall counties			
Target Population(s)/Need Addressed			
The target population were patients (adolescents and adults) served in the primary care clinics operated by Family Health Services (FHS) in the state public health district of Region 5 of South Central Idaho. Targeted intervention population were patients with a comorbid chronic condition and who were identified as needing brief behavioral health intervention due to their difficulty managing their chronic condition or making lifestyle changes recommended by their provider.			

Consortium/Network Partners

Partners in the Rural Health Care Outreach Collaborative (RHCOC) included Family Health Services (FQHC), Region V Mental Health Services and Valley Community Counseling (mental and health and substance abuse services) Intermountain Health Center, (CAH), YNot Innovators (independent consultant and treatment and recovery center).

Project Goals

RHCOC project goals: FHS intended to lead a regional consortium called the Rural Health Care Outreach Collaborative (RHCOC). The project developed and piloted a rural Virtual Health Neighborhood model for the integration of behavioral health, clinical pharmacy, and physical health care with an emphasis on medication management utilizing telehealth to improve chronic disease management in rural and frontier, low-resource, medically underserved communities in South Central Idaho.

Evidence-Based Model(s)/Promising Practice(s)

FHS proposed to improve the integration of behavioral health and pharmacy aspects of the Health Neighborhood model based on the patient-centered medical home (PCMH) and patient-centered medical home–neighborhood (PCMH-N) models. This aligned with the philosophy of the evidence-based practice of the Chronic Care Model (CCM). Additionally, the American College of Physicians (ACP) definition for PCMH was used because it provides practice guidance for both PCMH and PCMH-N. ACP defined PCMH as the central hub of patient information, primary care provision, and care coordination. The primary care clinics transitioned to an “integrated team-based care” model. The behavioral health consultant (BHC) was supported in several evidence-based practices, such as Guiding Principles Care Model, the Pathways Model, and the Primary Care Behavioral Health Consultant (PCBH) Model, which is based on Behavioral Health Optimization Program through the Air Force Medical Operations Agency.

Services and Activities

1. Project objectives: Developed a regional PCMH and virtual health neighborhood based on the PCMH-N model to coordinate care across outpatient treatment continuum and medical subspecialties.
2. First year, behavioral health integration in primary care: Developed and implemented a Primary Care Behavioral Health (PCBH) model in the team-based care program at FHS that embeds new behavioral health consultants in rural primary care clinics in Jerome and Burley.
3. Second year, clinical pharmacy integration in primary care: Developed and implemented clinical pharmacy program hub with added care team of pharmacist, pharmacy technician, and pharmacy liaison to the team-based care program in primary care clinic in Rupert.
4. Third year, integrated telehealth in primary care locations: Developed telehealth hub-and-spoke model for pharmacy and behavioral health consultant services that would be available to all of the smaller rural clinics in our region.

Outcomes

Program outcomes:

1. Clinic level — Improved professional satisfaction through provider engagement in PCMH model.
2. Model adoption — Increased adoption of integrated behavioral health and pharmacy models.
3. Consortium level — Improved in referrals and coordination of care.

Clinical outcomes: Assisted or improved —

1. Assisted behavioral health screenings for depression, anxiety, and substance use;
2. Improved access to clinical care for primary care patients with behavioral health concerns;
3. Improved chronic disease outcomes
4. Increased patient activation

Sustained Impacts

1. Integrated clinical pharmacy services in Rupert primary care clinics, which has impacted the fulfillment of our project but also has provided needed services for pharmacy in the Rupert community. Having easy access and free consultation services to pharmacists and pharmacy techs in the community has increased access and early intervention for patients struggling with pharmacy needs.
2. Developed hybrid retail and clinical integrated pharmacy model in Rupert primary care clinic to improve community and clinic coordination for pharmacy-related services.
3. Leveraged NextGen data to monitor behavioral health and pharmacy progress and to identify behavioral health and pharmacy patients who could benefit from behavioral health and pharmacy services.
4. FHS has successfully sustained the integrated behavioral health program in three of their primary care clinics and retained the original BHCs in all three of their clinics. This fulfills the intent of the project to increase access to behavioral health services in the rural areas.
5. FHS has developed creative workflows for both BHCs and PharmDs to help manage their targeted populations.

Lessons Learned and Considerations for Program Replication

1. Recruitment and retention was difficult for the BHCs and Behavioral Health Crisis Centers. Consider using a recruiting consultant.
2. COVID-19 expedited the use video conferencing but also revealed that certain clinicians were not comfortable using it. Consideration for replication — have a standard training and orientation process for telehealth to set up expectations and logistics on telehealth hardware and software but also etiquette.
3. Following the PCBH model was a great place to start but needed adaptation due to issues in some of the rural areas. Consideration for replication is to adapt to change and modify workflow because model fidelity may not work in certain rural areas.
4. Engagement with the consortium was difficult due to COVID-19, but we learned the members found the meetings helpful and wanted to continue even after the grant. Video conference options should always be available for rural members.

Organization Name		Firsthealth of the Carolinas Inc.	
Organization Information			
Grant Number		Organization Type	
D04RH31776		Hospital (non-CAH)	
Organization Website			
Address		City	State
P.O. Box 3000		Pinehurst	North Carolina
			ZIP Code
			28374
Primary Contact Information for Project			
Name		Phone	Email
Roxanne Elliott		910-715-3487	rmelliott@firsthealth.org
Focus Area(s)			
Behavioral/Mental Health			Oral Health
Cancer Care Management			Pediatric Care
Cardiovascular Disease (CVD) Care Management			Pharmacy Assistance
Case Management			Primary Care Services
Chronic Disease Management			Population Health
Chronic Obstructive Pulmonary Disease (COPD) Prevention			School Based Care Coordination
Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management			Specialty Care Services
Community-based Care Coordination		✓	Substance Abuse Treatment and/or Education
Diabetes Care Management			Telehealth/Telemedicine
Health Education/Promotion and Disease Prevention			Transitions of Care
Health Improvement Special Project (HISP)			Women's Health
Health Screenings			Other:
HIV/AIDS			Other:
Maternal and Child Health			Other:
Area(s) Served			
Moore and Richmond counties (designated rural counties).			
Target Population(s)/Need Addressed			
The target population for the Sandhills Opioid Response Consortium project was the 142,387 residents in Moore and Richmond counties. Primary needs addressed included increasing awareness regarding substance use/opioid use disorder (SUD/ODU), increasing referrals to treatment programs, increasing access to medication-assisted treatment (MAT), creating a network of peer support specialists to support individuals in a recovery journey, and developing a consortium dedicated to reducing opioid-related overdoses and deaths.			

Consortium/Network Partners

Consortium partners include but are not limited to the following: FirstHealth of the Carolinas (lead agency), Drug Free Moore County (nonprofit organization), Moore County Health Department (public health), Richmond County Health Department (public health), Richmond Department of Social Services, Sandhills Center (behavioral health center), Alcohol and Drug Services (nonprofit), Moore County Sheriff's Office (law enforcement), HealthNC+ (physician group), Richmond County Sheriff's Office, Daymark (behavioral services), and Pinehurst Comprehensive Treatment Center (MAT provider). The consortium continues to grow. Most important, the peer support specialists are all consortium members.

Project Goals

Goal: To form and sustain a community coalition dedicated to reducing opioid-related overdoses and deaths in Moore and Richmond counties.

Objective 1: By April 30, 2021, increase the individuals referred to the intensive inpatient and outpatient treatment programs available in Richmond and Moore counties by 35% for inpatient and 50% for outpatient.

Objective 2: Develop and implement a comprehensive Narcan and opioid awareness and outreach campaign to educate and increase awareness among Richmond and Moore County providers, partners, and residents (139,789 total) by April 30, 2021.

Objective 3: By April 30, 2021, to increase access to MAT and care coordination, 10 primary care providers in the two-county region will become buprenorphine-certified to provide MAT to individuals who are discharged from an intensive inpatient or outpatient treatment program.

Evidence-Based Model(s)/Promising Practice(s)

The project was based on the Project Lazarus model. This model has a hub-and-spoke function. In the center of the model are public awareness, coalition action, and data and evaluation. The spokes of the model include community education, provider education, hospital and emergency department policies, diversion control, patient support, harm reduction, and addiction treatment. This project focused on community education, patient support, harm reduction, and addiction treatment. As the project evolved, the peer support model became a strong component of the work, although that was not the initial model for the project proposal. In conclusion, both the Project Lazarus model framework and the peers support model have led to project success.

Services and Activities

The primary activities implemented during the project included:

1. Formed and sustained Sandhills Opioid Response Consortium.
2. Developed outreach and education materials on harm reduction, peer support services, caregiver resources, signs of an overdose, and stigma education.
3. Recruited 20 peer support specialists to attend trainings; sent 16 individuals through peer support specialist training.
4. Built a robust peer support program with peers placed in homeless shelters, the Department of Social Services, correctional facilities, MAT clinics, rapid response teams, treatment facilities, recovery centers, and more.
5. Increased public knowledge through the development of a comprehensive website (www.firsthealth.org/recoveryresources) and social marketing campaigns.
6. Conducted stigma education trainings for first responders (law enforcement and emergency medical services).
7. Distributed Narcan to first responders and distributed harm-reduction kits to individuals at high risk for an overdose.
8. Strengthened partnerships, collaboration, and referrals within consortium partners as well as other organizations.

Outcomes

The following are grant outcomes:

1. Certified 16 peer support specialists.
2. Created a robust peer support program.
3. Assisted over 150 individuals with linkages to treatment and recovery resources.
4. Averaged approximately 400 encounters per month for individuals seeking treatment and recovery resources through the peer support specialists.
5. In response to COVID-19, developed a Facebook Live peer support program that averages 75 attendees per week.
6. In response to COVID-19, developed a virtual application (vOBOT) to provide telehealth peer support and rapid response teams for individuals seeking assistance for SUD/OD.
7. Created successful marketing and social media campaigns to include billboards, print advertisements, website advertisements, and Facebook target advertisements that resulted in over 75,000 individuals exposed to the peer support specialist messaging.
8. Created a website (www.firsthealth.org/recoveryresources) that contains resources for caregivers and individuals struggling with addiction.
9. Created a consortium with over 25 active members that is dedicated to addressing OUD/SUD overdoses.
10. Shared project successes as part of two White House–sponsored events, as well as participated in panel discussion for the national Rx Summit.

Sustained Impacts

There were several sustained impacts for this project. Prior to this project, partners were not working collaboratively to link individuals to services and resources for addiction. Through this work, referrals patterns have been established and continue to be adjusted to ensure that individuals receive the appropriate linkage to treatment and recovery services. Partners continue to work together for “release” planning from correctional facilities focused on harm reduction and linkage to treatment and recovery. Attitudes and knowledge were impacted through the marketing, social media campaigns, and stigma education sessions for first responders. Individuals have attested to how the trainings made an impact. The website continues to get hits as a result of media promotions. The consortium is dedicated to continuing the work and building on the project successes. One of the most important sustained impacts is that the two target counties now have a robust peer support program. The peer support specialists approach this work from lived experience. The difference and impact they make on a daily basis literally saves lives.

Lessons Learned and Considerations for Program Replication

Using the Project Lazarus framework provided a solid model for conducting this work. If the program is replicated, I strongly urge other organizations to consider the framework and determine where their community deficits exist and implement a work plan to address those with regard to SUD/OD.

Building a peer support program was a challenge at the beginning. The consortium relied on treatment partners to identify individuals in active recovery that might be interested. Once an initial group of peers was trained, those peers began reaching out to their networks. Partners embraced embedding peers in their organizations. Although the certification requires peers to be in active recovery for one year, FirstHealth learned that individuals in that first year are still very delicate and need to focus on their recovery. FirstHealth strongly urges others to recruit peers that are two or more years in active recovery. Ensuring there are resources to support the peers in their own recovery is also essential.

Engaging the consortium members in all aspects of the work plan is essential to building a healthy collaborative consortium.

Organization Name		Garrett County Memorial Hospital	
Organization Information			
Grant Number		Organization Type	
D04RH31777		Hospital (non-CAH)	
Organization Website			
www.grmc-wvmedicine.org			
Address		City	State
551 N. Fourth St.		Oakland	Maryland
			ZIP Code
			21550
Primary Contact Information for Project			
Name		Phone	Email
Kimi-Scott McGreevy		301-533-4356	kmcgreevy@gcmh.com
Focus Area(s)			
✓	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	Other:	
	HIV/AIDS	Other:	
	Maternal and Child Health	Other:	
Area(s) Served			
Garrett and western Allegany counties, Maryland; Somerset and Fayette counties, Pennsylvania; and Grant, Preston, Tucker, and Mineral counties, West Virginia.			
Target Population(s)/Need Addressed			
The combined population of Garrett Regional Medical Center's (GRMC's) service area is approximately 40,000 people. The project addressed a severe lack of behavioral health resources in the hospital's service area, which covers parts of eight counties across three states.			

Consortium/Network Partners

Garrett Regional Medical Center, 55-bed acute care hospital located in Oakland, Md.

Mountain Laurel Medical Center, FQHC located in Oakland, Md.

Sheppard Pratt Hospital, psychiatric hospital located in Towson, Md.

Originally, West Virginia University (WVU) served in the role now filled by Sheppard Pratt; however, difficulties in getting WVU to participate led GRMC staff to approach Sheppard Pratt about joining the consortium. The partnership with Sheppard Pratt has been quite productive.

Project Goals

- Goal:** Establish acute care behavioral health and addictions clinic that integrates primary care checks and wellness programs into patient-management plans.

Objective: Reduce the number of patients presenting with behavioral health or non-life-threatening addictions issues at hospital's emergency department.

Objective: Improve access to primary care and wellness checks for patients with acute behavioral health issues.

Objective: Increase volume of behavioral patients with comorbid conditions receiving ongoing primary care and wellness program services.
- Goal:** Provide consultative opportunities for staff and increase patient access to licensed, credentialed behavioral health providers through affiliation with Sheppard Pratt Hospital using telehealth program approach of evidenced-based Project ECHO.

Objective: Increase overall volume of behavioral health patients receiving services while reducing number of behavioral health and addictions patients waiting to see a licensed, clinical provider.

Objective: Reduce number of patients not in need of inpatient facility care referred outside community for behavioral health and addictions services.

Objective: Create ongoing opportunity for staff consultations with accredited psychiatric hospital's providers.
- Goal:** Improve transitions to inpatient facility placements through creation of a four-bed "safe house" and a two-bed detox unit within acute care hospital for behavioral health or addictions patients requiring more intense intervention.

Objective: Increase number of successful inpatient facility transitions by housing patients in a staffed, four-bed safe house.

Objective: Increase number of addictions patients detoxing in medically safe environment.

Objective: Reduce readmissions at local hospital.

Evidence-Based Model(s)/Promising Practice(s)

The University of New Mexico's Project Echo model was selected, which uses telemedicine to connect local behavioral health staff with psychiatric staff at a highly acclaimed psychiatric hospital. Psychiatric staff consulted with local providers on individual cases, provided training for local providers in best practices, and engaged in discussions with staff about approaches to care, diagnosing patients, and providing behavioral health care in rural communities. Additionally, a medication-assisted treatment (MAT) program was later integrated as part of the grant. MAT used suboxone to treat people struggling with opioid addiction. This evidence-based model program was undertaken to assist patients after a physician licensed to provide suboxone treatments retired, leaving patients with substance use disorder without options. The MAT program, like the Project Echo program, is ongoing.

Services and Activities

Counseling services were provided to people of all ages, children through geriatric patients. In addition, basic well checks, checking weight, heart rate, and pulmonary function, were also conducted on all patients. Those patients who lacked a primary care provider were advised on the importance of good physical health to mental health and the importance of regular primary care checks. Interested patients were referred to Mountain Laurel Medical Center.

Patients received counseling services on smoking cessation and 12-step group programs, as appropriate. In addition, patients in need of community services (transportation, help with child or elder care, housing, nutrition, and the like) were referred to the appropriate community agency for assistance.

Outcomes

Patient numbers grew exponentially once the center opened. In 2019, patients' totals increased from 19 in January to 188 by June and 238 by December.

1. From 2019 through February 2021, a total of 979 patients were served.
2. Patient numbers dropped briefly during COVID, going from 269 in January 2020 to 141 in June of that year. However, the numbers bounced back to 302 by December 2020.

Thus far in 2021, 291 patients have been seen in January and 262 in February.

Patients struggling with addiction issues receiving MAT currently number 54, with 43 of those 54 receiving individual counseling services. When the MAT service first began in mid-2020, that number was as high as 70. However, COVID-19 impacted the program, with patients relapsing. As the health care industry learned to deal with COVID-19 while continuing to provide services, numbers began to climb. At this rate with current staffing levels, the expectation is to serve between 60 and 70 patients by summer 2021.

Sustained Impacts

1. People throughout GRMC's eight-county service area now have comprehensive behavioral health services available to them, including walk-in services. The only service lacking at this point is inpatient psychiatric services, and currently, the program is working to recruit a psychiatrist, though this is very challenging in rural areas. There is a designated detox bed in the hospital, and the Project ECHO program has allowed existing behavioral health staff to deal with patients struggling with highly complex behavioral health issues who likely would not have received care locally in the past.
2. The need for services has led to a plan to expand the Behavioral Medicine and Addictions Treatment Center. As funding becomes available, GRMC plans to expand the office space available in order to accommodate at least two to three additional staff, including another mental health nurse practitioner able to provide MAT services.
3. While the number of MAT patients dipped during COVID-19, the pandemic's ongoing impact has caused more people to struggle with addiction. It is expected that the MAT program will grow consistently over the next year.

Lessons Learned and Considerations for Program Replication

The program worked well in the GRMC service area. GRMC is geographically isolated, and private practice counseling services have come and gone over the years. In fact, the two small, private practice counseling providers mentioned in the grant application both closed prior to the opening of the Behavioral Medicine and Addictions Treatment Center. The Project Echo model, which will continue with Sheppard Pratt, has proven very effective. Not only has the staff at the GRMC counseling center benefited, the realities faced in rural behavioral health by the Sheppard Pratt psychiatric staff have provided them with background on experiences they do not encounter in their urban/suburban setting. The big takeaway in terms of lessons learned is that the commitment of both parties to the Project ECHO model is essential to its success. WVU Medicine was unable, from the beginning, to consistently meet with GRMC staff. Once the partnership was established with Sheppard Pratt, things have gone amazingly well. This partnership has grown to include monthly training sessions on various diagnoses and approaches to care provided by Sheppard Pratt.

Organization Name		Greater Meridian Health Clinic Inc.	
Organization Information			
Grant Number		Organization Type	
D04RH31635		Rural Health Clinic	
Organization Website			
https://magnetcares.org			
Address		City	State
2701 Davis St.		Meridian	Mississippi
			ZIP Code
			39307
Primary Contact Information for Project			
Name		Phone	Email
LaTonya Horne-Agbagwu		601-693-0118	lagbagwu@gmhcinc.org
Focus Area(s)			
✓	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
✓	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
✓	Diabetes Care Management	✓	Telehealth/Telemedicine
	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings		Other:
	HIV/AIDS		Other:
	Maternal and Child Health		Other:
Area(s) Served			
Coahoma, Copiah, Covington, Forrest, Hinds, Holmes, Kemper, Lamar, Lauderdale, Leflore, Noxubee, Oktibbeha, Panola, Pearl River, Quitman, Tunica, Warren, and Winston.			
Target Population(s)/Need Addressed			
<p>The target population for the Mississippi Access Group Network (MAGnet) is medically underserved citizens within our catchment areas, aged 18-65. Our primary focus is providing services that are aimed at holistically addressing the needs of our patients through promoting healthier lifestyles. Crucial to the achievement of the above was the support of social services, health education, and behavioral health to the delivery of clinical care. The implementation of this grant within our organization has increased our holistic approach with our patients by providing seamless delivery of clinical and behavioral health care. We also have been able to bridge the clinical proponent externally by means of case management, community health workers, integrated behavioral health, and health care programs and interventions.</p>			

Consortium/Network Partners

MAGnet's consortium/network partners include a collection of five Federally Qualified Health Centers (FQHCs) within the state of Mississippi: Aurelia Jones-Taylor, CEO, Aaron E. Henry Community Health Center, Coahoma County; Dr. Geroldean Dyse, CEO, Southeast Mississippi Rural Health Initiative, Forrest County; Dr. Jasmin Chapman, CEO, Jackson-Hinds Comprehensive Health Center, Hinds County; Dr. Rozell Chapman, CEO, Dr. Arenia C. Mallory Community Health Center, Holmes County, and Wilbert Jones, CEO, Greater Meridian Health Clinic Inc., Lauderdale County.

Project Goals

The MAGnet project goals for the years of 2018-2021 were to reduce cardiovascular risks among patients enrolled into programs and initiatives at MAGnet member sites in rural locations across the service areas, to improve access to integrated behavioral health and primary care services across rural counties served by MAGnet members, and to bridge the gap from the clinic to the community regarding health literacy.

Evidence-Based Model(s)/Promising Practice(s)

The systematic problem-solving approach used by MAGnet members is Plan Do Study Act to incorporate the Care Model (CM) and the Model for Improvement, demonstrating a multidisciplinary team approach. The Chronic Care Model organizes the care of a population with chronic disease and addresses a mix of effective interventions to improve clinical performance. Care becomes proactive rather than reactive, where there are missed opportunities to improve overall care or meet care goals. The following tools and programs were used to enhance the care being given: the With Every Heartbeat is Life community health worker (CHW) intervention curriculum taught by CHWs provides skills to help patients learn to make practical, lasting changes to aide in fighting cardiovascular diseases. Remote patient monitoring is a self-monitoring platform by which patients' glucose, blood pressure, and weight/BMI are monitored to capture data to be assessed and reported to clinical staff. Million Hearts 2022 is a self-monitoring platform that will aide in the decreasing of disability and death due to high blood pressure. Behavioral Health Integration with Primary Care, including SBIRT, is an approach to the delivery of early intervention and treatment of people with substance disorders and those at risk of developing disorders. Target: Blood Pressure; Check. Change. Control. Cholesterol Recognition; and Target: Type 2 Diabetes are AMA/AHA national initiatives to control blood pressure, cholesterol, and diabetes.

Services and Activities

MAGnet consortium provided the following services and activities during the grant period, and they are: implementation of integrated behavioral health services provided by a behavioral health provider; development of a ministerial alliance; remote patient monitoring to support patients diagnosed with CVD; launch of the Go Red for Women Campaign which brought awareness to women to prevent strokes and heart attacks; expansion of diverse collaboration with other community organizations/agencies to provide the best and most effective CVD care modality for consumers within our care; provision of case management services; and. community engagements and outreach events utilizing community health workers to provide health education.

Outcomes

The MAGnet outcomes for the years of 2018-2021 are as follows:

1. Engaged 30-plus patients through programs/initiatives;
2. Remote patient monitoring case management;
3. AMA/AHA Target BP, Check. Change. Control. Cholesterol, and Target:Type 2 Diabetes interventions assisted in reducing CVD;
4. Community alliances were increased to ensure the needs of patients are being meet;
5. Reduced risk factors of CVDs;
6. Lowered high blood pressure scores to 140/90;
7. Utilized heart-healthy choices (nutrition and exercise);
8. Complied with scheduled classes, meetings, and integrated care services;
9. Lowered diabetes A1c below 9; reduced obesity, overweight, and BMI;
10. Reduced the number of heart attacks and strokes; and
11. Lowered blood cholesterol LDL to less than 100mg/dL

Sustained Impacts

The grant has assisted with the integrated health care model within the MAGnet consortium, allowing a new ambiance of service provisions for our patients in regard to having their needs addressed across all perimeters. Case management and other services and activities have been an addition that will continue to proactively grow and help sustain our patients in the arena of health care and life. This grant has assisted in the comprehensive approach of patient care, and not only seeing the patient medically or behaviorally, but also seeing the patient from the peripheral view of the complete life of an individual.

Lessons Learned and Considerations for Program Replication

MAGnet's lessons learned and program replication considerations from implementing, assessing, and evaluating the programs and initiatives that were presented to the target population within a rural service area are the availability to modify and adapt programs and initiatives, time management and scheduling, pooling resources, brainstorming, and engage patients virtually. Consideration for program replication is to maximize what has been learned and utilize that structure to move programs and initiatives forward.

Organization Name

Harbor Beach Community Hospital Inc.

Organization Information

Grant Number

D04RH31778

Organization Type

Critical Access Hospital (CAH)

Organization Website

www.hbch.org

Address

210 S. First St.

City

Harbor Beach

State

Michigan

ZIP Code

48427

Primary Contact Information for Project

Name

Trish VanNorman

Phone

989-479-3691

Email

tvannorman@hbch.org

Focus Area(s)

<input checked="" type="checkbox"/>	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management	<input checked="" type="checkbox"/>	Telehealth/Telemedicine
	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings		Other:
	HIV/AIDS		Other:
	Maternal and Child Health		Other:

Area(s) Served

This project served those living in Huron and northern Sanilac counties, two rural counties in the thumb of Michigan.

Target Population(s)/Need Addressed

The integrated behavioral health component of the project impacted residents living in the hospital service area located on the east side of Huron county. According to the 2010 census, approximately 9,100 residents live in the service area. The tele-behavioral health portion of the project increased access to psychiatry services for more than 50,000 rural residents living in Huron and Sanilac counties. Other than the targeted programs implemented by the hospital, there are no mental health counselors in the eastern half of the county. Counselors located in other areas of the county carry high caseloads; children under age 5 and adults aged 20-65 are critically underserved.

Consortium/Network Partners

Primary project partners include a consortium comprising the following four organizations: Harbor Beach Community Hospital (CAH), Huron Behavioral Health (county public mental health authority), Professional Counseling Services (private counseling agency), and List Psychological Services (private counseling agency and substance use disorder state program provider).

Project Goals

The long-term outcomes of this project are an increase in individuals that are more resilient, adaptable, and able to cope. As participants realized this outcome, we also saw improved chronic disease and behavioral health patient outcomes. The project made behavioral health services available and reduced the rural disparity as it relates to behavioral health services. We had three program goals:

- Goal 1: Implement integrated behavioral health services in two primary care clinics located in Port Hope and Harbor Beach, Mich.
- Goal 2: Improve patient health outcomes in Port Hope and Harbor Beach primary care clinics.
- Goal 3: Improve access to behavioral health services by residents in the east part of Huron County.

Evidence-Based Model(s)/Promising Practice(s)

The Mental Health Access Team (MHAT) identified two specific strategies for increasing access to behavioral health services:

- 1 Originally, integrated behavioral health using two evidenced based models was pursued: the Chronic Care Model, <https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-trained/about-collaborative-care>, and the Primary Care Behavioral Health; Patient Centered Primary Care Institute, <http://www.pccpi.org/model>. Due to provider preferences, we transitioned to a colocation model.
- 2 Tele-behavioral health services: Local volume, living conditions, and distance to larger communities makes recruiting a psychiatrist to our rural community almost impossible.

Services and Activities

Activities included:

- 1 Outpatient therapy: A full time licensed social worker was hired to provide outpatient mental health therapy and counseling for substance use disorders. Initially the counselor intended to provide brief interventions for chronic disease, however the demand for outpatient mental health services was greater than anticipated and required a full-time position.
- 2 Telepsychiatry visits: Both adult and child/adolescent psychiatry services were provided through a contracted agreement with a telehealth provider group. Through the project, volume and need were identified. A final schedule of four hours per week for the adults and two hours per week for the child/adolescent psychiatrist was implemented.
- 3 Community outreach and education: Outreach and education included the use of billboards, radio ads, social media, and community presentations. During the COVID-19 pandemic, social media became a very important platform and was utilized for recorded and live education programs.

Outcomes

Process outcomes of the project included providing 1,780 services to 317 people. Services were funded through FORHP for 251 patients, and 66 patients received services through other funding.

1. Patient Health Questionnaire depression screenings were provided to 213 patients, and 208 received generalized anxiety disorder screenings. Target 200 screenings.
2. A total of 209 patients received counseling services. Services were funded through FORHP for 182 patients. An additional 27 patients received services through other funding. Target 100 patients.
3. A total of 175 patients received telepsychiatry services. Services were provided for 121 adults — 71 funded through FORHP and 50 through other funding. A total of 51 children received telepsychiatry services — 47 through FORHP funding and four through other funding. Target 100 adults and 35 children.
4. Through FORHP funding, substance use disorder services were provided to 18 patients with seven referrals to other providers. Targets 15 and five. Impact outcomes included system change and patient improvement. Based on observation and referrals from providers, staff have adopted attitudes and practices that support evidence-based care for behavioral health conditions. Medical providers indicated an increased ability to conduct behavioral health screenings, find quality counseling for patients, and foster access to psychiatry providers. Primary care providers reported still facing significant challenges related to prescribing behavioral health medications and accessing inpatient programs. Project data showed improvement in both behavioral and physical health. Of 90 participants meeting inclusion criteria, 74% showed a decrease in PHQ9 or GAD7 scores. Of 20 people with hypertension, 55% had decreased blood pressure readings. Of 70 patients with a high BMI, 50% reduced BMI.

Sustained Impacts

New ways of serving: MHAT consortium members continue to have a strong partnership, with all members attending meetings and offering valuable input and resources. New capacity created: Because of the project, there are more local options for behavioral health services, the ability to use providers for overflow, reduced waiting lists, greater appointment availability especially for telepsychiatry services, and access to child/adolescent psychiatry, which is subject to a shortage in the state. Members of the consortium, as well as health care providers, also increased their awareness of resources and thereby utilization of other services. Policy changes to support sustained impact: Through this project, there were many policy changes that were implemented in the primary care clinics as well as the hospital emergency department. Depression screenings are administered on a more routine basis and providers are more attuned to behavioral health needs. Changes in community attitudes and norms: Residents indicate they are more receptive to seeking out mental health services, more knowledgeable about services, and are more likely to have their mental health needs met.

Lessons Learned and Considerations for Program Replication

Staffing was our major challenge. It was challenging to recruit a social worker and psychiatrists. As a result of the state and national shortage of psychiatrists, when we experienced turnover, it took significant time to fill the positions. This was compounded by the lag in credentialing with our payers. A major lesson learned is making sure primary care providers are involved in the original selection of models. At the time we were planning our project, there was a provider vacancy, which meant the doctor was not involved in the planning. As we learned over the course of the project, there are many degrees of integration. To have a fully integrated practice using the Chronic Care Model requires a strong foundation of services for making referrals. Since we had no counseling services available in the local community, the need for outpatient therapy outweighed the primary care interest in fully integrated care. We have also learned that due to the psychiatrist shortage, costs for contracting with a psychiatrist are greater than revenue from insurance, making sustainability a great challenge.

Organization Name	Health Care Partners Foundation Inc.		
Organization Information			
Grant Number	Organization Type		
D04RH31779	Nonprofit Organization		
Organization Website			
Address	City	State	ZIP Code
P.O. Box 166	Julesburg	Colorado	80737
Primary Contact Information for Project			
Name	Phone	Email	
Rita Torres	719-250-6433	rita.torres@hcpfoundation.com	
Focus Area(s)			
<input checked="" type="checkbox"/>	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
<input checked="" type="checkbox"/>	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
<input checked="" type="checkbox"/>	Community-based Care Coordination	<input checked="" type="checkbox"/>	Substance Abuse Treatment and/or Education
	Diabetes Care Management	<input checked="" type="checkbox"/>	Telehealth/Telemedicine
	Health Education/Promotion and Disease Prevention	<input checked="" type="checkbox"/>	Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	Other:	
	HIV/AIDS	Other:	
	Maternal and Child Health	Other:	
Area(s) Served			
Las Animas County, Colo.; Huerfano County, Colo.; San Miguel County, N.M., and Colfax County, N.M.			
Target Population(s)/Need Addressed			
The target population is inmates in four county jails. These four county jails are in rural communities in two different states, but they are counties that experience the same issues of recidivism rates of over 50% for high-risk individuals with mental health and substance abuse disorders.			

Consortium/Network Partners

Primary project partners include four rural county detention centers in Colorado and New Mexico:

1. Las Animas County Detention Center, Trinidad, Colo.
2. Huerfano County Detention Center, Walsenburg, Colo.
3. Colfax County Detention Center, Raton, N.M.
4. San Miguel County Detention Center, Las Vegas, N.M.

Project Goals

The project goals were to develop strategies and systems for high-risk inmates through the creation and deployment of advanced technology solutions for discharge planning in order to achieve successful outcomes for continuity of care from jail to community transition to reduce recidivism rates. This included network consortium strategic planning processes, development of electronic tools for detention officer prescreenings, and provider comprehensive assessment tools to identify medical, mental health, and substance abuse needs inclusive of “well-being” needs such as social, economic, education, working skills, housing, transportation, and so on. The ultimate goal was to build a safety net for these high-risk individuals through advanced technology upon discharge from incarceration back into the community through telehealth, teled, and care coordination systems until these individuals can be successfully transitioned into lives within their own communities.

Evidence-Based Model(s)/Promising Practice(s)

In evaluating transition systems in the correctional environment, HRSA was able to assist in identifying some national evidence-based models. One of those models was the Jail-to-Community transition (TJC) initiative launched in 2007 through the partnership of the National Institute of Corrections (NIC) and the Urban Institute (UI). They had developed a detailed and comprehensive assessment form that focused on the well-being needs of detainees in all areas, inclusive of medical, mental health, substance abuse, socioeconomic needs, transportation, housing, education, and environment. This was very detailed assessment and was an ideal tool to develop electronically. The key was to simplify the electronic processes for providers and staff to gather as much information as possible for a transition plan from incarceration to community.

Services and Activities

Primary activities started with a formal network consortium strategic planning process that identified the challenges the county detention centers were facing with the “revolving door” of recidivism and the goals to develop objectives that would address the high-risk needs of these individuals while incarcerated and provide a transition plan to prevent them from recidivating back into the jail systems. This resulted in the development of very specific and comprehensive electronic tools by the IT team from the University of New Mexico, who worked with a team of providers and staff to utilize the tools and deliver the teled and telehealth services to support transition processes. This “dream team” included advanced technology staff, detention staff, administrative staff, medical staff, doctors, mental health counselors, and therapists. The team accomplished the objectives and goals together for the successful outcomes of this program.

Outcomes

The primary outcomes achieved as a result of the outreach grant project implementation are:

1. Strategic planning process with four different counties in two different states.
2. Identification of advanced technology and provider team for development of tools.
3. Development of a software platform for advanced technology tools inclusive of a prescreening tool for detention officers and a comprehensive provider-based assessment tool focused on the entire “well-being” of individuals. Software platform was data-based, which allowed for data collection of all inmates coming through the county detention centers.
4. Development of standardized systems and training among network partners for officers, staff, providers, and inmates.
5. Establishment of telehealth interventions utilizing telecounseling, telepsychiatry, telemed, lab, pharmacy, triage, referrals, care coordination, counseling, and inmate education.
6. Extended development of referral systems in electronic assessment tool to utilize in discharge planning for community integration.
7. Development of discharge transition-planning packet for inmates upon release inclusive of printed summary assessment and treatment referral plan.
8. Monthly data reports by county with demographic information (ethnicity, race, gender, age), as well as a breakdown of those groups who have behavioral health and substance abuse issues.
9. Inmate tracking upon discharge and community transition demonstrating up to 30% reduction in recidivism rates.
10. National recognition of program results in CorrectCare publication in December 2020 and three presentations in National Commission of Correctional Health Care conferences in 2019 and 2020 and one coming up in April 2021.

Sustained Impacts

The most significant sustained impact of grant activities was accomplishing the goal of reduced recidivism through the development and utilization of advanced technology tools and services. The program accomplished the outcome result of an average of 30% reduction in recidivism rates in the four counties. Another sustained impact included the creation of a screening process that generates data on population coming into jails. This data is very helpful to county administrations and government in understanding underlying issues of needs within their own communities. Another significant impact has been the funding assistance by state and county government, which was leveraged through results obtained through the outreach grant. The Colorado Office of Behavioral Health was made aware of the grant program and is now providing funding in their fiscal year 2021 budget for Las Animas County and Huerfano County to continue and expand the telehealth and telemed services of the grant, inclusive of providing \$25,000 of telehealth equipment to each of those counties. In New Mexico, the Medicaid insurance plans are working together with the grant program to assist in transition and funding of services upon inmate discharge.

Lessons Learned and Considerations for Program Replication

The main lesson learned is that advanced technology tools must be simple and developed through a collaborative effort among providers, detention, and medical staff in order to be effective. This has now been done, and this program can easily be replicated among any jail system. A difficult part of the program has been and continues to be the credentialing requirements of providers for reimbursement sustainability funding systems in two different states.

Ironically, the COVID pandemic has streamlined some of those systems, but it is still a difficult and noninclusive system to maneuver through since this is a population who may have insurance eligibility suspended while incarcerated. County and state government officials are interested in potential legislation in addressing this issue on interruption in coverage. Another issue identified was the gathering of past medical community-based utilization information for inmates, but program staff were able to be part of a demonstration program in Colorado, which allowed them to work with a data exchange nonprofit organization to acquire electronic past and current medical data for our participating jails, which is HIPAA-compliant.

Organization Name	Healthy Communities Coalition of Lyon and Storey Counties		
Organization Information			
Grant Number	Organization Type		
D04RH31780	Nonprofit Organization		
Organization Website			
www.healthycomm.org			
Address	City	State	ZIP Code
P.O. Box 517	Dayton	Nevada	89403
Primary Contact Information for Project			
Name	Phone	Email	
Wendy Madson	775-246-7550	wendy@hcclsc.org	
Focus Area(s)			
	Behavioral/Mental Health	✓	Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention	✓	School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
✓	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	✓	Other: Community Health Worker
	HIV/AIDS		Other:
	Maternal and Child Health		Other:
Area(s) Served			
Lyon County, Nev.			
Target Population(s)/Need Addressed			
<p>Food pantry clients needing connection to primary care providers and elementary school–age children for dental health services. Our community and school-based CHWs assist families and clients with connections to needed services. These services could include signing up for Medicaid, making and attending health appointments (in person or virtually), coordinating transportation to appointments, translation, and so. Lyon County is a Medically Underserved Area, and most individuals living here face barriers to obtaining needed services.</p>			

Consortium/Network Partners

The first year of the grant, the consortium partners were Community Chest Inc. (CCI) and Central Lyon Youth Connections (CLYC). The second and third years of the grant, CCI and Dayton Pediatric Dentistry (DPD) were our consortium partners. CCI is a nonprofit offering counseling, family advocacy, youth enrichment programs and employment assistance placement. CCI is a long-standing partner of HCC's and offered expertise on program management and training to the CHWs in this grant. DPD partnered with us for the Dental Days program in elementary schools, offering screenings and sealants. All partners are a subset of the larger communitywide group, the Health and Wellness Hub (HWH).

Project Goals

1. Expand the delivery of health care services to food pantry clientele and elementary school-age children in Lyon County through community health workers (CHWs), partner agencies, and providers. In the first approach was connecting food pantry clients to primary care providers (PCPs) through CHWs. Healthy Communities Coalition's (HCC's) coordination with Nevada Health Centers (NHC) allowed for the provision of telehealth referrals to NHC and enabled the project to track referral connections to NHC through the addition of an HCC referral agency added to NHC's drop-down menu. The project also partnered with the University of Nevada Reno Medical School to support Rural Outreach Clinics (ROCs) providing exams, immunizations, diabetes and blood pressure checks, and women's health. The addition of ROCs in local communities has provided additional opportunities to connect to primary care through CHWs working with food pantry clients and assisting with appointments and connection. The second approach to this goal was to work with school-based CHWs to assist in implementing a dental health program in partnership with a consortium member, DPD, and other community partners. The project implemented four Dental Days per school year, one in each of the four surrounding communities: Dayton, Fernley, Silver Springs, and Yerington. Dental Days were expanded the second year of the grant to include screenings and sealants.
2. Develop, grow, and enhance the effectiveness of the HWH through a focus on recruitment, information sharing, and collaboration. The project recruited additional partners (DPD and NHC) to the HWH through consortium members.

Evidence-Based Model(s)/Promising Practice(s)

The project utilized the following evidence-based/promising practice models:

1. Promotora or lay worker health model: In this model, CHWs are members of the target population and share many of the same social, cultural, and economic characteristics. As trusted members of their community, promotoras provide culturally appropriate services and often serve as patient advocate, educator, mentor, outreach worker, or translator to their clients.
2. Care coordinator/manager model: As care coordinators or care managers, CHWs help individuals with complex health conditions to navigate the health care system. They advocate for and liaise between their patients and a variety of health care and human services organizations. In this model, CHWs also support individuals by providing information on health and community resources, coordinating transportation, making appointments, and delivering appointment reminders.

Services and Activities

In order to best connect food pantry clients to primary care, the project first established food pantry intake practices and trained CHWs on the intake process. Questions regarding health insurance status and whether an individual wanted to be connected to a primary care provider were added to the current intake form. CHWs then connected these clients to telehealth via NHC and shared ROC information and connection. Additionally, diabetes management classes were coordinated to help food pantry clients manage their chronic illnesses. The Dental Days program was implemented at four elementary schools the first grant year and two schools the second (COVID interrupted the project's ability to implement at two out of the four schools in 2019-2020), and the final year of the grant, the project held a community-based dental event at a consortium partner's office, DPD. Thirty-two kids received services including restorative care and sealants at this event held in February 2021.

Outcomes

The consortium's Outreach activities and accomplishments to date include:

1. Planning and implementing six Dental Days in years 1 and 2 of this grant. COVID-19 interrupted our 2019-2020 plan to reach elementary school-age children at an elementary school in each community, and we reached two out of the goal of four elementary schools. Alternatively, the project hosted a community-based event at a consortium partner DPD's office in February 2021 and provided sealants, restorative care, and exams and cleanings to 32 children.
2. Strengthening partnerships in the HWH by adding DPD as a partner and consortium member, expanding efforts around oral health.
3. A new set of food pantry intake forms has been created and implemented including a mandatory civil rights training for all food pantry volunteers and staff at the three pantries in Dayton, Silver Springs, and Yerington. During COVID-19, the project updated the food pantry intake process to be completed through tablets, eliminating paper forms, allowing the program to best serve the population and maintain physical distance. A health survey was added to the intake process to see how many families in the community need connection to a primary care provider and identify gaps and barriers to care connection.
4. Work with NHC opened up opportunities to provide telehealth to individuals seeking primary care, and the ROCs provided vital connections through community-based clinics offering glucose and blood pressure checks, labs, vaccines, women's health, and evaluations.

Sustained Impacts

The sustained impacts of this Outreach grant include improving oral health among elementary school-age children, increasing the impact of CHWs through outreach around oral and physical health, and improving partnerships within the community related to connecting food pantry clients to primary care providers. The program is currently in the process of working with the FQHC, NHC, in creating a telehealth service option for food pantry clients, enabling community members to connect virtually while removing one of the major barriers in local communities (transportation). Additionally, the growing partnership with the University of Nevada, Reno (UNR) School of Medicine's ROC will help provide medical services to food pantry clients and beyond. As the clinic travels out to multiple communities, it is expected that there will be positive impacts on the ROC students as they gain experience in and understanding of providing care to rural residents in the community, meeting people where they are.

Lessons Learned and Considerations for Program Replication

Lessons learned from experience implementing this program include sustaining long-term partnerships between community organizations and HCC through the HWH. Strengthening partnerships and consortium members through the HWH continues to be a priority and has proven to be a supported and organized approach in bringing agencies, services, providers, and community members together in responding to the needs of our communities.

Another lesson learned is around recognizing the importance of deep connections and trust between CHW and client. Although CHWs are community-based and have been engaged with clients prior to this project, the time commitment to strengthen trust, particularly with regard to utilizing telehealth, has proven to be more challenging than anticipated. Many clients who identified as wishing to be connected to primary care were eager to start but opted out as they got closer to connection. Additionally, the project encountered many barriers with the telehealth program, including clients having limited access to devices and the internet, complicating the mission to connect to telehealth.

Organization Name	Hopewell Health Centers Inc.		
Organization Information			
Grant Number	Organization Type		
D04RH31781	Federally Qualified Health Center (FQHC)		
Organization Website			
www.hopewellhealth.org			
Address	City	State	ZIP Code
1049 Western Ave.	Chillicothe	Ohio	45601
Primary Contact Information for Project			
Name	Phone	Email	
Sherry Shamblin	740-590-1644	sherry.shamblin@hopewellhealth.org	
Focus Area(s)			
<input checked="" type="checkbox"/>	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination	<input checked="" type="checkbox"/>	Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	Other:	
	HIV/AIDS	Other:	
	Maternal and Child Health	Other:	
Area(s) Served			
Rural-designated Washington and Athens counties in Southeastern Ohio			
Target Population(s)/Need Addressed			
The targeted population for the project was children and adolescents living in the designated counties who were in participating school districts. The grant included the implementation of PAX Good Behavior Game, which is a universal substance abuse prevention program, and targeted group interventions for students.			

Consortium/Network Partners

Partners included the Washington County Health Department, Life and Purpose Community Mental Health, the Washington County Mental Health Board, Marietta City Schools, Fort Frye School District, Belpre City Schools, Wolfe Creek School District, Warren Local School District, Frontier School District, Washington County Boys and Girls Club, and Alexander School District.

Project Goals

The goal was a comprehensive and unified prevention-intervention system for students and caregivers in participating schools through the implementation of evidenced-based practices that would form a comprehensive continuum of care with three distinct levels:

1. A universal level designed to impact all students attending a participating school through prevention models;
2. A targeted level aimed at providing screening/identification and support for at-risk middle and high schools students as well as adult caregivers; and
3. An intervention level designed to provide appropriate treatment for students and adult caregivers who have behavioral health concerns.

Evidence-Based Model(s)/Promising Practice(s)

The following evidence-based and promising practice models were used as part of this project:

1. Pax Good Behavior Game for Schools/Pax Tools for community programs;
2. Early childhood/infant mental health consultation;
3. Triple P;
4. Zones of Regulation; and
5. Random Acts of Kindness.

Services and Activities

1. Developed the relationship among the partners to expand collaborative efforts, reduce redundancy, and expand the network of care among partners to continue implementation of this initiative and increased the ability to tackle other identified challenges in the project region.
2. Implemented the school-based universal/prevention strategies, which included early childhood mental health consultation and the PAX Good Behavior Game
3. Implemented parent supports in schools and community including Pax Tools and Triple P.
4. Implemented targeted strategies for at-risk students, including Zones of Regulation and Random Acts of Kindness.
5. Sustained the comprehensive program post grant funding.

Outcomes

The project has accomplished the following outcomes:

1. In the first year, 2,262 people received behavioral health training, prevention services, or behavioral health treatment; 2,684 in the second.
2. In the first year, 25 education sessions were held; 22 in the second.
3. Over 400 child-serving professionals and teachers increased knowledge and skills for implementing positive behavioral guidance and appropriately supporting children who have experienced trauma.
4. Three new counselors or clinical social workers were trained and hired to work with children and families.
5. Fifteen schools representing 82 classes, 106 teachers, 45 other school personnel, and 1,584 students participated in an evidence-based prevention program, the PAX Good Behavior Game.
6. Of the 15 schools, 11 participated in the outcome evaluation. Of these 11 schools, 100% had a decrease in “unfocused behaviors” on the PAX tool by participating students. Decreases ranged from 47% to 82%, with an average decrease of 61%.
7. Five hundred children and youth received individual or group targeted interventions delivered at their school.
8. Poster presentation of the project at the Human Resources & Services Administration (HRSA) Grantee Meeting was conducted in January 2020.

Sustained Impacts

Sustained impacts include:

1. The comprehensive and unified prevention-intervention system for students and caregivers in the project region.
2. Staff positions created through the grant, including the Pax coordinator, the new clinicians trained or retained, and the data analyst position.
3. The 15 schools implementing the Pax Good Behavior Game will continue. All have highly praised the program and the positive impacts that it has had.
4. The other prevention and parent support programs will continue to serve future students and caregivers, including Pax Tools, early childhood/infant mental health consultation, Triple P, Zones of Regulation, and Random Acts of Kindness.

Lessons Learned and Considerations for Program Replication

We have learned:

1. The importance of equity in the partnerships;
2. The importance of long-term sustained relationships in our rural Appalachian region;
3. The importance of planning for sustainability as the project is being designed; and
4. The necessity of blending funding across partners for long-term sustainability.

The models and programs employed by our project are highly replicable in other rural areas. The training for each of the models is now available in virtual formats since COVID. Each has proven successful in our rural region and has adaptations for specialized populations.

Organization Name		Indiana Rural Health Association	
Organization Information			
Grant Number		Organization Type	
D04RH31782		Statewide Rural Health Association	
Organization Website			
www.indianaruralhealth.org			
Address		City	State
201 E. Main St., Suite 414		Washington	Indiana
			ZIP Code
			47501
Primary Contact Information for Project			
Name		Phone	Email
Cindy Large		812-478-3919	clarge@indianarha.org
Focus Area(s)			
	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
✓	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
✓	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management	✓	Telehealth/Telemedicine
✓	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
✓	Health Screenings		Other:
	HIV/AIDS		Other:
✓	Maternal and Child Health		Other:
Area(s) Served			
Serving the rural designated counties in Indiana of Putnam, Owen, Greene, and Sullivan.			
Target Population(s)/Need Addressed			
The Rural Maternity Medical Home Network was formed to decrease the infant mortality rate by providing pregnant women with perinatal navigator services including maternity health screenings. This model has been adapted to meet specific rural-focused needs to enroll pregnant women in the rural maternity medical home to receive enhanced perinatal care services in four rural Indiana counties.			

Consortium/Network Partners

The four rural network partners directly involved in the implementation of the Rural Maternity Medical Home Network are all designated Critical Access Hospitals strategically positioned in West Central Indiana. The primary partners are Putnam County Hospital Women's Clinic, Greene County General Hospital, Indiana Health Center, and Sullivan County Community Hospital.

Project Goals

The goal of the Rural Maternity Medical Home Network was to establish a sustainable network of obstetrical patients, their family members, informal caregivers, community members, rural health care providers, and stakeholders committed to developing, delivering, and disseminating rural pregnancy-focused data to improve health outcomes for mothers and their babies, thereby positively affecting the region's infant mortality rate through enhanced perinatal care services, care coordination, and increased access to education and resources for clinicians and rural communities.

Evidence-Based Model(s)/Promising Practice(s)

The state-aligned promising practice of enhanced perinatal navigator model focused care coordination, outreach, referrals, and implementation of the evidence-based Healthy Start Maternal Health Screening Tools.

Services and Activities

The enhanced perinatal navigator primary service focused on existing obstetrician (OB) providers who are part of the network, including changes in referral patterns, practice patterns, provider reimbursement impact, and the community economic impact. That has improved access to continuity of care by providing or coordinating all health care and related social services during a woman's pregnancy, childbirth, and postpartum period.

Outcomes

All of the partners, through the implementation of a rural network of enhanced perinatal care services, have:

1. Implemented OB screenings;
2. Collected online data through REDCap for reporting through patient screenings; and
3. Established a functioning and sustainable perinatal network consisting of OB patients, their family members, and informal caregivers, as well as community-based stakeholders, advocacy groups, and health care providers, in a collaboration designed to improve the health and well-being of pregnant women and their newborns.

Sustained Impacts

The primary sustained impact of the network has been to increase access to maternal health services available in the rural communities in Indiana through (1) increased knowledge of community resources available to the nuclear family in addition to pregnant women, including public transportation and deployment of telehealth services, and (2) providing referrals for improvement of physical health, mental health, obesity, and diabetes and education about healthy food options and methods to foster healthy lifestyles, such as accessing exercise and community-based support programs.

Lessons Learned and Considerations for Program Replication

Using lessons learned and engaging in thorough data analysis, the Rural Maternity Medical Home Network has positioned the Outreach Program to be a flagship model for other regional and statewide initiatives to combat the dynamic and omnipresent high infant mortality crisis, especially in rural communities, including through the submission of publications, providing presentations to disseminate quality data and outcomes for replication, and supporting policy and reimbursement transformation.

Organization Name		Innis Community Health Center Inc.	
Organization Information			
Grant Number		Organization Type	
D04RH31783		Federally Qualified Health Center (FQHC)	
Organization Website			
https://www.arborfamilyhealth.org/			
Address		City	State
6450 LA Highway 1 Suite B		Innis	Louisiana
			ZIP Code
			70747
Primary Contact Information for Project			
Name		Phone	Email
Linda Matessino		225-921-5196	Linda@arborfamilyhealth.org
Focus Area(s)			
	Behavioral/Mental Health	✓	Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
✓	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings		Other:
	HIV/AIDS		Other:
	Maternal and Child Health		Other:
Area(s) Served			
Rural designated parishes (counties) within Louisiana: Pointe Coupee, Morehouse, Richland, East Feliciana, and Grant. The focus is on school-based health centers (SBHCs) operating within these parishes for students in elementary, middle, and high schools.			
Target Population(s)/Need Addressed			
The target population was students enrolled in SBHCs in rural parishes. The target area has high poverty rates, large numbers of African American children, and access challenges to oral care services. This initiative focused on improving children's oral health through the provision of primary oral health care, which included oral health education and protection services, intervention and restorative services, and dental case management services to provide referrals for dental interventions and connect students to a primary dental home. The global objective was to integrate oral health services with a prevention strategy into the primary care setting.			

Consortium/Network Partners

The consortium network partnership consisted of SBHCs operated by Federally Qualified Community Health Centers: Innis Community Health (Arbor Family Health), Morehouse Community Medical Center, Delhi Community Health Center, Winn Community Health Center, and RKM Primary Care. Partners used their SBHC programs to access students.

Project Goals

- Goal 1: Integrate a solid oral health assessment into the comprehensive physical exams in SBHCs (primary care settings) with documentation of findings in electronic medical records (EMRs) by the primary care provider.
- Goal 2: Provide an evidenced-based oral health prevention strategy through the application of fluoride varnish to reduce dental caries during the primary care visit with the student.
- Goal 3: Implement dental case management on all referrals with tracking to completion and identifying barriers to overcome, thereby increasing access to dental providers for interventions.
- Goal 4: Utilize the role of a community health case worker in Pointe Coupee parish to assist with the referrals on challenging cases that need additional interventions and assistance with removing barriers.

The primary interventions for this grant initiative included the ultimate change of embedding a thorough oral health examination into the comprehensive physical by primary care providers, improving documentation of the oral health findings in an EMR, utilizing fluoride varnish as an evidenced-based prevention strategy, providing students with oral health education, and completing a referral to a dental home of choice for treatment plan implementation through effective dental case management.

Evidence-Based Model(s)/Promising Practice(s)

The use of evidenced-based practices and promising models has been the underpinning to the success of this grant. The organization has focused on three areas of practice: integration of oral health assessment in a primary care setting, application of fluoride varnish in a primary care setting, and implementation of dental case management on referrals that arise out of assessments. The references to these models are as follows:

1. HRSA — Integration of Oral Health and Primary Care Practice (IOHPCP), U.S. Department of Health and Human Services, 2014.
2. Fluoride Varnish — An evidenced based approach, Research Brief, Association of State and Territorial Dental Directors, published 2007, updated 2014.
3. Dental Case Management — ASTDD, Health Center Oral Health Promising Practice, Butler County Dental Care Case Management Program, March 2007.
4. Community Health Worker — ASTDD, Health Center Oral Health Promising Practice, Number, 0009, Finger Lakes Community Health, April 2012.

Services and Activities

Utilizing each agency's SBHC as the portal of access to children in a primary care setting, the centers used the comprehensive physical exam to perform the following activities:

1. Integrated oral health assessment in primary care (SBHC) with documentation of findings in EMRs.
2. Made referrals for interventions upon abnormal findings or need for preventive visits.
3. Increased provider proficiency in oral health assessment skills through education and training, thus embedding a change of clinical practice into the clinical assessment of body systems.
4. Implemented evidenced-based practice by applying fluoride varnish during comprehensive physical exams on students enrolled in SBHCs for prevention of dental caries.
5. Completed student oral health education at primary care visits to improve oral health hygiene with a focus on prevention.
6. Utilized dental case managers in SBHCs for follow-up on all referrals, problematic or preventive, in order to increase the "closure rate" on referrals to completion.
7. Continued to build upon consortium partnerships so that change in clinical practice will become sustainable as well as institutionalized in practice post-grant.

Outcomes

The following is an overview of key program outcomes from years 1 and 2 of implementation.

1. Volume: Students seen, interventions completed (cumulative):
Years 1 and 2 — total comprehensive physical exams with oral health assessment = 3,946
Total fluoride varnish applications = 3,017
Percentage fluoride varnish applied = 76%
Total referrals (problematic and preventive) = 1,367
Total referrals completed (students seen) = 480
Percentage of total referrals completed = 35%
2. Oral health education documented in EMR (chart review) > 95%
3. Provider training completed Smiles for Life curriculum = 100%
4. Documentation of referral in EMR plus findings = 100%
5. Dental case managers designated in each SBHC = 100%
6. Reviewed annual statistics with each consortium CEO years 1 and 2 = 100%

Sustained Impacts

The long-term effects in these communities with these embedded clinical practice changes in SBHCs will improve the oral health status of school-age children. Oral health education gives the student an ownership of their oral preventive health. Early interventions with fluoride varnish and routine cleanings have identified that problematic referrals are on the decline. Students owning their oral health with good hygiene habits also have an impact on their families. When a student's oral health is good, this contributes to improved academic performance. Children in rural areas are at risk for issues with their health, and this model contributes to reducing risk by improving access to health assessments, oral health education, and timely prevention and early treatment services. Over time, this preventive approach reduces the amount of restorative services needed for children. Furthermore, other health issues can be identified as a result of thorough oral health assessments leading to earlier intervention with treatment on-site or through referral to their dental or medical home. This integrated model is a proven approach that can be replicated in other settings.

Lessons Learned and Considerations for Program Replication

Utilizing SBHCs as an access portal to improving children's health is a significant opportunity. Clinical practice is changeable when evidenced-based models confirm outcomes. Integrating oral health into primary care recognizes the oral cavity as a major entry point to body systems that should not be left out of total body assessments by primary care providers. Maintaining a healthy oral status in children requires early intervention with the child establishing positive oral hygiene habits carried through to adulthood and prevention strategies such as regular cleanings visits. Taking ownership of having an established dental home is essential for the child and their family. Referral tracking and dental case management are critical in closing the loop when the child needs timely interventions. It must be a flexible model for the setting. Virtual learning during COVID challenged SBHCs to design creative models to reach students for assessments with consistent follow-up on referrals made for prevention or intervention issues. Educating teachers on oral health status and its influence on academic performance is a quality collaborative opportunity.

Organization Name		Inspire Development Centers	
Organization Information			
Grant Number		Organization Type	
D04RH31784		Nonprofit Organization	
Organization Website			
www.Inspire-Centers.org			
Address		City	State
105 S. Sixth St., Ste. B		Sunnyside	Washington
			ZIP Code
			98944
Primary Contact Information for Project			
Name		Phone	Email
Rick Garza		509-837-2225	Rick.Garza@inspire-centers.org
Focus Area(s)			
Behavioral/Mental Health		Oral Health	
Cancer Care Management		Pediatric Care	
Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance	
Case Management		Primary Care Services	
Chronic Disease Management		Population Health	
Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination	
Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services	
Community-based Care Coordination		Substance Abuse Treatment and/or Education	
Diabetes Care Management		Telehealth/Telemedicine	
Health Education/Promotion and Disease Prevention		Transitions of Care	
Health Improvement Special Project (HISP)		Women's Health	
Health Screenings	✓	Other: Childhood Obesity	
HIV/AIDS		Other:	
Maternal and Child Health		Other:	
Area(s) Served			
Yakima County, Wash.			
Target Population(s)/Need Addressed			
<p>The target population was children at risk for overweight and obesity, and children with overweight and obesity, and their caregivers in seven rural areas in Yakima County (service area). Compared to children in Yakima County, children in the service area are more likely to be overweight and obese, consume simple carbohydrates, and participate in sedentary screen time. In addition, compared to children in Yakima County, children in the service area are more likely to be Hispanic/Latin, uninsured, below the poverty level, noncitizen, and limited-English-proficient, demographic factors associated with overweight and obesity.</p>			

Consortium/Network Partners

Consortium partners were Catholic Charities Housing Services (CCHS), one of the largest affordable housing organizations in the region; Inspire Development Centers (IDC), the largest early childhood learning and knowledge center in the region; and Yakima Valley Memorial Hospital (YVMH), the largest health care system in the region.

Project Goals

The project goal was to improve the health of low-income, Hispanic/Latin, and agricultural worker families in rural Yakima County, Wash., through consumption of healthful foods, regular physical activity, and healthy body weights.

Evidence-Based Model(s)/Promising Practice(s)

The consortium provided the Mind, Exercise, Nutrition, Do It! (MEND) program for children aged 2-5 at risk for overweight and obesity and their caregivers and the Actively Changing Together (ACT!) program for children aged 6-13 with overweight and obesity and their caregivers. In the MEND program, children and caregivers participated in one 1.5-hour session per week for 10 weeks. A parent/caregiver leader and active/creative play leader provided nutrition, physical activity, and behavior change content in each session. In the ACT! program, children and caregivers participated in one 1.5-hour session per week for 12 weeks. A nutritionist and physical activity coach provided nutrition counseling sessions and facilitated energizing games, activities, and light meals in each session.

Services and Activities

Activities included hiring a project manager; contracting with CCHS, Healthy Weight Partnership (HWP), and YVMH; hiring an active/creative play leader, childcare provider, exercise leader, mind and nutrition leader, and parent/caregiver leader; training staff and contractors on the MEND program; training staff and contractors on the ACT! program; receiving referrals from community partners; recruiting, enrolling, and providing the MEND program for children aged 2-5 at risk for overweight and obesity and their caregivers; and recruiting, enrolling, and providing the ACT! program for children aged 6-13 with overweight and obesity and their caregivers. The consortium enrolled 120 children and their caregivers in 10 MEND cohorts and 51 children and their caregivers in four ACT! cohorts.

Outcomes

1. MEND participants with pre-post data showed that 55% increased their consumption of fruits and vegetables by 12%, 33% decreased their sedentary screen time by 2%, and 73% with overweight and obesity improved their healthy weight status by 9%.
2. For ACT! participants with pre-post data, 83% increased their consumption of fruits and vegetables, 92% decreased their consumption of simple carbohydrates, 88% decreased their sedentary screen time, and 88% increased their physical activity.
3. Most consortium members and project personnel believed that they communicated amongst themselves during regularly scheduled meetings, proactively initiated communication amongst themselves, and jointly made decisions about overall project direction and utilization of resources, and had a shared interest in project outcomes.
4. Most consortium members and project personnel believed that partnerships were assessed and expanded to include organizations that could address the problem and that they exhibited a deep understanding of the context within which they operated and had designed an approach that took into account current contextual factors.

Sustained Impacts

The consortium has sustained impacts through new ways of serving, new capacity created, and policy changes to support sustained impact. For new ways of serving, CCHS, IDC, and YVMH have developed working relationships with each other and community providers, developed referral procedures for coordinating services with each other and community providers, and developed shared use of facilities procedures with community providers. For new capacity created, CCHS, IDC, and YVMH staff and contractors participated in MEND and ACT! program developer training, participated in Biennial Childhood Obesity Prevention Coalition conference training, and improved family outcomes (e.g., increased consumption of fruits and vegetables, decreased sedentary screen time, improved healthy weight status, decreased consumption of simple carbohydrates, and increased physical activity). For policy changes to support sustained impact, IDC's food vendor revised its food guidelines to be more healthful. All of these impacts will endure in the community, whether for MEND, ACT!, or other CCHS, IDC, or YVMH programs, without the need for dedicated resources.

Lessons Learned and Considerations for Program Replication

Factors contributing to program success included consortium collaboration, community-based services, staff and contractor training, community partner referrals, technical assistance, service delivery flexibility, staff expertise, bilingual and bicultural staff and contractors, evidence-based programs, and consensus decision-making. Factors that limited program success included new programs (e.g., lack of knowledge and skills that hindered implementation), consortium scheduling, staff and contractor turnover, training scheduling, HRSA staff turnover, essential health benefits challenges, COVID-19 stay-at-home order, staff and contractor travel time, and limited facilities. Lessons learned included the need for staff and contractor contingency planning to address difficult scheduling of consortium members and project personnel, adequate facilities to address difficult recruitment and implementation in housing developments, multiple staff access to data to address staff turnover, bilingual and bicultural facilitator curriculum to address lack of Spanish-language trainer manual, staff and contractor cross-training to address staggered training, and caregiver relationship building to address access barriers.

Organization Name		Lake Cumberland District Health Department	
Organization Information			
Grant Number		Organization Type	
D04RH31636		Health Department	
Organization Website			
https://www.lcdhd.org/			
Address		City	State
500 Bourne Ave.		Somerset	Kentucky
			ZIP Code
			42501
Primary Contact Information for Project			
Name		Phone	Email
Jamie Lee		606-678-4761	jamiel.lee@lcdhd.org
Focus Area(s)			
	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
✓	Health Education/Promotion and Disease Prevention		Transitions of Care
✓	Health Improvement Special Project (HISP)		Women's Health
✓	Health Screenings	✓	Other: Faith-Based Initiative
	HIV/AIDS		Other:
	Maternal and Child Health		Other:
Area(s) Served			
Cumberland and Casey counties in Kentucky.			
Target Population(s)/Need Addressed			
The projects targeted a population of 232 congregation members living in Casey and Cumberland counties and 500 additional community members who were impacted indirectly. The Heart 4 Change grant was designed to provide community-based education programs that focused on reducing risk factors (smoking, obesity, and inactivity) associated with cardiovascular and other preventable chronic diseases.			

Consortium/Network Partners

The Heart 4 Change consortium was made up of eight organizations: Lake Cumberland District Health Department (local health department, Kentucky), Casey County Extension Office (community-based, Kentucky), Cumberland County Extension Office (community-based, Kentucky), Centerpoint Church of the Nazarene (church, Kentucky), Dunnville Christian Church (church, Kentucky), Lake Cumberland Regional Hospital (hospital, Kentucky), American Heart Association—Green River Affiliate (nonprofit organization, Kentucky), and Marshall University (academic institution, West Virginia).

Project Goals

The project's overarching goal was to reduce morbidity and mortality related to cardiovascular disease (CVD) by reducing the associated risk factors. This driving goal was consistent with the Healthy People initiative: HDS-1 (Developmental) — Increase overall cardiovascular health in the U.S. population. The Heart 4 Change program was designed to offer programs and education that would reduce risk factors associated with chronic diseases.

To achieve this goal, the program sought to:

1. Reduce cigarette smoking by adults;
2. Increase the proportion of adults whose blood pressure is under control;
3. Increase the number of adults who meet the recommended guidelines for physical activity and body mass index (BMI);
4. Increase the number of adults who are aware of the early warning symptoms and signs of a stroke and the importance of accessing rapid emergency care by calling 911 or another emergency number;
5. Reduce the proportion of adults with high blood cholesterol levels and glucose levels; and
6. Mobilize health committees to continue offering health programs in the church and community.

Evidence-Based Model(s)/Promising Practice(s)

The consortium chose to use the promising practice Jackson County Health Department Closing the Gap Cardiovascular Disease Program model which addresses health disparities related to CVD prevention and education within communities. This model was used as the guide for developing cross-agency collaborations that integrated educational programs that are traditionally community-based into the faith-based setting. Programs such as Gentle Yoga, Cooking Matters, Heart Saver First Aid CPR, Check Change Control, Kentucky Diabetes Prevention and Control Program's Diabetes Self-Management Education, and Freedom from Smoking were used to modify the proposed model and form the primary educational components of this program.

Services and Activities

The primary activities implemented by the Outreach Program grant were biometric screenings including lipid profile, A1c, glucose, blood pressure, waist measurements, and BMI; tobacco use screening; and heart risk screening using the Centers for Disease Control and Prevention's Heart Age Calculator. Annual health education classes were provided, including Cooking Matters (six weeks), Diabetes Self-Management Education Classes (four weeks), National Diabetes Prevention Program (one year), Gentle Yoga classes (six weeks), Freedom from Smoking classes (eight weeks), Stop the Bleed training, CPR/first aid, and CPR instructor training at each church. The consortium members implemented Healthy Habits challenges, plus developed weekly bulletin inserts, monthly newsletters, and health awareness videos to improve health literacy. Community gardens and health committees were established at each church. A Heart 4 Change toolkit was developed to be used by other faith-based organizations, and participants received a book of healthy recipes. Community events were held Year 1, but were unable to be held years 2 and 3 because of COVID.

Outcomes

The following is a summary of some of the primary outcomes achieved under this initiative:

1. Twenty-six project staff, consortium partners, and faith-based community representatives were adequately trained to teach health promotion and risk-reduction curricula in their community, such as Gentle Yoga, Freedom from Smoking, Walk 15, and CPR/first aid so the programs will continue after the grant period.
2. Community gardens were established, but one has exceeded expectations and is serving the community.
3. Twenty-five community members were certified in CPR
4. Two faith-based wellness committees were established and actively implemented health promotion and risk-reduction activities and education.
5. Five hundred seventy-one community members received direct services, such as biometric screenings, cooking classes, diabetes classes, CPR/first aid, smoking cessation classes, walking programs, and the like.
6. The initiative reached 59,587 community members indirectly through a mass education campaign via the Lake Cumberland District Health Department Facebook page during Year 3.
7. Twenty-four percent of the individuals who reduced at least one CVD risk factor had participated in one or more program interventions.

Sustained Impacts

Some of the sustained impacts of this project include changes in the target populations' behavior and knowledge regarding CVD risk factors. Forty-four individuals have learned to cook healthy meals and have improved their eating habits; participants of the diabetes prevention self-management program have 5.4% weight loss at the end of Year 1; and 30 people learned about smoking cessation, with nine completing the class and now tobacco-free. The Walking Club has walked 3,917 miles and lost 124 pounds collectively; three people have decreased their blood pressure medication. However, the biggest impact on the community may be the community garden in Cumberland County. The garden has provided fresh vegetables to hundreds of community members. Now the garden is at the local housing authority property so that residents can assist, harvest, and share produce. Produce is also shared with the local food pantry and those in need throughout the community. The community is engaged with the garden work, children enjoy picking vegetables, and vegetables are shared with those who are unable to come to the garden to work or pick.

Lessons Learned and Considerations for Program Replication

One of the major lessons learned was to make sure all partners have the same vision and goals. Good communication is essential, and thorough screening of potential partners is a must before you begin your project. Another lesson learned was that all groups do not have to do the same thing at the same time. The initiative tried to have programs going simultaneously at each church, but that didn't work at times. Each church has its own personality, and not all programs will be fully embraced by each one, so it is important to focus more on the programs each church wants to do and let them thrive in those programs. For example, the health committees established community gardens at each church, but only one showed a real interest and had great success. It was also learned that to be successful, the more people there are involved and taking lead roles with the programs the better — there is definitely strength in numbers. Additionally, success measures relied too heavily on one activity. The annual biometric screenings, which supplied multiple data points, were stopped due to COVID, and that left the overall program without reliable data necessary for determining success.

Organization Name		Lana'i Community Health Center	
Organization Information			
Grant Number		Organization Type	
D04RH31637		Federally Qualified Health Center (FQHC)	
Organization Website			
www.lanaihealth.org			
Address		City	State
333 Sixth St. P.O. Box 630142		Lanai City	Hawaii
			ZIP Code
			96763
Primary Contact Information for Project			
Name		Phone	Email
Diana Shaw, Executive Director		808-565-6919	dshaw@lanaihealth.org
Focus Area(s)			
✓	Behavioral/Mental Health		Oral Health
	Cancer Care Management	✓	Pediatric Care
✓	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management	✓	Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
✓	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	✓	Other: Childhood Obesity
	HIV/AIDS		Other:
✓	Maternal and Child Health		Other:
Area(s) Served			
Island of Lanai			
Target Population(s)/Need Addressed			
<ol style="list-style-type: none"> 1. School-based intervention: Grades K–12 providing health education on making right choices and choosing a healthy lifestyle with the focus on overweight and obese children. 2. Pediatric population: Those who are overweight and obese, as well as who might have a tendency to become those that are at risk of becoming overweight and obese. 3. Obstetrics population: High-risk patients who currently require frequent off-island travel and early transfer to another island at the time of delivery. 4. Cardiology: Patients with an unstable cardiac condition and patients with new onset cardiac conditions or new patients with an underlying cardiac condition without a cardiologist in Hawaii 			

Consortium/Network Partners

Consortium partners: Lanai Community Health Center, Diana Shaw, PhD, MPH, MBA, FACMPE; Department of OB/GYN, University of Hawaii, Cori Ann Hirai, MD; Cardiology, Anil Punjabi, MD, MBA, d/b/a Ohana Heart LLC, Maui Hawaii; Pediatrics, Jessun Nam, MD, MPH, private practice, Irvine California; Hawaii Public Health Institute, Jessica Yamauchi, executive director; Lanai High and Elementary School (LHES) and Foundation, Natalie Ropa; Hawaii Public Health Institute (HPHI), Jessica Yamauchi, executive director.

Project Goals

The project goals and anticipated outcomes include the following:

1. Goal: Consortium — To provide high-quality access to services not available or supportable on island due to size of the community (3,102 population); focus for this project will include OB/GYN (to include co-management of high-risk cases, curbside consults, meet-and-greet with delivering obstetrician, and the like), and cardiology (including echo cardiology).
Objectives: Expanded on-island services; enhanced capabilities regarding on program development and management of obesity in the youth, as well as obesity prevention, with access to state and national experts; active partnership with consortium members.
2. Goal: Pediatrics — Improved decision-making of students in choosing health lifestyles.
Objectives: Increased education regarding wellness (working with LHES and HPHI to develop, implement, and manage an obesity program and an obesity prevention program, in addition to teaching the routine health curriculum); identification of students with interest in health-related careers; reduction in the proportion of children and adolescents who are considered overweight and obese.
3. Goal: OB/GYN — Increased percentage of patients who receive timely prenatal care and management of high-risk pregnancies and complex gynecological problems.
Objective: First trimester entry into prenatal care.
4. Goal: Cardiology — Improved access to cardiology consultation and co-management of post-hospitalized patients and patients with cardiac conditions requiring diagnostic evaluation or co-management.
Objective: Reduced readmission and length of stay for patients with cardiac diagnosis and increased co-management of cardiac patient with cardiologist.

Evidence-Based Model(s)/Promising Practice(s)

The promising practice model of patient-centered medical home (PCMH) with vertical integration is used; a best resource was “The Integrated Patient-Centered Medical Home: Tools for Transforming Our Healthcare Delivery System,” by Matias A. Klein, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4106556/>. PCMH is focused on the patient — a focus even more critical in a rural environment, where a trip to the specialist might mean increased costs, travel, and even overnight stays. The development of our childhood obesity program comes from a commitment to follow the U.S. Preventive Services Task Force guidelines and an existing school-based education program that provides core education, with the potential to address one of the pressing problems: childhood obesity. For this effort, Lana'i Community Health Center (LCHC) used an evidence-based intervention for management of childhood obesity. See reference <https://effectivehealthcare.ahrq.gov/topics/obesity-child/research>, only school-based programs have positive outcomes.

Services and Activities

Consortium held monthly meetings (moving to quarterly in years 2 and 3) and utilized meetings (primarily teleconference) to share information and individual project status. This venue was also an opportunity to develop relationships. OB/GYN activities focused on development and implementation of the workflow, as well as education of staff and patients regarding having the OB/GYN provider involved via telemedicine, usually every other visit. Advertising of the program was conducted, along with education regarding the importance of early entry into prenatal care. Pediatrics activities initially involved working with HPHI to provide guidance in youth obesity. However, we were lucky to find a pediatrician to work with us, Dr. Nam. In addition to advising us on youth obesity, she became a telehealth provider for our team. Cardiology activities included identification of a cardiologist on Maui, Dr. Punjabi. We completed a contract and are working toward a telemedicine-based program. Childhood obesity activities included working closely with the school to develop and implement a survey for the youth to respond to and LCHC staff teaching the health education curriculum.

Outcomes

Total for three-year period of the grant:

1. OB/GYN

Full-term deliveries without complications: 42

Premature deliveries, weight less than 2,500 grams (PIMS): Nine babies whose mothers were high-risk because of gestational diabetes and/or hypertension. Number of infants with complications requiring extended hospital stay (more than two days): 0

2. Complex cardiology patients

Number of hospitalization of patients with complex cardiac conditions: NA, due to COVID; study will continue beyond grant funding. Number of readmissions in 30 days: NA, due to COVID; study will continue beyond grant funding.

Number of deaths: NA, due to COVID; study will continue beyond grant funding

3. Childhood obesity school-based intervention

BMI and percentage BMI every six months for patients enrolled in the weight program (PIMS): due to COVID, we do not have data analyzed; we are continuing to train new surveyors and will continue obtaining survey data and analyze even beyond the grant funding period. Percentage of patients who completed six months or more of the program: NA, due to COVID; study will continue beyond grant funding. Percentage of patient with weight maintenance or weight loss based on previous outcome studies' metrics. (To be determined by consortium partners): NA, due to COVID; study will continue beyond grant funding.

Sustained Impacts

1. Childhood obesity: The school health education project promotes healthy choices that result in living a healthy lifestyle. Ultimately, as we learn more about the community children's eating and physical exercise habits, we will implement interventions that we anticipate will result in a reduction of the number of children gaining weight and reduce other behaviors that negatively impact long-term health outcomes.
2. Pediatric: This program is directly impacting children and improving their quality of life and providing training for our providers.
3. OB/GYN: This program is improving coordination of prenatal care, allowing for more families to experience a pregnancy, including those of higher-than-normal risk, with minimal stress caused by the health care system's inefficiency.
4. Cardiology: This program is just starting; we expect it to have direct results on our patients with complex cardiac disease, most with daily symptoms, reducing the number of people who are forced to seek off-island medical care and echocardiograms, reducing morbidity and mortality. Effective treatment will improve the quality of life for those with limited life expectancy.

Lessons Learned and Considerations for Program Replication

Nurture partnerships: Through our partnership between consortium members, we were able to utilize the network resources at the local, state, and national levels to develop a sound program including evaluation.

Nurture Relationships: Identify existing relationships and utilize them for your project. For example, LCHC had an existing footprint with the school on Lanai through previous work with the elementary, middle, and high schools, making program development easy.

Telehealth is critical: Especially for a rural, remote community, telehealth is the most efficient and effective way to obtain specialty care that is required for the provision of high-quality service and quality outcomes.

Know your target: Address cultural aspects of programs up front; customize programs to meet the cultural and health needs of your target audience. This will maximize acceptance.

Incorporate members of the target audience into the program team: When members of the target audience are educating other members of the target audience, the message is more likely to be welcomed and understood.

Celebrate program achievements and milestones: Energy is created by periodic celebrations!

Organization Name		Mariposa Community Health Center Inc.	
Organization Information			
Grant Number		Organization Type	
D04RH31638		Federally Qualified Health Center (FQHC)	
Organization Website			
www.mariposachc.net			
Address		City	State
825 N. Grand Ave.		Nogales	Arizona
			ZIP Code
			85621
Primary Contact Information for Project			
Name		Phone	Email
Rosie Piper		520-375-6050	rpiper@mariposachc.net
Focus Area(s)			
✓	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
✓	Health Education/Promotion and Disease Prevention		Transitions of Care
✓	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	✓	Other: Healthy Eating, Active Living
	HIV/AIDS		Other:
	Maternal and Child Health		Other:
Area(s) Served			
Santa Cruz County, Arizona			
Target Population(s)/Need Addressed			
<p>The target population is Hispanic adults aged 50-74 with one or more cardiovascular disease (CVD) risk factors. There are high rates of diabetes in the local Hispanic population as a result of obesity, sedentary lifestyle, and poor dietary habits. This program addressed the risk factors by focusing on nutrition information, physical activity and walking, and weight management.</p>			

Consortium/Network Partners

The Vivir Mejor Consortium is made up of four contracted partners and up to five noncontracted partners. The contracted partners include Southeastern Arizona Area Health Education Center (SEAHEC), which provides continuing education for health providers and promotes health careers among local youth; Pinal Hispanic Council (PHC), a behavioral health organization; Nogales Community Food Bank (NCFB), which provides food boxes for residents and distributes produce donated by produce warehouses; and the University of Arizona Prevention Research Center, which provides evaluation services and engages in community-based participatory research.

Project Goals

Goal: To promote heart health among adults 50-74 years of age with one or more CVD risk factors in order to prevent heart disease. This goal was achieved through the following objectives.

Objectives:

1. Utilize trained community health workers (CHWs) (promotoras de salud) to implement the Meta Salud (Meta Health) Curriculum to help 75 adults and seniors adopt a heart-healthy lifestyle.
2. Provide continuing education to local medical providers from the local hospital, health center, private practices and fire districts regarding the latest research and best practices to promote heart health and prevent heart disease among adults who are at risk.
3. Support access to healthy foods by issuing fruit and vegetable prescriptions and collaborate with local grocery stores, food banks, and the farmers market to increase consumption of fruits and vegetables.
4. Work with local community centers and gyms to arrange use of their facilities for participants to fulfill personal wellness goals.
5. Work with the Nogales commercial kitchen to engage participants and their family members in six classes to learn to cook with local, seasonal produce using healthy fats and alternatives to salt.
6. Lay leaders will lead walking groups and cooking clubs with participants in their neighborhoods or community.
7. Participants will take advantage of group behavioral health services offered to address barriers to compliance and participation, such as depression and substance use.
8. Use technology in the form of fitness trackers and social media in order to support participant healthy lifestyle change.

Evidence-Based Model(s)/Promising Practice(s)

The approach for this grant initiative utilized seven evidence-based and promising practices to promote and sustain lifestyle change among program participants. These were Meta Salud, an evidence-based curriculum; use of CHWs to deliver classes and volunteer lay leaders to lead walking groups; providing fruit and veggie prescriptions to promote healthy eating for heart health; conducting cooking classes to provide healthy recipes; distributing physical activity tracking technology (Fitbits) to motivate participants; and referring participants to behavioral health support to address anxiety and depression.

Services and Activities

The following activities were implemented as part of this grant-funded initiative:

1. Trained CHWs (promotoras de salud) implemented the 13-week Meta Salud (Meta Health) Curriculum to help 75 adults and seniors adopt a heart-healthy lifestyle.
2. Consortium partner SEAHEC provided continuing education to local medical providers from the local hospital, health center, private practices, and fire districts regarding the latest research and best practices to promote heart health and prevent heart disease among at-risk adults.
3. Mariposa Community Health Center (MCHC) provided fruit and vegetable prescriptions (FVRx) and collaborated with local grocery stores, food banks, and the farmers market to increase consumption of fruits and vegetables.
4. Program staff conducted cooking classes to teach participants how to prepare healthy meals, using a practical, interactive approach.
5. Provided an exercise program four times a week that included Zumba, aerobics, and yoga provided by certified instructors.
6. Three lay leaders provided neighborhood walking groups weekly.

Outcomes

The following is a highlight of some key outcomes seen in participants from baseline to six months.

	Baseline	6 Months	Change
Total cholesterol (n = 48)	171.6	166.2	-5.4
HDL (n = 48)	48.6	49.9	+1.25
LDL (n = 47)	94.8	81.5	-13.3*
HbA1c (n = 47)	5.8	5.7	-0.1
Triglycerides (n = 48)	149.9	150.6	+0.7
Systolic blood pressure (n = 48)	126.4	121.6	-4.8
Diastolic blood pressure (n = 48)	75.2	71.8	-3.4
BMI (n = 47)	28.5	28	-0.5
Smoking	8%	6%	-2%
		13 Weeks	
Attends yoga classes	13%	38%	+25%
Attends Zumba classes	17%	33%	+16%
Attends aerobics classes	19%	37%	+18%

Sustained Impacts

The Vivir Mejor program aims to create long-standing impact for those living in Santa Cruz County. Over the past few years, the Vivir Mejor Consortium has made significant progress toward achieving its goals and objectives focused on improving health outcomes for those living in Santa Cruz County. Evaluation results demonstrate that participants increased self-reported knowledge and behaviors relevant to improving cardiovascular health, preventing chronic disease, and maintaining wellness. Participants exercised for more days during the week, exercised for longer periods of time, attended more cooking and exercise classes, and showed improvements on physical health measures, such as lowered LDL cholesterol.

Additionally, a significant impact has been the strengthening of the Vivir Mejor Consortium over the past nine years. Each partnering organization has increased its capacity through knowledge of and involvement in the Vivir Mejor goals and objectives and the activities it has carried out.

Lessons Learned and Considerations for Program Replication

Despite the successes the data above demonstrates, keeping participants engaged over two and a half years was a challenge. In addition, the unfortunate fact of COVID-19 and the abrupt stop to so many in-person activities became an additional barrier. A quarterly “booster” class/event was scheduled after participants completed the 13-week intervention for the duration of the program. Once COVID hit, this enabled the program to stay in contact with participants, albeit only virtually. Participant loss to follow-up for 12- and 24-month assessments translated to fewer participants surveyed for the evaluation. Although post-questionnaires were conducted by phone, some participants felt comfortable enough to come in person for the biometric screening. However, despite all the challenges that 2020 presented, Vivir Mejor program staff remained dedicated to the health and well-being of participants and drew upon their creativity and tenacity to continue serving participants, while prioritizing the health and safety of the community.

Organization Name		Mary Imogene Bassett Hospital	
Organization Information			
Grant Number		Organization Type	
D04RH31785		Hospital (non-CAH)	
Organization Website			
https://www.bassett.org/			
Address		City	State
1 Atwell Rd.		Cooperstown	New York
			ZIP Code
			13326
Primary Contact Information for Project			
Name		Phone	Email
David Strogatz		607-547-3676	david.strogatz@bassett.org
Focus Area(s)			
	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
✓	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
✓	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	✓	Other: Chronic Pain Self-Management
	HIV/AIDS		Other:
	Maternal and Child Health		Other:
Area(s) Served			
Four rural counties in central upstate New York: Chenango, Herkimer, Madison, and Otsego.			
Target Population(s)/Need Addressed			
<p>The target population consisted of adults 18 years of age and older who suffer from chronic pain due to various conditions and who have been diagnosed with or are at risk for developing opioid dependence. Need for the program was reflected by the prevalence of conditions associated with chronic pain (e.g., arthritis, back pain, fibromyalgia), the relatively high rate of opioid analgesic prescription rates in the rural counties of central New York, and the corresponding excess rates of emergency department visits and hospitalizations for opioid overdoses. A general shortage of primary care clinicians and pain-management programs also contributed to the needs addressed by this project.</p>			

Consortium/Network Partners

Our consortium partners include three state-funded rural health care networks (Chenango Health Network, Herkimer County HealthNet, and Madison County Rural Health Council), two county service agencies (Madison County Office for the Aging and Otsego County Community Services), a community-based private service agency (Leatherstocking Education on Alcoholism/Addictions Foundation (LEAF)), and a neighboring regional health care provider (Oneida Healthcare). All partners are located within one of the four counties identified as the area served.

Project Goals

Three project goals were stated in the funded grant application:

1. To develop a consortium of primary care and substance use disorder health care providers and supportive service agencies in the Bassett service area to promote, sustain, and expand the Chronic Pain Self-Management Program (CPSMP) in Bassett's service area.
2. To adapt an evidence-based practice, the CPSMP, and establish workshops at nine community-based sites in the Bassett service area to address the problem of opioid dependence
3. To show an improvement in measures of pain-related management and experience by the end of the program and three months after program completion. Objectives for Goal 1 was to engage at least six health care and supportive service agencies to serve with Bassett on the Consortium Advisory Committee and to have members actively participate in the committee's meetings and conference calls. The objectives for Goal 2 were to train a sufficient number of program leaders to deliver the CPSMP and to enroll at least 135 primary care patients in Year 1 and 270 patients in each of years 2 and 3. The objectives for Goal 3 were to document improvement by CPSMP participants in self-efficacy for pain management, use of pain medication and mental health in addition to reduction in pain intensity and pain-related disability.

Evidence-Based Model(s)/Promising Practice(s)

To address the needs and gaps in resources for adults experiencing chronic pain, the consortium was organized to provide workshops for the CPSMP. The CPSMP was created and is maintained by the Self-Management Resource Center (SMRC) and is a health-promotion workshop consisting of six two-and-a-half-hour sessions delivered to groups of up to 16 adults participating at community sites such as libraries, churches, and senior centers. It is designed to provide individuals in chronic pain with the tools to manage pain and its physical, social, and emotional consequences. Program participants create weekly action plans, share experiences, and help each other solve problems in developing and carrying out their self-management program. The SMRC requires that the CPSMP be delivered by two program leaders who follow a scripted *Leader's Manual* while instructing in skills and leading role-playing scenarios.

Services and Activities

All member organizations of the consortium were active during the funding period and represented at each meeting of the Consortium Advisory Committee (three meetings in each year of the project). Trainings for program leaders were held in August 2018, March and August 2019, and March 2020 for delivery of the CPSMP and for cross-training to deliver the Chronic Disease Self-Management Program (CDSMP). In-person workshops for the CPSMP were offered in fall 2018 and spring and fall of 2019. Some individuals with chronic pain associated with a chronic condition expressed interest in the CDSMP as potentially having a broader range of benefit related to pain and other manifestations of their condition. Beginning in 2019, we began to offer CDSMP as an option for those patients and used the same instruments for evaluation to compare the two programs' effects on management of pain. In-person implementation of CPSMP and CDSMP was suspended in spring 2020 due to the emergence of COVID-19. A period of translation and planning led to three remote versions for delivery of these programs in fall 2020 and spring 2021: by Zoom, by conference call, and by oneself using self-instructional material.

Outcomes

1. Seven organizations joined Bassett in the consortium and were active throughout the funding period.
2. Four trainings for program leaders were held, with a total of 16, 22, and nine peer leaders trained and certified in 2018, 2019, and 2020, respectively.
3. For the in-person version of CPSMP during fall 2018 and fall and spring 2019, 429 individuals registered for the program, 264 actually enrolled (62% of registrants), and 191 completed the program (72% of enrollees).
4. For those who completed the CPSMP, pre-to-post comparisons showed improvement in self-efficacy for managing pain. For example, the percentage uncertain they can —
 - a. “Continue most daily activities” went from 32% to 20%
 - b. “Decrease pain quite a bit” went from 45% to 27%
 - c. “Reduce pain with methods other than extra medication” went from 37% to 12%
 - d. An improvement in mental health was shown by the reduction in percentage reporting most or nearly every day—
 - i. “Feeling down, depressed, hopeless” went from 25% to 11%
 - ii. “Feeling tired or having little energy” went from 55% to 33%
 - iii. “Poor appetite or overeating” went from 36% to 22%
 - e. Reduced reports of activity limitations due to pain for a list of 24 typical activities in daily life
 - f. Thirteen activities showed improved ability (more than 5% decrease in limitation)
 - g. Ten activities showed no change
 - h. One activity showed reduced ability (more than 5% increase in limitation)
5. For the first 36 individuals with chronic pain who completed CDSMP in 2019, improvements in self-efficacy, mental health and pain-related limitations were similar to the pre-post changes observed for individuals completing the CPSMP.
6. Evaluation is ongoing for the individuals who in fall 2020 and spring 2021 completed the remote versions of CPSMP and CDSMP. Initial data suggest greater levels of attrition in the first cycles of these remote forms of program delivery.

Sustained Impacts

The training and certification of program leaders has enhanced regional capacity for supporting CPSMP and CDSMP, particularly within organizations of the consortium whose staff have been trained and whose responsibilities now include support for these programs. The project has achieved recognition and institutionalization within the Bassett Healthcare Network (BHN). CPSMP has been included as a resource for pain management by the Comprehensive Opioid Epidemic Strategy (COPES) Task Force, a committee of Bassett clinicians and representatives of community-based organizations formed to create and promote regional programs to prevent, treat, and manage opioid use disorders and conditions causing acute or chronic pain. Within the BHN (the major source of CPSMP participants) we worked with the Office of Information Services to better embed CPSMP within the Epic electronic medical record system. Clinicians now have a link within Epic to make referrals to CPSMP. Additional elements being added to the electronic medical record are documentation of referral to CPSMP as part of the after-visit summary statement and notification when a referred patient completes CPSMP.

Lessons Learned and Considerations for Program Replication

During the project’s “in-person” phase, transportation was a major challenge for enrollment (initial attendance) and completion of the program. Multiple strategies identified over time included using Medicaid resources for transportation, organizing shared rides for participants in the same workshop, and facilitating access to public transportation or ride services provided by county and local agencies. We also staged programs in group residential facilities and housing developments so that participants could attend without traveling. Another challenge during the in-person phase was collecting data for evaluation at three and six months after the program — the plan to bring participants back for a “reunion” that would include data collection and sharing experiences with a new group of CPSMP participants was appealing in theory but difficult to schedule. It is ironic that transportation-related barriers were eliminated with the emergence of COVID-19 and its own set of challenges — how to modify an in-person, group program for remote delivery in settings with limited access to the internet and familiarity with technology. The effectiveness of the alternatives is still being evaluated!

Organization Name	Mercer, County of		
Organization Information			
Grant Number	Organization Type		
D04RH31786	Nonprofit Organization		
Organization Website			
Address	City	State	ZIP Code
305 N.W. 7th St.	Aledo	Illinois	61231
Primary Contact Information for Project			
Name	Phone	Email	
Jennifer Hamerlinck	309-582-3759	jennhamerlinck@gmail.com	
Focus Area(s)			
<input checked="" type="checkbox"/>	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
<input checked="" type="checkbox"/>	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination	<input checked="" type="checkbox"/>	Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
<input checked="" type="checkbox"/>	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	Other:	
	HIV/AIDS	Other:	
	Maternal and Child Health	Other:	
Area(s) Served			
The Mercer County Mental Health Action Program (MHAP) serves Mercer County, Ill.			
Target Population(s)/Need Addressed			
The MHAP targets high-risk groups of rural, low-income, uninsured, or underinsured, and youth and adolescents for early intervention. As the program progressed, target groups were further defined to identify young adults aged 19-26, adolescents aged 10-18, and senior citizens experiencing isolation or grief. Outreach was also included for farmers and veterans. Primary needs addressed were access to mental health providers and reduction in barriers to care such as transportation, insurance, prescriptions, and social determinants of health such as food and housing.			

Consortium/Network Partners

Primary project partners include a local health department (Mercer County Health Department), a community foundation (Mercer Foundation for Health), a Critical Access Hospital (Genesis Medical Center-Aledo), a rural health clinic (Genesis Health Group), a municipality (City of Aledo), a law enforcement agency (Mercer County Sheriff), and a substance use counseling/treatment agency (Rock Island County Council on Addictions).

Project Goals

The Mercer County MHAP functions under six overarching goals:

1. Identify and establish baseline data and measures, program processes, and tools to ensure continuous quality improvement, sustainability, and replicability.
2. Increase capacity of mental health providers and resources in Mercer County through a strong consortium and public health approach to delivery of new and enhanced mental health services.
3. Improve utilization and compliance with mental health services and treatment recommendations through care coordination and a patient navigation model.
4. Provide early intervention and prevention mental health services to target populations of youth, adolescents, pregnant women and the very low income (indigent population).
5. Enhance community knowledge and awareness of mental health issues and existing or newly developed resources.
6. (Approved by HRSA via amendment as part of strategic plan) improve capacity and availability of case management, education, and prevention strategies for adolescents through school-based programming and services.

Evidence-Based Model(s)/Promising Practice(s)

MHAP implemented a patient navigation model from Boston Medical Center to guide development and initiation of a model program to increase capacity of mental health services through a strong consortium and public health approach to provide improved access, utilization, case management, early intervention and prevention, and education regarding mental health services. MHAP also utilized portions of Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities program from National Academies Press. The practices included in this prevention model provided guidance and best practices related to key areas of family, school, and community interventions and the prevention of specific disorders and the promotion of mental health. Training also followed Mental Health First Aid (National Council for Behavioral Health): teaching staff a five-step action plan to support someone developing signs and symptoms of a mental illness or experiencing an emotional crisis.

Services and Activities

1. Completed mental health needs assessment.
2. Developed/disseminated a Mental Health Resource Directory.
3. Finalized tools for program including policy, procedure, media, team toles, staffing plan and communications.
4. Finalized quality improvement tools.
5. Entered into MOUs with four additional partners.
6. Networked with over 50-plus providers and partners.
7. Implemented and trained a volunteer spiritual care support team.
8. Trained staff in Mental Health First Aid, mandated reporting, Signs of Suicide, the Community Cares model, and trainings such as ACES, trauma-informed care, and Motivational Interviewing.
9. Implemented a mental health navigation/case management program to over 200 individuals.
10. Provided services such as transportation, insurance counseling, counseling, and substance counseling as wraparound services to over 600 individuals.
11. Developed and disseminated program brochure, info letters, presentation, and media materials.
12. Implemented a school-based pilot of mental health case management, social/emotional wellness, and coping skills.
13. Trained staff and participated in county threat assessment teams.
14. Implemented Signs of Suicide curriculum at two local school districts.

Outcomes

Completed mental health needs assessment; developed program tools; completed resource directory; completed sustainability plan; consortium adopted plan, team roles, and referral/communication systems; exceeded project goal of 100 referrals by responding to 276 referrals over grant period; increased capacity of consortium with two new members annually; exceeded goal for increasing mental health providers from 1.7 FTE to 4.65 FTE providers to a total program 5.54 FTE through HRSA and grant, private, and government funding; enhanced bridge between primary care and mental health services 19.39% of clients; established volunteer spiritual care support team of six; increased numbers screened for depression (current 54.59%); decreased delays in mental health service for persons in Mercer County; increased access to substance use treatment, 8% received substance use counseling; exceeded three-year goal of 50 unduplicated clients in MHAP case management — 309 unique individuals as of March 1, 2021, and 600-plus received counseling, 66% new provider, 32% insurance, 30% medication/prescription management, 28% transportation, 27% food, and 14% housing; established demographic/socioeconomic baseline data in Year 1 and collect annually; distributed target population specific education to youth, farmers, veterans, and seniors; developed electronic education/media campaign — 72 minutes of radio airtime, 3,500-plus information pieces distributed, 40 public appearances, 2,364 individuals reached via social media; piloted school-based case management in two local districts — currently serving 37 students; engaged 242 students through case management, education, social/emotional wellness strategies, support groups, and 1,117 students were screened/navigated based on Signs of Suicide curriculum; threat assessment team trained/implemented with Mercer County School District; and evolving training in Sherrard School District.

Sustained Impacts

Increased local capacity: MHAP built capacity of mental health service providers to 4.65 FTEs from 1.7 FTE. The program as a whole generated 5.54 FTEs, \$691,680 in economic impact, with \$1-\$10.23 return on local investment. Integrated service model: Established and utilized a long-term evidence-based service model that promotes coordination of care across multiple agencies, allows for colocation of services and has shared staffing approach, and allows for formal integration into partner agencies. Shared data collection: MHAP established processes to gather local primary mental health data from partners. MHAP also receives qualitative data through interviews and focus groups during needs assessments. Establishing local data is critical to provide factual information to inform decision-making. Systemic impact across multiple agencies. Policy and advocacy: Ongoing creation of policies has impacted consortium/partners as systemic changes followed in service delivery, e.g., community mental health funding, threat assessment teams, and hospital emergency department policies. Legislative and rural advocacy impacted program through relationships built with local decision-makers and legislators and identifying local champions.

Lessons Learned and Considerations for Program Replication

Continuous learning on the part of clients, staff, and supervisors is critical. To address the social determinants of health has proven to create a deeper understanding of these issues and their ongoing impact on clients and the need for health equity. Problem resolution is much more multifaceted than initially thought, with many social determinants of health building upon and compounding for clients. Communitywide system changes start with community education and sharing of local data. The program has learned not to project a sense of values or norms onto others based on our or our staff's upbringing, experiences, or socioeconomic status. One successful approach to community engagement is to just "throw out" important pieces of information and data (i.e., a community need) and allow it to percolate in the community for a while. This allows people who are interested or passionate about a project to step forward as a champion. Embracing an open door and continuous learning philosophy encourages community members and organizations to bring ideas to the table. A focus on sustainability from day one of the program is essential.

Organization Name		Mid-Valley Healthcare Inc.	
Organization Information			
Grant Number		Organization Type	
D04RH31787		Critical Access Hospital (CAH)	
Organization Website			
Address		City	State
525 N. Santiam Highway		Lebanon	Oregon
			ZIP Code
			97355
Primary Contact Information for Project			
Name		Phone	Email
Molly Gelinias		541-405-2233	mgelinias@samhealth.org
Focus Area(s)			
✓	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination	✓	Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings		Other:
	HIV/AIDS		Other:
	Maternal and Child Health		Other:
Area(s) Served			
This project served the cities of Brownsville, Lebanon, and Sweet Home, along with remote communities in East Linn County. These communities have rural designations within Linn County, Ore.			
Target Population(s)/Need Addressed			
The target population for the project is individuals with opioid use disorder (OUD), their families and friends, and specifically targeted the highest-risk users, those most at risk of overdosing and those most at risk of not entering treatment. The project focused on increasing peer support services, medication assistance treatment options, overdose prevention with Narcan distribution, and outreach education to reduce the rates of opioid hospitalization and mortality rates.			

Consortium/Network Partners

Coast to the Cascades Community Wellness Network's Mental Health and Substance Use Disorder (SUD) Subcommittee has the responsibility of implementing the grant activities. The primary partners are Samaritan Lebanon Community Hospital (Samaritan Treatment and Recovery Services), Linn County Department of Health Services (Linn County Alcohol and Drug Program), Family Tree Relief Nursery (peer support services), Communities Helping Addicts Negotiate Change Effectively (CHANCE) (peer support services), and Milestones Recovery Center (SUD/ODU treatment services).

Project Goals

1. Utilize trained, local peer support specialists (PSSs) to support individuals with OUD and their families at critical opportunities for intervention. Through Goal 1, peer support activities will be integrated in the emergency department (ED) in conjunction with the implementation of the Brief Negotiation Interview (BNI) and buprenorphine (Bup) administration with referral to treatment (ED-BNI+Bup). Community-based peer support will be conducted throughout east Linn County, providing peer follow-up to treatment referral, community access to peer support for those who do not enter treatment, peer support for individuals in recovery, and support for families and friends of individuals with OUD.
2. Conduct education campaign to educate friends and family members, providers, and other stakeholders on OUD and aid in identification of high-risk users. Through Goal 2, education to the community and bringing the local opioid crisis into focus, STARS Outreach will conduct an education media campaign that will include billboards, radio spots, newspaper articles, and website announcements.

Evidence-Based Model(s)/Promising Practice(s)

The STARS Outreach projects utilized multiple methods recognized by the Substance Abuse and Mental Health Services Administration as either evidenced-based or a promising practice:

1. Emergency department-initiated Brief Negotiation Interview + buprenorphine (evidenced-based);
2. Peer-delivered recovery support (evidenced-based);
3. Motivational Interviewing (evidenced-based);
4. Opioid overdose education and community naloxone distribution (promising practice);
5. Medication-assisted treatment;
6. ASAM Criteria;
7. ASAM National Practice Guidelines; and
8. Trauma-informed care in behavioral health sciences.

Services and Activities

The primary activities implemented:

1. Peer support, outreach, and warm handoffs in the ED at Samaritan Lebanon Community Hospital (SLCH) to capitalize on patients' greater readiness for change after a life-threatening event such as an overdose.
2. Community resourcing and marketing. The project director and Samaritan Health Services marketing department launched a website providing information on overdose prevention and Narcan availability in East Linn County. The educational campaign has targeted regional communities through various media. Radio broadcast messages and a live interview for Overdose Awareness Month reached more than 10,000 listeners.
3. Provider education supports two related goals: preventing opioid misuse through better prescribing habits and improving access to effective OUD treatments by educating providers on current treatment options. Naloxone distribution has been credited with reducing opioid overdose deaths.
4. Support groups for family and friends to provide vital support and recovery resources.
5. Rapid access to MAT and substance use treatment services.

Outcomes

1. PSS integration into the Samaritan Lebanon Community Hospital ED has led to an increase in services provided to substance users. Since June 2018, surpassed the goal of meeting 60% of opioid users and overdoses in the ED and have provided services to approximately 70% of this population.
2. Community resourcing and marketing resulted in five radio interviews, education materials distributed to over 1,200 community members at local events (pre-COVID), presentations at four local community agencies, launching a rural OUD/SUD website, and the leasing of three local billboards each year to reduce the stigma around OUD/SUD.
3. Provider education has resulted in 160 current and future providers trained on the role of prescribing practices and medication-assisted treatment services.
4. Naloxone distribution resulted in 860 kits distributed over the grant period.
5. The first Nar-Anon meeting was started in the East Linn County region for families of substance users.
6. Patients have been inducted on buprenorphine in the ED.
7. Patients have been directly admitted from the hospital to residential treatment.
8. At the onset of the grant, there was a small outpatient substance use program in the hospital. There is now a full continuum of care: Outpatient, intensive outpatient, and a new residential program.

Sustained Impacts

The project lead, project director, and peer supports meet not just with substance users but also with families and friends who can ask questions and receive support, often. ED-BNI-Bup plus peer support has been a significant change strategy for the hospital system. There has been a development of coalitions and partners who are coming together to support substance use treatment and recovery, all working with the ED to design nonpunitive medical protocols for opioid patients. As a result, patients are more willing to stay in the ED and talk to peer support and treatment personnel. The ED's nurse manager and the medical director of alcohol and drug services have developed protocols to ensure a smooth transition between the ED and treatment programs. The medical director, project lead, and project director attend ED staff meetings to review overdose cases. This has improved service integration and access to care through STARS Outreach's gender-responsive groups. And, hospital nurses have advocated a consistent approach to opioid and alcohol withdrawal protocols. This collaborative approach has led to the SUD staff being seen as a well-integrated part of the hospital staff.

Lessons Learned and Considerations for Program Replication

PSSs offer a level of "lived experience" that traditional behavioral health specialists and medical professionals are unable to provide. Candidates that we considered for these positions and others would have normally been disqualified from being hired at the hospital level due to their criminal history. The project lead had meetings with human resources, recruiting, legal, risk, and compliance personnel to address these issues, and the vice president-CEO was the champion of this process. Filling PSS positions was also difficult. This person had to have the ability to communicate with medical providers in the ED setting and other hospital departments while being able to connect with patients, and as the medical director emphasized trying to "bring hope into the room." Last, it is important to find a champion within the hospital system to support the integration process. Substance use services are a subculture within the hospital culture, and "end user" support is invaluable and necessary. This is vital to sustainability. If the end user does not see the services as valuable, then the work has been done in vain.

Organization Name		Miners' Colfax Medical Center	
Organization Information			
Grant Number		Organization Type	
D04RH31788		Critical Access Hospital (CAH)	
Organization Website			
Address		City	State
203 Hospital Dr.		Raton	New Mexico
			ZIP Code
			87740
Primary Contact Information for Project			
Name		Phone	Email
Charles Pollard		575-445-4546	cpollard@minershosp.com
Focus Area(s)			
	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management	✓	Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management	✓	Telehealth/Telemedicine
	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
✓	Health Screenings	✓	Other: Miner Health
	HIV/AIDS		Other:
	Maternal and Child Health		Other:
Area(s) Served			
The project served the following areas: Stillwater and Musselshell counties in Montana; Carbon and Sevier counties in Utah; and various counties in Wyoming through televisits, with a focus on Converse and Sweetwater counties.			
Target Population(s)/Need Addressed			
The primary target population were the miners of Montana, New Mexico, Utah, and Wyoming. The secondary target population were the mid-level provider staff in the mobile unit. For miners, the impact of this program was new chronic conditions detected, such as occupational lung disease as it relates to coal worker's pneumoconiosis, and a high level of miner satisfaction for the care services they received. A primary purpose of the program was to bring access to specialty care to undeserved rural areas.			

Consortium/Network Partners

The following represent the partners involved in this project: Miners Colfax Medical Center (hospital, Raton, N.M.); Critical Nurse Staffing (CNS) (home health organization, Grand Junction, Colo.); University of New Mexico (UNM) (university, Albuquerque, N.M.); and Northwest Community Action Program (NOWCAP) (community action agency, Sheridan, Wyo.).

Project Goals

1. Expand the existing New Mexico program to Wyoming, Utah, and Montana in partnership with HRSA-funded Northwest Community Action Program (NOWCAP) of Wyoming, and Critical Nurse Staffing, LLC (CNS), a for-profit home health care partner serving miners and energy workers.
2. Augment the existing program by providing innovative add-on telehealth services to mobile screening clinics. By combining two innovations (i.e., mobile screening expansion plus telehealth augmentation), the proposed project can better provide health care screening for rural miners.

The long-term goals of the project are to improve access to screening for currently underserved miners and to develop innovative models for screening multiple chronic conditions among miners, a rural population with disproportionate racial and ethnic minority and disadvantaged subjects.

Evidence-Based Model(s)/Promising Practice(s)

1. Evidence-based screening: Because miners are at great risk for developing respiratory and other chronic health conditions, National Institute of Occupational Safety and Health (NIOSH) guidelines advocate screening miners for dust-related lung diseases.
2. Promising practice use of mobile units: Provision of health care services through mobile units has been shown to be feasible and comparable to traditional approaches in diseases, such as stroke and tuberculosis, as well as in mammography, dental, and vision screening programs. Mobile screening clinics are being increasingly used by NIOSH to improve geographical accessibility for miners.
3. Promising practice use of telemedicine and telementoring: Telemedicine is the use of telecommunication systems to deliver health care at a distance.

Services and Activities

Access to a new or expanded health service was achieved through a novel state-of-the-art, mobile screening-telemedicine-telementoring program that provided services to rural remote areas in a three-state area (Utah, Wyoming, and Montana). The services provided on the mobile unit were a chest X-ray, pulmonary function test, ambulation oximetry, and a medical encounter with a nurse practitioner. Once completed, the miner was given the option to return at the end of the day to receive telemedicine services with a pulmonologist in which the miner's testing was reviewed in real time in a virtual "face-to-face" consultation.

Outcomes

Over the course of the three-year project period:

1. Thirty mobile and 34 telemedicine clinics were planned and held inside New Mexico, and four mobile and 12 telemedicine clinics were planned and held in Utah, Wyoming, and Montana.
2. Fourteen provider competencies were identified and published (Sood, Assad et al. 2020).
3. Three outcome measures were established, including new diseases diagnosed, patient satisfaction, and provider outcomes.
4. One hundred twenty-five weekly Mining Advisory Council meetings were held to discuss the impact of the program, as well as strategic planning of goals to produce favorable outcomes.
5. Two town hall meetings were held, five advertisements recruiting to the clinic were run, and 14,133 recruitment postcards were mailed.
6. The evaluation plan indicated that the project's strategies supported the diagnosis of new conditions, high levels of satisfaction with providers, and improved provider competencies.
7. The project successfully completed multiple dissemination and implementation (DI) activities, including 13 abstracts and nine manuscripts to both low-impact and high-impact journals. The project also successfully obtained one National Institutes of Health (NIH) grant and submitted for one NIOSH grant.

Sustained Impacts

This project established the effectiveness of augmenting mobile clinic screening services with telehealth strategies (including telemedicine services to miners and telementoring services to mid-level clinic providers), by comparing patient satisfaction and provider outcomes. A long-term impact was that the use of telehealth and mobile screening clinics can change the approach that stakeholders (such as physicians and health care leaders) use to screen miners in other mining-intense predominantly rural states in the country with similar social determinants of health. This intervention will thus be scalable and generalizable to other states in the country. Our consortium was in a unique position to fill the critical evidence gap, which will help improve screening services and thereby improve health care and outcomes for miners.

Lessons Learned and Considerations for Program Replication

Mining intense rural communities in the United States with challenging social determinants of health that are interested in the use of telehealth and mobile screening clinics can implement similar programs to screen miners. The recommend metrics when considering creating a similar project are: number of mobile and telemedicine clinics, number of provider competencies identified for teletraining, number of outcome measures established, number of methods to administer outcomes, number of mobile and telemedicine clinics held, number of providers trained in use of telehealth, number of town hall meetings held, and number of advertising strategies.

Challenges to consider in developing a rural mobile program are the availability of cellular service or internet connection, lack of response from the miners due to distance they live from the mobile unit clinic site, lack of follow-up from other rural health care providers once the clinic is completed, inability to travel due to unforeseen circumstances, and lack of staff willing to travel for lengthened clinics.

Organization Name		Mississippi Headwaters Area Dental Health Center	
Organization Information			
Grant Number		Organization Type	
D04RH31639		Nonprofit Organization	
Organization Website			
www.northerndentalaccess.org			
Address		City	State
1405 Anne St. NW		Bemidji	Minnesota
			ZIP Code
			56601
Primary Contact Information for Project			
Name		Phone	Email
Jeanne Edevold Larson		218-444-8933	Jeanne.Larson@northerndentalaccess.org
Focus Area(s)			
Behavioral/Mental Health	<input checked="" type="checkbox"/>	Oral Health	
Cancer Care Management	<input type="checkbox"/>	Pediatric Care	
Cardiovascular Disease (CVD) Care Management	<input type="checkbox"/>	Pharmacy Assistance	
Case Management	<input type="checkbox"/>	Primary Care Services	
Chronic Disease Management	<input type="checkbox"/>	Population Health	
Chronic Obstructive Pulmonary Disease (COPD) Prevention	<input type="checkbox"/>	School Based Care Coordination	
Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management	<input type="checkbox"/>	Specialty Care Services	
Community-based Care Coordination	<input type="checkbox"/>	Substance Abuse Treatment and/or Education	
Diabetes Care Management	<input type="checkbox"/>	Telehealth/Telemedicine	
Health Education/Promotion and Disease Prevention	<input type="checkbox"/>	Transitions of Care	
Health Improvement Special Project (HISP)	<input type="checkbox"/>	Women's Health	
Health Screenings	<input type="checkbox"/>	Other:	
HIV/AIDS	<input type="checkbox"/>	Other:	
Maternal and Child Health	<input type="checkbox"/>	Other:	
Area(s) Served			
The northwestern Minnesota counties of Norman, Polk, Mahnommen, and Clay, and the northeastern North Dakota counties of Cass, Traill, Steele, and Grand Forks were served by the current Outreach Program grant.			
Target Population(s)/Need Addressed			
In order to continue serving the growing number of patients who needed care and began traveling from farther and farther west to the Bemidji, Minn., clinic for oral health care, expansion of services was critical. Opening a satellite location in western Minnesota would alleviate the physical burden on the facility in Bemidji, as well as reduce the distance traveled and time needed for families living more than two hours away to access much-needed dental care. Further, with the pending closure of the only dental clinic in Halstad, Minn., even more patients would be left without access to dental services.			

Consortium/Network Partners

Primary project partners include Northern Dental Access Center (lead organization), a nonprofit community dental clinic; Legal Services of Northwest Minnesota, a regional legal aid organization; and Tri-Valley Opportunity Council, a nonprofit, community action agency providing an array of services to support families with housing, childcare, insurance, nutrition, literacy, and more.

Project Goals

The goal of this project was to improve oral health of children and families in western Minnesota and eastern North Dakota by replicating the innovative and successful approach of the community dental access clinic in Bemidji and bringing that same comprehensive, wraparound support care concept to far western Minnesota.

Strategies employed to achieve the goal:

1. Expand delivery of oral health care to low-income people in an unserved, rural area of Minnesota and North Dakota; and
2. Deliver dental care and wraparound support services through a consortium of providers committed to reducing oral health disparities.

Evidence-Based Model(s)/Promising Practice(s)

Dental home and social determinants of health: Establishing a “dental home” (AAPD, 2017) enhances our ability to assist children and their parents in pursuing optimum oral health care. Wraparound support services provided to each patient in need embraces this comprehensive approach to care, intertwining what we have come to learn about addressing the social determinants of health. Ruby Payne Bridges Out of Poverty and community health worker (CHW) emerging profession: Northern Dental Access Center is rooted in the teachings of Ruby Payne’s *Framework for Understanding Poverty* (2005). The extension of Ruby Payne skills (acquired through regular training of staff and providers) into an integrated CHW team has created a unique blend of cultural competence practices. Medical-legal partnership (MLP): Northern Dental Access Center and Legal Services of Northwest Minnesota have partnered to address the health-harming legal needs of the target population.

Services and Activities

Expand the delivery of oral health care to low-income people in an unserved, rural area of Minnesota and North Dakota through the transition of a private practice clinic into a community dental access center and integration of the new clinic into the successful care delivery model of the original dental access center in Bemidji, Minn.

Provide effective access to dental care by offering wraparound patient support services through a consortium of providers committed to reducing oral health disparities, tackling health-harming legal issues, and assisting all patients in addressing barriers to care.

Outcomes

The primary outcomes of this funded Outreach Program project are as follows:

Process outcomes:

1. Clinic transition (from private practice to community access) complete.
2. Care team hired in Year 1 and expanded in Year 3.
3. Patient/client screening tools in place for data collection and analysis.
4. Orientation of consortium partners on promising practices complete.
5. Patients have access to a dental home in their region.

Other outcomes:

1. In the first two years of operation, 3,125 unduplicated patients have received dental care.
2. In the first two years of operation, 94% of patients report receiving excellent care.
3. Insurance navigator on-site weekly for insurance counseling, MnSure navigation and enrollment, and provision of other support services.
4. Screening in place for all patients to assess need for legal services; attorney on-site monthly to meet with clients and connect them with other support services.
5. Strategic partnerships continue to expand and grow within the region, particularly with those serving mutual clients/patients.

Sustained Impacts

The original grant proposed two distinct strategies for accomplishing our goals:

1. Expand delivery of oral health care to low-income people in an unserved, rural area of Minnesota and North Dakota, and
2. Deliver dental care and wraparound support services through a consortium of providers committed to reducing oral health disparities.

During the grant period, we've been able to blend these into a single approach (a "dental home") whereby the dentistry and patient support services are provided in concert, seamlessly between consortium partners.

Activities that will be maintained long term include the full array of preventive and restorative dental procedures to low-income people in the service region. Patient support services will also continue, including the patient transportation program, legal services through Legal Services of NW Minnesota, insurance counseling and community resource referrals through Tri-Valley Opportunity Council, and care coordination through our CHW team.

Lessons Learned and Considerations for Program Replication

Critical lessons, particularly centered on staffing, were gleaned from the implementation of this Outreach Program project and will serve to inform the replication process when we expand our services to yet another satellite clinic location in the future. Originally, it was assumed that staffing would be effortless, and we projected we could discontinue borrowing talent from the home operation in Bemidji, Minn., in Year 2. However, the carefully cultivated team culture the organization is proud of requires visits to, meetings at, and connection with the satellite clinic on a weekly (at minimum) basis. This is critical to ensuring the staff receives the support and attention they deserve, which translates into clients having the best patient experiences possible. Further, the lesser licensing requirements just over the border in North Dakota for dental assistants proved to be a barrier in finding adequately licensed assistants for practicing in Minnesota. This has motivated leadership at Northern Dental to work within the legislative landscape to alleviate some of the licensure requirements in the state of Minnesota, where a dental assistant talent shortage has been ongoing for several years.

Organization Name	Missouri Bootheel Regional Consortium Inc.		
Organization Information			
Grant Number	Organization Type		
D04RH31789	Nonprofit Organization		
Organization Website			
www.mbrcinc.org			
Address	City	State	ZIP Code
903 S. Kingshighway, Suite A	Sikeston	Missouri	63801
Primary Contact Information for Project			
Name	Phone	Email	
Terrico Johnson	573-471-9400	tjohnson@mbrcinc.org	
Focus Area(s)			
	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
✓	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	Other:	
	HIV/AIDS	Other:	
✓	Maternal and Child Health	Other:	
Area(s) Served			
Dunklin, Mississippi, New Madrid, Pemiscot, and Scott counties.			
Target Population(s)/Need Addressed			
<p>The target population for this project is African American families with children residing in the Missouri Bootheel who are obese or at risk for obesity. African American children were selected because of the prevalence of racial disparities in the health outcomes experienced in the African American communities. The project provided health education to the five counties the project served, and increased opportunities for family recreational activities such as at family fun nights and during faith-based activities. Improved physical activity opportunities for children in the service area. Provided education on breastfeeding to families as a mean of preventing childhood obesity.</p>			

Consortium/Network Partners

Missouri Bootheel Regional Consortium (MBRC), a nonprofit organization, serves as the lead organization for the project. Housing Authority of the City of Charleston serves approximately 300 kids, of which 92% are African American. Word of Faith Outreach Center, a nonprofit organization, is a major focal point in the community for those in need of nutritional and social services. Delta Area Economic Opportunity Corporation (DAEOC), a nonprofit organization, has Early Head Start and Head Start programs that support the mental, social, and emotional development of children from 3 through age 5.

Project Goals

Implement a system to decrease risk factors for childhood obesity, increase family engagement in childhood obesity prevention, and improve physical activity opportunities for children in the service area.

Evidence-Based Model(s)/Promising Practice(s)

The consortium partners implemented the project by using community health workers as an evidence-based practice and Youth4Health and the Coordinated Approach to Child Health (CATCH) Curriculum as promising practices. All the community health workers in this project live in or have strong roots in the communities they serve. They understand or share any or all language, culture, ethnicity, socioeconomic status, life experience, and disease state with their clients. Youth4Health combined nutrition, physical activity, and family components to address the growing challenge of childhood obesity. CATCH Curriculum is proven to prevent childhood obesity and supported by 25 years and 120 academic papers indicating as much 11% decrease in overweight and obesity. Two of the most important ways that CATCH creates behavior change are by enabling children to identify healthy foods and by increasing the amount of physical activity children engage daily.

Services and Activities

The funding we received from the Outreach Program grant allowed us to have monthly family fun nights with families of the Housing Authority of the City of Charleston. At each family fun night, health education and physical activity challenges were provided to parents and their children. Quarterly family fun nights were held with Word of Faith Outreach Center, and at least one family fun night was hosted in each of the five counties served. A community resource book, a Facebook page, and newsletters to share with residents in the five counties served was created. Transportation to all events was provided to ensure anyone who wanted to attend had access to attend. An eight-week Traffic Light eating program for adults and children was developed to teach new healthier living habits. The partners hosted a yearly diabetes and obesity conference with speakers from around the country sharing health education and physical activity tools with the residents in the counties served. The funding received from the Outreach Program grant supported weekly nutrition and physical activity lessons to Head Start centers, after-school programs, and faith-based programs.

Outcomes

1. Enrolled over 1,000 African American children into the project.
2. Screened over 500 African American childrens' body mass index (BMI).
3. Developed monthly family fun nights with Housing of Authority of the City of Charleston and quarterly family fun nights with Word of Faith Outreach Center.
4. Trained over 150 faith-based community members in Traffic Light eating programs.
5. Developed and created a project logo and tagline to ensure the program is visible in the communities served.
6. Over 100 youths participated in sports leagues, and all of them were provided water during all events.
7. Created weekly nutritional and physical activity short videos and posted them to all our social media sites for parents and their children to gain new healthy living tips.
8. Taught weekly health and physical education classes to over 300 African American kids.
9. More than 600 African American children stated they learned new eating behaviors.
10. Over 400 African American children reported eating more fruits and vegetables weekly.

Sustained Impacts

The project expanded the program audience by forming new partnerships with local childcare centers, faith-based organizations, and after-school programs, sustaining the nutrition and physical activity components of this project for years to come. The newsletter, a community resource book, new nutrition and physical activity flyers, an eight-week Traffic Light eating program, and short educational videos are easily access and shared with residents in the five countries served.

Lessons Learned and Considerations for Program Replication

A big lesson learned from this project is that many of the families we serve frequently move from one home to another, creating a challenge to mail program flyers. Sending the program information to the childcare centers and after-school programs works best to ensure the program information made it home with the child. Partnering with pre-existing sports leagues works better than trying to create them. Most youth sports leagues have been around for years, and the people in those communities trust them.

Organization Name		Monroe County Hospital	
Organization Information			
Grant Number		Organization Type	
D04RH31790		Critical Access Hospital (CAH)	
Organization Website			
www.mchalbia.com			
Address		City	State
6580 165th St.		Albia	Iowa
			ZIP Code
			52531
Primary Contact Information for Project			
Name		Phone	Email
Veronica Fuhs		641-932-1755	vfuchs@mchalbia.com
Focus Area(s)			
Behavioral/Mental Health		Oral Health	
Cancer Care Management		Pediatric Care	
Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance	
Case Management		Primary Care Services	
Chronic Disease Management		Population Health	
Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination	
Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services	
Community-based Care Coordination		Substance Abuse Treatment and/or Education	
Diabetes Care Management		Telehealth/Telemedicine	
Health Education/Promotion and Disease Prevention		Transitions of Care	
Health Improvement Special Project (HISP)		Women's Health	
Health Screenings	✓	Other: Advance Care Planning (ACP)	
HIV/AIDS		Other:	
Maternal and Child Health		Other:	
Area(s) Served			
Monroe County, Iowa			
Target Population(s)/Need Addressed			
<p>The limited availability of advance care planning (ACP) services in Monroe County does not meet the needs of the project target population of Monroe County Hospital & Clinics (MCHC) patients aged 65 and older. Monroe County has a higher percentage of residents aged 65 and over who have a greater burden of chronic disease, higher incidence of premature death and injury death, higher rate of poverty, lower median household income, and higher uninsured rate than both Iowa and the United States. Improving ACP access, usage, and advance directive completion improves health care quality, patient involvement in treatment decisions, and standardizes improved ACP processes provided by medical providers and community partners.</p>			

Consortium/Network Partners

Primary consortium/network partners included the following nine organizations: Monroe County Hospital (Critical Access Hospital), Monroe County Medical Clinic (rural health clinic), Monroe County Public Health (public health), EveryStep Hospice (hospice), Brees Rest Home (nursing facility), Homestead Assisted Living (assisted living), Oakwood Specialty Care (nursing facility), Care Initiatives Hospice (hospice), Monroe Care Center (nursing facility).

Project Goals

The purpose of the project was to expand the delivery of ACP services in Monroe County. The three overarching project goals were:

1. Improve access to ACP services in Monroe County;
2. Increase the number of patients/consumers served by consortium members who have a documented advance care plan; and
3. Create a shared understanding of successful ACP development and documentation among consortium partners.

Evidence-Based Model(s)/Promising Practice(s)

The project utilized the evidenced-based model Respecting Choices[®] curriculum to facilitate ACP counseling. Respecting Choices is an internationally recognized, evidence-based model of ACP that creates a health care culture of person-centered care — care that honors an individual's goals and values for current and future health care.

The project also utilized two promising practice advance directives: Five Wishes and Iowa Physicians Order for Scope of Treatment (IPOST). Five Wishes is an advance directive with a comprehensive approach to encourage discussion and documentation of medical care and comfort choices. Five Wishes includes personal, spiritual, medical, and legal wishes all in one document. The IPOST is the state of Iowa's Physician Orders for Life-Sustaining Treatment (POLST) form which is a portable medical order. POLST is a promising practice approach that identifies and respects the treatment goals of a person with end-stage or chronic unmanaged illnesses.

Services and Activities

The primary activities were guided by the project goals. Goal 1 of improving access to ACP services was achieved through providing Respecting Choices training to certify facilitators who provided ACP education and guidance to residents, and certifying Instructors to increase capacity for the continuation of training more facilitators throughout the community. This project also developed MCHC processes to standardize ACP services for patients and improving access to these supports. Increasing documented advance care plans of Goal 2 is the development and implementation of the education and outreach plan which exposes, educates, and promotes ACP throughout the community. ACP services are provided to community members through educational presentations; development and distribution of several educational materials and tools; and facilitation of ACP conversations with residents one-on-one, in group settings, and virtually. Goal 3 of the consortium, creating a shared understanding of successful ACP development and documentation, is reached by consortium organizations developing processes for advance directive documentation, data monitoring, and achieving sustainability.

Outcomes

1. Improved access to ACP services in Monroe County, Iowa, through increasing capacity by 17 Respecting Choices ACP-certified facilitators and four Respecting Choices ACP-certified instructors available through five organizations serving Monroe County residents.
2. Increase in advance directives on file at MCHC by 350% (end of grant Year 2).
3. Thirteen ACP educational tools or resources developed and in circulation.
4. Thirty-seven educational outreach events reaching 3,792 people (end of grant Year 2).
5. Sixteen educational presentations to consortium organization staff educating a total of 192 staff.

Sustained Impacts

The sustained impacts in Monroe County as a result of this Outreach Program grant for ACP include increased accessibility, knowledge and understanding, capacity, and prevalence of ACP in the community. Training several ACP facilitators and instructors and distributing improved ACP resources and tools has increased ACP access for Monroe County residents. The diverse educational outreach performed, including the distribution of educational materials, increased Monroe County's overall understanding and knowledge regarding ACP. Capacity increased with the training and certification of ACP facilitators and instructors and the implementation of improved workflows and processes throughout Monroe County Hospital & Clinics and consortium organizations. The prevalence and use of ACP have increased significantly as a result of the successful Outreach Program grant activities.

Lessons Learned and Considerations for Program Replication

The lessons learned throughout the three-year grant period have been integral to the success of the program. The primary lesson learned was the unidentified need for ACP education for MCHC and consortium staff. It became evident that grant activities could not be performed effectively for the public without initially training and educating the staff performing those activities. Increasing staff ACP literacy improved the efficiency and effectiveness of program activities. The assessment of health information technology capabilities and gaps for supporting ACP documentation in the electronic medical record (EMR) led MCHC health coaches to identify inconsistent scanning of advance directives in the EMR. This inconsistency led to complications in advance directive retrieval and unreliable data collection. A health information management (HIM) workflow process improvement and staff education led to increased understanding of advance directives by HIM staff, consistent advance directive documentation in the EMR, and easier access to patients' advance directives. These lessons learned will improve the plan to spread and scale grant activities throughout partnering networks.

Organization Name		Mountain Comprehensive Care Center Inc.	
Organization Information			
Grant Number		Organization Type	
D04RH31791		Federally Qualified Health Center (FQHC)	
Organization Website			
www.mtcomp.org			
Address		City	State
330 W. Main St.		Grayson	Kentucky
			ZIP Code
			41143
Primary Contact Information for Project			
Name		Phone	Email
Rachel Willoughby		606-886-8572	rachel.willoughby@mtcomp.org
Focus Area(s)			
Behavioral/Mental Health		Oral Health	
Cancer Care Management		Pediatric Care	
Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance	
Case Management	✓	Primary Care Services	
Chronic Disease Management		Population Health	
Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination	
Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services	
Community-based Care Coordination		Substance Abuse Treatment and/or Education	
Diabetes Care Management		Telehealth/Telemedicine	
Health Education/Promotion and Disease Prevention		Transitions of Care	
Health Improvement Special Project (HISP)		Women's Health	
Health Screenings		Other:	
HIV/AIDS		Other:	
Maternal and Child Health		Other:	
Area(s) Served			
Through this funding, Mountain Comprehensive Care Center Inc. (MCCC) expanded the reach of its health care for the homeless clinics to Carter County, Ky., an eligible rural area in Central Appalachia and a designated Medically Underserved Area and Health Professional Shortage Area for both primary and mental health care.			
Target Population(s)/Need Addressed			
The targeted area has a population of 31,240, of which 44% (13,721) is homeless or very low-income and only 3.23% is currently served by health centers. The area is designated as "distressed" and among the nation's top 5% of poorest communities. While health disparities (smoking, obesity, poor health/mental health, drug use) are significant in Kentucky as the state has dropped to 49th in America's Health Ranking, rates within Carter are even more severe, ranking 99 out of 120 as among the least healthy counties.			

Consortium/Network Partners

Throughout the project, MCCC has partnered with PrimaryPlus, a Federally Qualified Health Center in neighboring Boyd and Lewis counties, and the Carter County Health Department to provide medical services (diagnostic, specialty, OB/GYN, hospitalization) and dental care outside the scope of MCCC HomePlace Clinic per the memorandum of understanding.

Project Goals

Project goals included:

1. Ensuring project implementation adheres to its targeted goals, objectives, and outcomes and facilitates continuous quality improvement.
2. Improving access to and use of comprehensive, culturally competent, and integrated quality health care services for homeless and very low-income patients.

These goals were met through maintaining timely completion of activities to include needs assessments, consortium meetings, integrated team meetings, outreach, community partnerships, and clinical data collection.

Evidence-Based Model(s)/Promising Practice(s)

MCCC utilized the evidence-based practices of the Chronic Care Model (CCM) and the patient-centered medical home (PCMH). CCM leads to improved patient care and better health outcomes. It can also strengthen patients' level of control over their health, improve health literacy, increase trust between patients and their doctors, and is effective with persons with mental health disorders. Likewise, the PCMH offers an effective model for responding to patients, particularly homeless persons with comorbid medical and behavioral health needs, who have complex health issues that require supports from a wide variety of providers and caregivers — which is demonstrative of the targeted population.

Services and Activities

The work plan aligned throughout the life of the grant with the goals of the Rural Health Care Services Outreach Program because it included activities that were intended to increase the number of homeless and low-income patients who have access to health care. This includes increasing the number of homeless and low-income patients who have a specific payment source, have access to community-based resources, participate in health promotion and disease prevention activities, and are screened for key health issues, like mental health and substance use disorder and are provided or referred to appropriate treatment.

Outcomes

1. As a result of MCCC HomePlace Clinic, not only have patients had an ongoing, affordable source of care, but the community has also realized saving by decreasing unnecessary emergency department and hospital visits for preventable or treatable conditions. The evaluation data suggests that awareness of the HomePlace Clinic has increased substantially during the first three years of operation. Although the patient/visit volume has been lower than expected, much in part due to the COVID-19 pandemic, the numbers are increasing through the available use of telehealth services. Patients continue to be satisfied with the staff and quality of care and will continue to spread the word about the HomePlace Clinic to family and friends, which is our best form of outreach — word of mouth. Along with an expanded patient base, the office itself is expanding. MCCC has purchased property in Carter County, Ky., to build a new integrated primary care site.
2. At least 80% of patients were connected with a payer source and connected to community resources.
3. All HRSA diabetic education measures were met at this site.
4. All behavioral health screenings were completed with appropriate referrals made for patients in need of behavioral health services.

Sustained Impacts

MCCC's goal throughout the life of the grant was to ensure long-term sustainability. This worked through a multipronged approach. First, for uninsured patients, HomePlace Clinic staff assisted patients in checking for eligibility and navigating the enrollment process for Kentucky Child Health Insurance Program (KCHIP)/Medicaid or insurance through the state's Health Benefit Exchange (Kynect). With patients enrolled in KCHIP, Medicaid, Medicare, or other insurance programs, MCCC was able to bill eligible services as it has established Medicaid and Medicare numbers and rates. As an HRSA Health Care for the Homeless Provider, MCCC was also able to utilize funds from its existing service area component award to supplement the Rural Health Outreach award and billable services with a goal of moving towards sustainability by the end of Year 3.

Lessons Learned and Considerations for Program Replication

The COVID-19 pandemic certainly affected several areas of this project. Workarounds to offer telehealth services as well as ways to still connect with the patient population through enabling services were two major lessons learned. COVID-19 also added to challenges of slow clinic growth. However, the consortium experienced no changes through the lifetime of the grant, which we see as a great success as those partnerships will continue to have a lasting impact on services. Last, MCCC collected much-needed survey data throughout the life of the project utilizing a patient survey tool. This data will be used when considering program replication. One specific question was exceptionally interesting to note, asking, "If MCCC's HomePlace Clinic did not exist, where would you go for care?" Results were 38% would utilize urgent treatment, 25% wouldn't seek care, and 25% would use home remedies. This spoke to the significant role the RHO project played in emergency department and urgent treatment diversion, as well as assisting in treatment options for those who wouldn't have received any care or appropriate care.

Organization Name		North Central Iowa Mental Health Center	
Organization Information			
Grant Number		Organization Type	
D04RH31640		Mental Health Provider	
Organization Website			
Address		City	State
720 Kenyon Rd.		Fort Dodge	Iowa
ZIP Code			
50501			
Primary Contact Information for Project			
Name		Phone	Email
Brienne Lundberg		515-955-7171	brienne.lundberg@unitypoint.org
Focus Area(s)			
<input checked="" type="checkbox"/>	Behavioral/Mental Health		Oral Health
<input type="checkbox"/>	Cancer Care Management		Pediatric Care
<input checked="" type="checkbox"/>	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
<input type="checkbox"/>	Case Management		Primary Care Services
<input type="checkbox"/>	Chronic Disease Management		Population Health
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
<input type="checkbox"/>	Community-based Care Coordination	<input checked="" type="checkbox"/>	Substance Abuse Treatment and/or Education
<input type="checkbox"/>	Diabetes Care Management		Telehealth/Telemedicine
<input type="checkbox"/>	Health Education/Promotion and Disease Prevention		Transitions of Care
<input checked="" type="checkbox"/>	Health Improvement Special Project (HISP)		Women's Health
<input type="checkbox"/>	Health Screenings		Other:
<input type="checkbox"/>	HIV/AIDS		Other:
<input type="checkbox"/>	Maternal and Child Health		Other:
Area(s) Served			
Berryhill Mental Health Center served the following counties: Webster, Calhoun, Pocahontas, Hamilton, Wright, Humboldt, Buena Vista, Sac, Kossuth, and Franklin.			
Target Population(s)/Need Addressed			
The Rural Health Care Services Outreach Program project served adults aged 30-74 with rising risk of mental health or substance abuse risk factors through screenings and referrals:			
<ol style="list-style-type: none"> 1. Individuals with high and rising risk Health Improvement Special Project (HISP) indicators: heart age, blood pressure, BMI, smoking, blood glucose, and cholesterol. 2. Individuals benefitting from evidence-based health and wellness activities supporting HISP health factors. 3. Individuals with pain-management issues who may benefit from cognitive behavioral therapy (CBT), an intervention reducing the potential of long-term drug dependence or opioid misuse. 4. Families who may benefit from nurturing skills for family. 			

Consortium/Network Partners

Five health-related organizations were consortium members and demonstrated purposeful care coordination efforts. The consortium consisted of Berryhill Center, a licensed mental health center; Trinity Regional Medical Center, a safety net hospital, community hospital, and rural referral center; UnityPoint Clinic, comprising 50-plus physicians, mid-level providers, and specialists covering 25 locations; UnityPoint at Home, a home health agency that worked with individuals and their families so they remained in the home, covers a 50 mile radius; and Webster County Public Health providing additional services.

Project Goals

1. Enhanced care coordination program for high-risk individuals with mental or substance abuse issues, utilizing evidence-based guidelines for care management.
2. Demonstrated improved population health and improved outcomes for the rising risk target populations through select interventions.
3. Expanded the delivery of health care services including new and enhanced mental health and substance series in nine rural north central Iowa communities through five targeted outreach efforts to address growing issues including growing opioid use in the target area.
4. Utilized new and expanded existing evidence-based programs (EBPs) for expanded screening, intervention, and health and wellness supports that target individuals with mental illness or substance abuse disorders to provide effective strategies to improved HISP outcomes.

Evidence-Based Model(s)/Promising Practice(s)

Berryhill Center continued case management services for existing participants, provided EBP services such as the health and wellness groups of Nutrition and Exercise for Wellness and Recovery (NEW-R), Whole Health Action Management (WHAM), Nurturing Skills for Families, and additional healthy living education. Berryhill Center continued to provide Screening, Brief Intervention, and Referral to Treatment (SBIRT) Screenings for adults and youth aged 12 and up.

Services and Activities

Berry Center provided:

1. EBPs, activities being continued in the Integrated Health Home program, including WHAM, New-R, Nurturing Skills for Families, and CBT for pain management.
2. SBIRTs for individuals 12-17 and adults aged 18 and older was implemented. Screening the adolescent population for patterns to inappropriate alcohol and or drug use, early identification, and intervening while decreasing the risk of health risks at a younger age was accomplished.
3. SBIRTs for ages 18-plus; completing the SBIRT was imperative in identifying any substance use disorders that were present. Through identification, Berryhill Center addressed any potential health risks.
4. Care coordination/case management services — Berryhill Center served patients with inadequate funding for these services. Through Integrated Health Home (IHH) program, this program activities have been integrated into the existing program to continue these services into the future.

Outcomes

1. Berryhill Center was able to hire and sustain all necessary staff needed to meet our grant goals and HRSA requirements as well as providing the necessary direct care to support the project.
2. Berryhill Center implemented and completed Performance Improvement Measurement Systems (PIMS) measures on all members enrolled under the HRSA grant.
3. Berryhill Center expanded services to new populations in the rural service area that were not funded by another funding source.
4. SBIRTs were completed on patients 12 and over that were seen at the Berryhill Center.
5. CBT group — Berryhill Center was able to start this group; however, due the COVID pandemic and restrictions in place this activity was not able to continue.
6. Medicaid-assisted treatment — Berryhill Center did not provide these services due to a local partnership with another agency in the area that was providing the service.
7. Health and Wellness Services — Berryhill Center was able to provide health and wellness classes, plus one walking group to program members. Due to COVID, these groups were put on hold, but walking group resumed by the end of the grant year.

Sustained Impacts

Berryhill Center was able to implement and continue to provide SBIRT, Health and Wellness classes, and continued the care coordination services and Outreach programs. Berryhill Center will continue to sustain partnerships with community partners including Webster Co. Public Health, Iowa Heart, Unity Point Clinics, and servicing and expanding services into the 10 counties Berryhill Center serves.

Lessons Learned and Considerations for Program Replication

1. Berryhill Center built relationships with other agencies not only in the local community but also in the communities Berryhill Center served, which provided additional services to those areas and individuals in those areas to address health needs.
2. During the COVID pandemic, it did hinder much of the progress due to the restrictions placed and not being able to see our patients face-to-face. Berryhill Center was able to continue some of programing, but it looked different than originally intended. For example, Berryhill Center conducted more phone contacts. Due to the population being served, using technology was difficult such as Zoom or Skype and many patients did not have smart phones.
3. Throughout the process, Berryhill Center learned that the parameters of the cardiovascular disease and age range of 30-74, it was difficult to enroll patients. Many of the referrals received over the past couple of years were for individuals who were younger than 30 and many of the patients had some sort of cardiovascular disease.

Organization Name	North Country Health Consortium		
Organization Information			
Grant Number	Organization Type		
D04RH31641	Nonprofit Organization		
Organization Website			
www.nchcnh.org			
Address	City	State	ZIP Code
262 Cottage St., Suite 230	Littleton	New Hampshire	03561
Primary Contact Information for Project			
Name	Phone	Email	
Diana Gibbs	603-259-3700	dgibbs@nchcnh.org	
Focus Area(s)			
	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
<input checked="" type="checkbox"/>	Community-based Care Coordination	<input checked="" type="checkbox"/>	Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	Other:	
	HIV/AIDS	Other:	
	Maternal and Child Health	Other:	
Area(s) Served			
Coos and northern Grafton counties in New Hampshire.			
Target Population(s)/Need Addressed			
<p>The target population for this initiative is adults 18 years old and over in the service area. Rural residents face an even greater disparity as they are more likely to have higher rates of overdose deaths. Conditions in the local service around the social determinants of health put all adults are greater risk of opioid use disorder (OUD), including rurality of the region; higher percentage of white residents; low health literacy; lower educational attainment; high rates of uninsured and unemployed; high rates of chronic illness and disability; higher median age that the rest of the state; and higher opioid prescribing habits by area providers, attributable to the prevalence of physically demanding employment.</p>			

Consortium/Network Partners

The primary consortium for this project is service areas health care organizations including three Federally Qualified Health Centers (Indian Stream Health Center, Coos County Family Health Services, and Ammonoosuc Community Health Services) as well as three Critical Access Hospitals and two Rural Health Clinics (Upper Connecticut Valley Hospital, Weeks Medical Center, Littleton Regional Healthcare, Androscoggin Valley Hospital, Cottage Hospital) and the CAH Affiliation organization (North Country Healthcare). Additionally, significant network partners have included substance use disorder (SUD) treatment and recovery programs, social service and support organizations, and community-based coalitions.

Project Goals

Goal: To improve OUD intervention strategies and increase access to treatment for North Country adults.

Outcome 1: Implement a warm hand off model in emergency departments (EDs) for patients presenting with OUD.

Objective 1: Incorporate dually trained community health workers/recovery coaches (CHWs/RCs) into EDs to ensure access to treatment and recovery options.

Objective 2: Provide continuing education for ED and hospital staff in Motivational Interviewing, Mental Health First Aid, and regional OUD/SUD treatment options.

Outcome 2: Enhance care coordination practices by integrating CHWs/RCs into treatment and referral protocols.

Objective 1: Increase North Country Health Consortium (NCHC) CHW capacity.

Objective 2: Integrate Recovery Coach Academy curriculum into CHW training.

Objective 3: Collaborate with hospitals, Federally Qualified Health Centers (FQHCs), treatment programs, and recovery centers to incorporate CHW/RCs into treatment/recovery teams.

Objective 4: Cross-train peer RCs to also work as CHWs.

Outcome 3: Improved knowledge and understanding by law enforcement regarding the best practices for identifying, screening, and linking opioid abusers to treatment.

Objective 1: Develop outreach and educational resources for distribution in a variety of settings.

Objective 2: Explore innovative models to engage law enforcement in coordinating efforts to address the drug/addiction problem and direct individuals to treatment programs.

Evidence-Based Model(s)/Promising Practice(s)

NCHC's Outreach Program identified two evidence-based/promising practice models for this intervention — the warm handoff model and integration of CHWs who are dually trained as RCs:

Warm handoff model — supported by the Agency for Healthcare Research and Quality, described as a handoff between two members of a health care team and the patient. Community health worker/recovery coach — This dually trained workforce is trained in care coordination and resource navigation and uses Motivational Interviewing to engage clients using a CHW curriculum that's been developed based on national core standards. This workforce is also trained as RCs using a peer support service model, which an evidenced-based mental health model consisting of qualified providers assisting individuals with recovery from substance use disorders and is adapted from the Affiliated Services Providers of Indiana Network.

Services and Activities

Direct service referral systems with health care and other partners: NCHC designed referral channels for the program to include phone, a secure web form in Apricot (NCHC's care coordination programming), and fax referral. Appropriate consents were developed and discussed with referring agencies to ensure confidentiality and compliance with HIPAA and 42 CFR Part 2. Intake processes and ongoing services commence within 24 business hours of receiving a referral to begin one-on-one direct services. Developed ED workflows for program integration: NCHC developed warm hand off workflows and other program materials to engage health care partners to integrate NCHC CHW/RCs into their patient support and discharge planning for families and individuals to help with recovery needs. Community education: Engaged prevention and intervention coalitions in the region to collaborate and provide community education, development of an RC network, and other activities to achieve the program outcomes of increasing communities' and professional understanding of SUD/OUD, reducing stigma, and increasing access to treatment and recovery services.

Outcomes

1. Enhanced care coordination practices through integration of NCHC CHW/RCS into diverse care teams, including health care, behavioral health, and social services,
2. Increased access to effective resources for clients through systems-level navigation and recovery support.
3. Enhanced and improved referral and tracking systems to support increased outcomes for individuals with SUD/OD.
4. Network members benefit from CHW/RCS who enhance patient outcomes.
5. Created a partnership between the medical community and treatment services to reduce ED utilization.
6. Increased community and professional awareness and understanding of SUD/OD, stigmatizing language, and best practices for supporting individuals on their path of recovery.
7. Improved knowledge and understanding by law enforcement and other first responders regarding the best practices for identifying, screening, and linking individuals with SUD/OD to treatment.
8. Reduced stigma connected to substance use disorders.
9. Expanded recovery support workforce through development of RCS across multiple disciplines.
10. Demonstrated evidence of an innovative rural model to expand and support treatment and recovery while enhancing individual stability around the social determinants of health.

Sustained Impacts

NCHC's Outreach Program project has strengthened regional interventions, enhanced access to treatment and recovery services, and has created a care coordination model that is flexible and adaptable to meet the complex needs of individuals with SUD/OD. Further, this model of care coordination has: demonstrated positive return on investment for clients in recovery and the health care system; facilitated timely access to treatment services; created referral systems to address client stability such as connection resources and services along their pathway to recovery; and provides evidence for inclusion of CHWs in payment reform models. NCHC's Outreach Program project has changed attitudes and enhanced knowledge of both community members and professionals, especially law enforcement and first responders. NCHC was able to shift the perspective of addiction as a moral failing to the understanding that addiction is a treatable chronic illness that requires a greater recovery community to adequately support individuals. While creating a sustained culture of change is a work in progress and will require a more long-term approach, NCHC's work has set the foundation for this recovery movement.

Lessons Learned and Considerations for Program Replication

NCHC's Outreach Program project began with a clear vision for integration of a care coordination model within health care systems, such as EDs and primary care. Through networking and leveraging over other partnerships, it became apparent that some of the most valuable collaborations resulted from community mental health, business, treatment, social services, and even other recovery organizations. It became evident that the most critical gap in the region was systems-level navigation to support client needs across the social determinants of health. NCHC's care coordination model became the bridge to connect across all health and human service providers, including engagement and interaction with law enforcement. If replication were to occur in another community, NCHC would advise that partnerships be more inclusive of local sectors beyond health care, recognizing the opportunity to connect across these spheres to enhance outcomes.

Organization Name	Northeast Oregon Network		
Organization Information			
Grant Number	Organization Type		
D04RH31642	Nonprofit Organization		
Organization Website			
www.neonoregon.org			
Address	City	State	ZIP Code
2008 Third St., Suite A	La Grande	Oregon	97850
Primary Contact Information for Project			
Name	Phone	Email	
Liberty Avila	541-910-1929	lavila@neonoregon.org	
Focus Area(s)			
✓	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management	✓	Primary Care Services
✓	Chronic Disease Management	✓	Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention	✓	School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
✓	Community-based Care Coordination	✓	Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
✓	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
✓	Health Screenings	Other:	
	HIV/AIDS	Other:	
	Maternal and Child Health	Other:	
Area(s) Served			
Baker, Malheur, Umatilla, Union, and Wallowa counties in Northeastern Oregon.			
Target Population(s)/Need Addressed			
Rates for opioid prescriptions and "risky" medication prescriptions are high in the region, and there are limited services to address both opioid misuse and the underlying conditions that create the risk for opioid misuse. Populations in the area face challenges specific to rural areas, including social isolation, long travel times to access treatment, and stigmas against getting help for mental and behavioral health challenges. The target population is predominantly white, but also includes Latin, Asian Pacific Islander and American Indian groups.			

Consortium/Network Partners

Primary project partners include Baker 5J School District, Center for Human Development (CHD), Department of Human Services (DHS), Elgin Health Center, Good Shepherd Health Center, Grande Ronde Hospital and Clinics, Lifeways Inc., Northeast Oregon Housing Authority, Saint Alphonsus Medical System, Umatilla County Human Services, Valley Family Health Care, Wallowa Valley Center for Wellness, and Winding Waters Medical Clinic.

Project Goals

1. Strengthen existing community coalition to align strategies for opioid use interventions.
2. Educate CHWs and nonprescribing providers in opioid misuse risk, promotion of alternative pain-management strategies, and early detection of opioid misuse.
3. Educate the public about the risks of opiate misuse and where to find resources.
4. Implement risk assessment and quarterly medication use assessment for target populations; and
5. Assess health-related social needs among those misusing and at risk for misusing opiates and provide links to appropriate resources, including linking to and monitoring participation in opioid treatment.

Evidence-Based Model(s)/Promising Practice(s)

The project utilizes the AHRQ Pathways Community Hub Model, pioneered by the Community Health Access Project in Richland County, Ohio, and replicated across the county. In this model, NEON acts as a neutral entity (neither a payer or provider), training community health workers (CHWs), helping contracted organizations integrate CHWs into their practice, providing data aggregation and quality control, and paying organizations for the outcomes CHWs achieve with community members.

Services and Activities

NEON provides trainings to CHWs and supervisors in opioid risk assessment, alternative pain-management strategies, and treatment guidelines. With our partners, we coordinate services and support for at-risk community members. CHWs and referring providers utilize the Opioid Risk Assessment Tool to identify those at risk of opioid misuse and those using already. CHWs perform health-related social need risk assessments, assign Pathways based on need, and link and connect individuals until identified needs are met. In the case of substance abuse treatment, CHWs follow up with the patient to ensure they remain in treatment and provide problem solving assistance as needed. CHWs conduct quarterly medication reconciliation with the primary care provider to ensure that any prescribed opioids are being taken as prescribed and that additional prescriptions are not being accessed. NEON conducted patient satisfaction surveys with participation incentives to identify CHW coaching opportunities. We partnered with Heal Safely, a community developed campaign to share resources on our social media and via radio advertisements. We compiled a five-county treatment resource guide on our website.

Outcomes

1. Quickly rolled out our program and began with high Hub enrollment volume which continued through the course of the grant.
2. Elgin Health Center, Umatilla County Human Services, Northeast Oregon Housing Authority, and Baker 5J School District joined the Hub as partners.
3. Collaborated closely with two other Pathways-based programs to share and refine data collection and program operation strategies and successfully navigated a challenging transition to a new data collection user interface in the CLARA program.
4. To date, the Hub program portion that is funded by this grant has served over 333 clients, completing over 1,150 resource linkages successfully. Overall, the Hub has served 1,100 clients with over 3,000 resource linkages including transportation, medical care, utilities assistance, housing, food access, and other types of financial assistance. Currently, the program is operating at 11 sites with 15-20 active CHWs.
5. Surveyed key contacts about local treatment resources and developed an Eastern Oregon Treatment Resource Guide that includes information about SUD treatment services, sober living, support groups, detox, and other related resources, and published to our website for public access.
6. Partnered with local prevention coalitions to write news articles on prescription drug risks and resources and partnered with Heal Safely to raise awareness about alternative pain management options using printed materials and a radio ad campaign reaching an estimated 350,000 listeners in the service area.
7. Successfully developed and grew the training program infrastructure, to offer a variety of trainings tailored to the needs of CHWs, home visitors and other partners via in-person trainings. The trainings were adapted to be offered online, which resulted in growing participation and higher visibility across the state. In total, 638 seats have been filled in in-person and online courses, 229 of whom were counted toward this project.

Sustained Impacts

NEON has become a cornerstone of collaborative projects in Eastern Oregon and the agencies we serve value the skills and expertise we offer. This project has resulted in significant growth in the numbers of resource linkages completed by CHWs. Due to our success integrating CHW programs, we've found that partner sites relying on outcome payments from NEON-secured grants have identified the value of CHW interventions in their respective agencies. Many of these programs have stated they will sustain their CHW programs regardless of payment for outcomes. There is a movement statewide in adding additional CHW fee for service billing codes and have been involved in supporting this process, which will allow our partners to have some alternate funding for CHW work outside of the Pathways model. There has been a growing demand for CHW program support in the region and this is projecting to continue to grow, with changes to Medicaid policy. In addition to these changes, there is an increased demand for trainings and contract services, which will enhance the sustainability of these services and NEON as a whole.

Lessons Learned and Considerations for Program Replication

This program provides best practices, policies, and procedures that are not specific to Northeast Oregon and can be replicated by other rural organizations, including those serving different target populations. For other rural sites interested in implementing this type of program, we have the following key pointers:

1. Participate in state- and national-level discussions about the different CHW models being utilized and monitor statewide health care trends to be sure your program model aligns with the needs of local payers.
2. Be responsive to the various needs of the community and CHW workforce and have flexibility to provide support with non-Pathways strategies.
3. Be clear with messaging and communications to ensure social service and direct health care service entities understand what you can offer.
4. Make sure that payment models can reimburse for all costs associated with services rendered, including mileage for home visiting services.

Organization Name		Ohio University	
Organization Information			
Grant Number		Organization Type	
D04RH31792		Nonprofit Organization	
Organization Website			
https://www.ohio.edu/			
Address		City	State
1 Ohio University		Athens	Ohio
			ZIP Code
			45701
Primary Contact Information for Project			
Name		Phone	Email
Elizabeth Beverly		740-593-4616	beverle1@ohio.edu
Focus Area(s)			
	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
✓	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
✓	Diabetes Care Management		Telehealth/Telemedicine
	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	Other:	
	HIV/AIDS	Other:	
	Maternal and Child Health	Other:	
Area(s) Served			
The program served seven counties in southeastern Ohio: Athens, Hocking, Meigs, Morgan, Perry, Vinton, and Washington. All counties were designated as Health Professional Shortage Areas and Medically Underserved Areas. Six counties were designated as rural and one was designated as partially rural (i.e., Washington).			
Target Population(s)/Need Addressed			
Diabetes affected 19.9% of adults in rural southeastern Ohio. People were 19% more likely to live below the poverty line, 14% more likely to be unemployed, and were 12% less likely to earn a bachelor's degree compared to the rest of the United States. Moreover, people with diabetes were more likely to have a delayed diabetes diagnosis, limited access to health care, and lower health literacy. For these reasons, people with diabetes are more likely to suffer from complications, which contributed to a diabetes mortality rate that is 28.4% higher than the national average. The target population were children and adults with diabetes with social determinants of health in southeastern Ohio.			

Consortium/Network Partners

The Diabetes Consortium included partners from six groups: Department of Primary Care, the Ohio University Heritage College of Osteopathic Medicine; the Diabetes Institute at Ohio University (OU); OhioHealth Physician Group Heritage College Diabetes Endocrine Center; Athens City-County Health Department; Ohio University Psychology and Social Work Clinic; and the Ohio University Diabetes Outreach Support and Education for Students (DOSES).

Project Goals

The goal was to implement a new approach to diabetes navigation in rural Appalachia to improve health outcomes and lower health care expenditures for children and adults with diabetes through the development and coordinated implementation of three programs:

1. Child Diabetes School Navigation Program.
2. Community Health Worker Program.
3. Peer Support Program. The objective of the Child Diabetes School Navigation Program was to establish the Child Diabetes School Navigation Program to support children in our region who are dealing with type 1 and type 2 diabetes. The objective of the Community Health Worker Program was to train and certify community health workers to provide full-time diabetes navigation services for adult diabetes patients in the region. Finally, the objective of the Peer Support Program was to engage college students as peer mentors with the children enrolled in the Child Diabetes School Navigation Program.

Evidence-Based Model(s)/Promising Practice(s)

For the Child Diabetes School Navigation Program, OU selected the patient navigation model, created by Dr. Harold P. Freeman, based on empirical evidence demonstrating reduced barriers and improved outcomes for diabetes care. Navigators were trained personnel who engage patients on an individual basis to determine barriers to accessing care or following treatment recommendations and provided services relevant to overcoming modifiable barriers, improving access to care, and facilitating self-management. For the Community Health Worker (CHW) Program, OU selected the CHW model based on empirical evidence supporting its effectiveness for diabetes and hypertension-related outcomes as well as improved health-, equity-, and efficiency-related outcomes. For the Peer Support Program, OU selected the peer support model based on systematic evidence demonstrating the effectiveness of peer support in diabetes self-care for improving diet, exercise, monitoring, and taking medication.

Services and Activities

Ohio University's Child Diabetes School Navigation Program was the first of its kind to coordinate a navigator, health care providers, and school nurses to navigate children and their family through and around barriers in the health care system. Specifically, OU's navigator addressed barriers in the school system, such as hypo- and hyperglycemia, blood glucose monitoring, carbohydrate counting, insulin administration, glucagon administration, diabetes technology (i.e., insulin pump, continuous glucose monitoring), medical appointments, and diabetes supplies. OU's CHW Program provided navigation services aimed at addressing social determinants of health. OU's full-time CHW helped navigate patients through the health care system, supported engagement in diabetes self-care behaviors, offered financial and community resources, and provided social and emotional support to adults with type 2 diabetes. OU's Peer Support Model provided peer support from trained mentors living with diabetes to the children in the Child Diabetes School Navigation Program. The peer support mentors belonged to a university organization dedicated to supporting people with diabetes.

Outcomes

The child diabetes navigator provided care and support to children with diabetes in 11 schools in five of the seven southeastern Ohio counties. More than 50 children received navigation services, with the majority receiving continuous care over the course of the three-year grant period. Outcomes for the participating children and families included the provision of diabetes care supplies (i.e., hypoglycemia treatment kits, snacks, insulin), education for the treatment of hypoglycemia and glucagon administration, increased engagement in diabetes self-care behaviors, reduced hypoglycemia, improved A1c levels, and reduced school absences. Over the past three years, OU provided more than 100 hypoglycemia treatment kits and snack boxes to children in the local schools. In addition, OU educated 48 school personnel and 230 community members in hypoglycemia treatment and glucagon administration. In Year 1, the CHW program trained 12 community members to be CHWs. In Year 2, one CHW was hired full-time and provided intense navigation services to adults with type 2 diabetes. Preliminary results showed the average reduction in A1c for these adults was 1.9% points. A reduction of 0.5% in A1c was deemed a clinically significant reduction in A1c, which translated into a reduced risk for microvascular complications (e.g., retinopathy, nephropathy, neuropathy). The mean A1c of the participants before receiving services was 10.1%, and the mean after working with the CHW was 8.2% (mean improvement = 1.9%, t-value = 4.590, p = .004). The Peer Support Program trained 12 peer support mentors from Ohio University's official student organization, DOSES. The Peer Support Program hosted multiple in-person events and virtual hangouts with the children in the Child Diabetes School Navigation Program. In addition, the peer mentors participated in the three-day diabetes camp, CAT Camp, in the summer.

Sustained Impacts

The Peer Support Program leader developed a diabetes summer camp, CAT Camp, that included both the peer mentors and the children from the Child Diabetes School Navigation Program. The CAT Camps will be an annual event hosted by the Ohio University Diabetes Institute for the children in the Child Diabetes School Navigation Program and peer mentors. The leader of the Peer Support Program developed a written peer-to-peer curriculum for the mentors. This is a sustained impact because it will provide training to future individuals interested in becoming peer mentors to children with diabetes in the region. The project director developed a written hypoglycemia and glucagon administration training program for school personnel and community members. This training can be delivered in-person or virtually. The project director is in the process of creating an online training module for school personnel and community members. The online module will be distributed to all school districts in southeastern Ohio at no cost. Finally, the publication of OU's research was a sustained impact because the findings have the potential to inform future interventions and policy.

Lessons Learned and Considerations for Program Replication

In the Child Diabetes School Navigation Program, the most important lesson learned was that before OU could improve health outcomes, first the program needed to provide children with the basic resources to manage diabetes. For example, a child could not lower their A1c level without access to a blood glucose monitor and insulin. Moreover, to reduce the number of hypoglycemic events, the program had to provide children with healthy snacks and diabetes supplies to treat hypoglycemia (e.g., glucose tablets, blood glucose monitor, lancets). Last, and most important, for children to improve health outcomes and reduce health care expenses, they needed to be in the classroom. Therefore, OU's navigator focused on providing services to help children reduce the number of school absences. After OU addressed the children's basic needs, the navigator was able to help the children improve their diabetes self-care and improved clinical outcomes.

In the CHW Program, the most important lesson learned was that it was not the number of people served by a CHW that mattered, but the quality of outcomes that determined the effectiveness of the program.

Organization Name		Peacehealth	
Organization Information			
Grant Number		Organization Type	
D04RH31643		Critical Access Hospital (CAH)	
Organization Website			
https://www.peacehealth.org/peace-harbor-medical-center			
Address		City	State
400 Ninth St.		Florence	Oregon
			ZIP Code
			97439
Primary Contact Information for Project			
Name		Phone	Email
Cheri Payne		541-902-6931	cpayne@peacehealth.org
Focus Area(s)			
✓	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention	✓	School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management	✓	Telehealth/Telemedicine
✓	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings		Other:
	HIV/AIDS		Other:
	Maternal and Child Health		Other:
Area(s) Served			
The project serves western Lane County communities that are in designated rural census tracts of the coastal region of Lane County, Ore.			
Target Population(s)/Need Addressed			
The project's target population is children living in the rural communities of Florence, Mapleton, Swisshome, Deadwood, and remote unincorporated areas in western Lane County. The primary need addressed was to expand child/adolescent behavioral health services for the approximately 2,300 children under the age of 18 years living in the service area.			

Consortium/Network Partners

Primary consortium partners directly involved in the implementation of our outreach project are PeaceHealth Peace Harbor Medical Center, a Critical Access Hospital, and its affiliated medical group, plus two public school districts, Siuslaw School District, and Mapleton School District. All are located in western Lane County, Ore. These partners were supported by additional consortium members including Lane County Public Health, Trillium Community Health Plan, a Medicaid coordinated care organization, and two additional provider organizations; The Child Center, and Options Counseling and Family Services.

Project Goals

The overarching goals of our grant funded outreach project were to further develop network infrastructure to support new services, to expand access to child/adolescent behavioral health services, and to improve service coordination and broaden coordination with nontraditional community health partners by establishing community health and wellness resource centers.

Specific objectives were to:

1. Fully activate network infrastructure enabled by the outreach grant funds to establish a sustainable network by the end of the project;
2. Open community resources centers in the service area and establish service coordination; and
3. Expand child and adolescent behavioral health services for the 2,300 children under 18 years of age in the service area.

Evidence-Based Model(s)/Promising Practice(s)

The project drew from three promising practices models: The Family Resource Center (FRC) located in Reedsport, Ore.; the Oregon School Based Health Clinics model (OSBHs); and for telehealth aspects of our project we drew from Health-e Schools model, created by the Center for Rural Health Innovation. The FRC model serves an isolated, rural coastal community with similar demographic characteristics and social economic challenges and is also a community collaboration between health care and nontraditional providers. OSBHs are located on school grounds and provided evidence that behavioral health care on school campuses is more effective due to early identification of need, accessibility of service, low attrition and no-show rates, and lack of stigma. Health-e Schools, was a well-designed physical medicine model involving telehealth consults from regional specialty providers which could be adapted for telepsych and remote counseling given our project's mental health focus.

Services and Activities

The primary activities implemented during our grant funding period included activating a capital funding campaign (nongrant funding) for site remodels in two school locations, recruiting and hiring qualified clinical and support staff, operationalizing a shared service model which involved fielding an RFP for resource center operations and service delivery amongst network provider partners, finalizing the scope of services to be provided, determining days/hours of operation, establishing appointment instructions integrated with the provider's current operations, and designing partner referral protocols and procedures. Communication and outreach materials, including a website, parent brochures, community PowerPoint presentation, and other parent, referrer, and community outreach tools and events were developed. One such event involved primary care providers providing sports physicals in the Mapleton Resource Center, this activity provided direct health promotion value to 10% of the district's students and earned local media promotion. The project established telephone and video visit capabilities.

Outcomes

Key outcomes achieved by this funded outreach grant project include:

1. Expanded capacity of behavioral health providers available in the service area, added one FTE LCSW counselor specializing in child/adolescent behavioral health.
2. Created two mental health resource centers located on two school districts grounds, reducing access barriers for 2,300 children in rural and remote communities.
3. Implemented telecounseling capability.
4. Provided 577 visits to 56 children to date in a 15-month period since operational launch. This was in spite of Oregon state COVID-19 mandates that severely disrupted ability to provide mental health services (for six months) and school closures over the past 12 months' time. We are back on track offering both in person and telecounseling options.
5. Created a sustainable, shared service model that will be institutionalized/absorbed by three primary partners involved in implementation of the project.
6. Leveraged consortium communications/meetings to catalyze and expand partnerships that led to development of an innovative pilot project for rural mobile crisis response (nonoutreach grant funded).

Sustained Impacts

The activities, partnerships, and focus afforded by the Outreach Program grant provides sustained impact by increasing the capacity of the local delivery system to provide counseling for children/adolescents. Introducing a new, shared service model between two rural school districts, provided an affordable way to improve access for children living in the most remote areas we serve. Because centers are located on school grounds children/teachers/parents have fewer "collateral" issues (e.g., transportation, missed school, stigma) to contend with in the future. Outreach Program grant activities also catalyzed funding from community philanthropy to construct two resource centers. These sites provide a lasting footprint and place for additional services in the future. Sustained impacts also resulted from simply meeting and learning to work together in new ways. Collaboration increased awareness/knowledge of the broader system of care so Partners nimbly expanded partnerships which resulted in the launch of a now active, growing pilot project for mental health mobile crisis response which is viewed as a model program for other rural communities.

Lessons Learned and Considerations for Program Replication

Lessons learned are relevant in any case but were much more pronounced in the COVID mandates environment which stalled health services delivery and closed schools. Lesson 1: Communicate. Communication keeps coherence and buoys resilience when barriers arise. Biweekly check-ins can be brief, but were important. Lesson 2: Consortium compositions morph, but do not worry, impact will still result. The broader network group engagement waned as project implementation became the focus. Transitions with people are pivotal points in reshaping the consortium, project directors should expect to adapt.

Consideration for replication 1: The shared service model between two schools is key to sustainability in very remote areas and our overall process was standardized to great benefit, but do expect to localize some elements to be culturally relevant for each school district and community. Consideration 2: Our initial expectation of significant coordination by noncounseling staff did not happen. Robust local services were simply not available. The focus may rightly turn to development, filling major gaps in the rural of system of care.

Organization Name		Pennyroyal Healthcare Service Inc.	
Organization Information			
Grant Number		Organization Type	
D04RH31644		Federally Qualified Health Center (FQHC)	
Organization Website			
www.communitymedicalclinic.org		www.4heartssake.com	
Address	City	State	ZIP Code
310 Hawthorne St.	Princeton	Kentucky	42445
Primary Contact Information for Project			
Name	Phone	Email	
Kecia Fulcher	270-365-0227	kfulcher@communitymedicalclinic.org	
Focus Area(s)			
<input type="checkbox"/>	Behavioral/Mental Health	<input type="checkbox"/>	Oral Health
<input type="checkbox"/>	Cancer Care Management	<input type="checkbox"/>	Pediatric Care
<input checked="" type="checkbox"/>	Cardiovascular Disease (CVD) Care Management	<input type="checkbox"/>	Pharmacy Assistance
<input type="checkbox"/>	Case Management	<input type="checkbox"/>	Primary Care Services
<input checked="" type="checkbox"/>	Chronic Disease Management	<input type="checkbox"/>	Population Health
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD) Prevention	<input type="checkbox"/>	School Based Care Coordination
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management	<input type="checkbox"/>	Specialty Care Services
<input type="checkbox"/>	Community-based Care Coordination	<input type="checkbox"/>	Substance Abuse Treatment and/or Education
<input type="checkbox"/>	Diabetes Care Management	<input type="checkbox"/>	Telehealth/Telemedicine
<input type="checkbox"/>	Health Education/Promotion and Disease Prevention	<input type="checkbox"/>	Transitions of Care
<input checked="" type="checkbox"/>	Health Improvement Special Project (HISP)	<input type="checkbox"/>	Women's Health
<input type="checkbox"/>	Health Screenings	Other:	
<input type="checkbox"/>	HIV/AIDS	Other:	
<input type="checkbox"/>	Maternal and Child Health	Other:	
Area(s) Served			
Pennyroyal Healthcare Services Inc. (PHS) is a nonprofit FQHC in southwestern Kentucky, with clinics located in Princeton (Caldwell County), and in both Hopkinsville and Oak Grove (Christian County). Lyon, Trigg, Crittenden, Todd, and Livingston County residents are also served.			
Target Population(s)/Need Addressed			
PHS served residents of Caldwell, Lyon, and Christian counties, many of whom are low-income, underserved, and vulnerable, and some of whom experience health disparities, including racial and ethnic minorities and rural residents. This project was designed to enhance access to and delivery of prevention, screening, and treatment services in order to improve patients' cardiovascular health. The project assisted patients with diagnoses of cardiovascular disease, hypertension, obesity, diabetes, and tobacco use cessation with the goal of improved cardiovascular functioning.			

Consortium/Network Partners

PHS invited the following to participate as consortium partners because of their unique expertise to meet the target population's needs: Christian County Health Department, Pennyroyal District Health Department, Pennyroyal Center Regional Prevention Center, American Cancer Society–North Central Region, Kentucky Cancer Program, and American Heart Association.

Project Goals

1. Expanded the delivery of health care services to include new and enhanced services exclusively in rural communities in Lyon, Caldwell, and Christian counties primarily, but also Crittenden, Trigg, Todd, and Livingston counties.
2. Delivered health care services through a strong consortium, in which every consortium member organization is actively involved and engaged in the planning and delivery of services.
3. Improved population health by demonstrating health outcomes that show changes to cardiovascular risk as a result of the activities supported by the Outreach Program, and by ensuring sustainability.
4. Built knowledge regarding effective strategies for improving rural health.

Evidence-Based Model(s)/Promising Practice(s)

The consortium selected the Franklin Cardiovascular Health Program (FCHP), a model rated “effective” in Rural Health Information Hub’s Community Health Gateway. The FCHP was developed and implemented in Franklin County, Maine, another low-income rural community that sought to address hypertension, cholesterol, smoking, diet, and physical activity. PHS also integrated the Chronic Care Model into clinic services, which has been used to develop specific approaches for serving individuals with chronic conditions, such as diabetes, cardiovascular disease, asthma, depression, and other chronic disorders. One of the key elements of this model is to educate and involve patients in their care, forming a partnership between the patient and their health care providers. The partnership also selected the Health Belief Model from the Rural Health Information Hub. This model addresses compliance with health-related directives based on the patients’ perception of their ability to make changes.

Services and Activities

1. Conducted outreach at planned community events such as the annual heart walk, county fairs and festivals, and so on.
2. Promoted prevention and awareness through a coordinated marketing campaign.
3. Offered free screening and patient education at outreach events such as heart age calculator assessments, blood pressure monitoring, and tobacco cessation.
4. Identified high-risk patients using CDC Heart Age calculator.
5. Referred to service provider network for treatment, Freedom from Smoking classes, Kentucky Quit Line, health department classes on nutrition, and the like.
6. Provided 60-plus stage 2 hypertensive patients with Omron blood pressure monitoring kits.
7. Offered enabling assistance to promote accessibility.
8. Provided immediate assistance such as quit packets for tobacco users, blood pressure monitoring kits, and so on.
9. Followed up with patients to encourage initial treatment and follow-through.
10. Offered incentives for engagement.
11. Convened quarterly consortium meetings to solicit input on the project design, community needs, and progress towards meeting goals.
12. Secured MOUs with key partners who can leverage expertise and resources.
13. Developed strategic plan for outreach, education, and referrals.

Outcomes

There were outcomes and impacts at multiple levels. At the patient health level, the program saw:

1. Increased awareness and knowledge about health factors that contribute to cardiovascular disease and resources available to help;
2. Changed attitudes to value healthy behaviors and seek treatment;
3. Increased patients' knowledge of their risk for cardiovascular disease;
4. Increases volume of patients seeking treatment, using treatment tools, and receiving treatment;
5. Increased compliance with treatment plans;
6. Decreased rates of adults with hypertension;
7. Increased number of people managing their hypertension;
8. Increased the number of adults who quit using tobacco products (40 individuals in 2019 quit smoking) through a referral system developed by the consortium partners; and
9. Improved health conditions and reinforced behaviors/attitudes.

The consortium improved coordination and quality of care and increased capacity to address cardiovascular disease:

10. Consortium committed to engagement and accountability;
11. Improved and streamlined local response to cardiovascular disease and related health factors;
12. Built staff knowledge and skills to fulfill project duties;
13. Improved skills related to heart health and smoking cessation;
14. Developed a working relationship with three farmers markets in the region to assist with food insecurity;
15. Made over 4,000 contacts regarding cardiovascular health through one-on-one contacts, through community events such as health fairs, or through other activities completed by the consortium partners;
16. Created a desire for the consortium partners to continue to work together for sustainability beyond the grant cycle completion, an
17. Partnerships assisted in the coordination of COVID-19 testing, quarantine, and response.

Sustained Impacts

Tobacco cessation successes are not only helpful for that individual, but for family members, friends, coworkers, and anyone that would be impacted by secondhand smoke. This has long-term gains for population health/finances. For those individuals who quit smoking prior to the COVID-19 pandemic, smoking cessation may have saved their lives from additional mortality risk. Also, managing diabetes, hypertension, and obesity have long-term sustained impacts on the individual's health and propensity for illnesses, including COVID-19. Improving nutritional health through collaboration with patients and the farmers market can have long-term sustained impacts and on the future choices of their children to select healthy foods, while the vouchers help with food insecurity of patients. Working together on fitness/exercise is sustainable in the community, and consortium partners are committed to working together beyond the grant cycle ending. The 4heartssake logo and website are sustainable for ongoing education and marketing to the community, being linked to the partners websites for events, education, and health improvement opportunities.

Lessons Learned and Considerations for Program Replication

The original plan was to use software for remote patient monitoring. The company went out of business just prior to making the purchase. The plan then changed to purchase the Omron digital blood pressure monitors for patients to use at home with memory capability. However, expanding and improving to include remote patient monitoring equipment which uploads into PHS' EMR, eClinical Works, is a much better choice for expansion/improvement for the future. Project momentum centered on in-person events including one-on-one nurse visits/blood pressure monitoring, tobacco cessation classes coordinated by the consortium, referral to in-person diabetes classes, community events for education, heart age screening, and other health monitoring/screening, and in-person meetings of the consortium members. These were stopped due to the COVID-19 pandemic, as there was a period where all staff worked from home and only virtual visits and referrals to the above activities were available. This interruption in service was challenging for patient retention and engagement and virtual contact is challenging in rural areas.

Organization Name

Plainview Foundation for Rural Health Advancement Inc.

Organization Information**Grant Number**

D04RH31793

Organization Type

Nonprofit Organization

Organization Website**Address**

P.O. Box 727

City

Hart

State

Texas

ZIP Code

79043

Primary Contact Information for Project**Name**

Retta Knox

Phone

806-937-0014

Emailretta.knox@region16.net**Focus Area(s)**

✓	Behavioral/Mental Health	✓	Oral Health
	Cancer Care Management	✓	Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management	✓	Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management	✓	Telehealth/Telemedicine
	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	✓	Other: Community Health Workers
	HIV/AIDS		Other:
	Maternal and Child Health		Other:

Area(s) Served

Six-county area of the Texas Panhandle, encompasses 5,500 square miles and 28 small communities. The targeted rural counties are Briscoe, Castro, Hall, Lamb, Parmer, and Swisher. Three clinic sites provide services, reaching additional clients in surrounding counties without medical/dental services.

Target Population(s)/Need Addressed

The target population is uninsured or underinsured clients in a six-county area (ranging in size from 100 to 6,274) of the Texas Panhandle. Clients outside the targeted area are accepted as time and resources permit. The foremost need is access to affordable health care by the low-income, uninsured population. Access to care is directly affected by availability of providers. The lack of providers in the area is a key issue. Plainview Foundation for Rural Health Advancement has put together a framework of partnerships to bring providers to the area and the population on a part-time schedule supplemented by telemedicine to fill the gap in available providers.

Consortium/Network Partners

The consortium members included Plainview Foundation for Rural Health Advancement (lead agency, coordination, and administration); Texas Tech Health Science Center Department of Pediatrics (medical services); Dr. Kevin Pope, DDS (dental services); Nelson Counseling (counseling); and Hart Independent School District (facility). Other partnerships supplemented the consortium, including TTUHSC Marie Hall Institute for Rural and Community Health (telemedicine); DeTar Hospital Texas A&M Health Science Family Practice residency program in Victoria, Texas (medical and telemedicine); Coastal Bend Education Center (diabetes education); and Plains Memorial, University, and Covenant hospitals (labs and X-ray).

Project Goals

Goal 1: Coordination of medical, dental, and mental health programs. Strengthen and enhance medical services by promoting coordination between medical, dental, mental health, and educational programs. Utilizing the community health workers model to accomplish. Utilize an EMR across all services to improve coordination and communication between providers. Goal 2: Education. Design educational intervention packets targeting chronic health issues. Establishing the educational component as part of all preventive and primary care visits across all services. Goal 3: Dental. Make oral health/dental preventive and primary services accessible regardless of funding status of the client. Oral health education available as part of dental visits, in addition to the public via local community events. Goal 4: Mental health. Make mental health services acceptable and available to all clients regardless of funding status. Have medical and dental providers screening clients for mental health referrals. Provide counseling via telemedicine to increase accessibility of services. Goal 5: System efficiency. Improve the efficiency of the systems to maximize revenues. The project was composed of seven parts: (1) Ensure continuation of medical, dental, and mental health services. (2) Develop a care coordination model program utilizing community health workers with a registered nurse care coordinator. (3) Develop and implement educational modules focusing on chronic disease risk, management, and education. (4) Continue to expand dental services. (5) Continue to expand mental health services and utilize telemedicine. (6) Integrate dental, mental health, primary care with the educational component. (7) Analyze clinical systems including billing to increase efficiency and produce more revenue.

Evidence-Based Model(s)/Promising Practice(s)

The evidence-based/promising practice models adapted were:

1. Coordination of care via the Donabedian's Quality Framework utilizing the Rural Care Coordination Toolkit on the Rural Health Information Hub, adapting the model type in the Community Health Workers Model for Care Coordination — A Promising Practice for Frontier Communities.
2. The Rural Services Integration Toolkit presented on the Rural Health Information Hub merged with the Technology and Telehealth Model.
3. A modified school-based health center model for delivery of dental services. Modified in that it accepted clients of all ages while located on a school campus while serving children as a priority.
4. Mental health services provided via an adapted Primary Care–Behavioral Health Integration Model Reverse Co-location. Adaptations included operating in coordination with the school-based health center and delivering some services via telemedicine.

Services and Activities

The focus area of integration/coordination of care included oral health delivery, mental health services, and primary/preventive medical care. The project focused on maintaining existing services while enhancing and improving them with the addition of CHWs. Education and coordination were enhanced by the utilization of a CHW. Services included medical (preventive and acute primary care, chronic disease management), dental (exams, cleanings, sealants, fluoride varnish, X-rays, fillings, extractions), mental health (individual and family counseling, school consults, Eye Movement Desensitization Reprocessing interventions), education (obesity, diabetes, asthma and attention deficit hyperactivity disorder management, and oral health), telemedicine (medical visits, mental health counseling, and educational sessions), and coordination between services and community resources.

Additional activities outside of service provision: funding searches, billing efficiency, outreach, staff education and development, data analysis, consortium expansion, and board development.

Outcomes

1. The stability and enhancement of existing services and increased access to total comprehensive medical/dental/mental health services to an underserved area and rural/low-socioeconomic population.
2. The coordination of services and implementation of community health workers will impact the effect of health services to change health-related lifestyle choices and supplement the local health care workforce. All four of the full-time clinic staff are certified community health workers.
3. The provision of services as demonstrated by encounter data is an accomplishment that the project is very proud to report. PIMS data remained very stable even in the difficult times of coronavirus. Data showed an amazing number of new dental clients.
4. The increased utilization of telemedicine is very encouraging for the future delivery of services in rural settings. Saw a dramatic increase in the number of telemedicine visits. Also saw increased utilization of telemedicine equipment to provide educational sessions.
5. The new partnership formed for diabetes education looks very promising for future educational efforts.
6. The increased utilization of mental health services, especially via telemed is positive in the light of acceptance of mental health services and provides an avenue to deliver services in rural areas without local providers. The project has significantly increased the number of mental health visits.
7. The dental program has operated at maximum level demonstrating the need for dental services in the area.
8. The success of the consortium working together to organize and provide services will set the stage for future projects. An additional clinic site was added to the project.

Sustained Impacts

The project's sustained impacts are:

1. The improved health impact on individual health due to interaction with the program will have a long-lasting effect.
2. The staff training to become certified community health workers will have a lasting effect on their individual performance and the approach they take to client interactions, contributing to the development of the local workforce.
3. Interagency working relationships developed will continue in the future. The development of leadership and trust will support future innovative projects, fostering cooperation among providers to address community problems.
4. The project made great progress in coordination of services. Providers now routinely cross refer to other services, which will continue.
5. The EMR has provided a means of communication between providers and has become the accepted expectation of care.
6. Economic impact to the community and school is significant. The improved health of students ensures school attainment.
7. There were changes in healthy lifestyle expectations and behaviors as a result of education. The newly implement dietary education program will affect healthy food choices for many years to come.

Lessons Learned and Considerations for Program Replication

Lessons learned: It is extremely difficult to change the existing role of and employee. Educating community on duties and benefits of community health workers is challenging. Modifications of clinic workflow is stressful for staff and clients. Telemedicine is a valuable tool in delivery of care in rural areas. Modifying school scheduling to accommodate clinic flow is difficult, time-consuming and requires flexibility.

Considerations for program replication: Recruiting dental providers for a part-time position is very challenging. Identify and build leadership within staff from day one of a program. Maintaining efforts to improve the billing process to recover all revenues is a total staff focus not just the billing staff. Seeking additional funding sources is a continuous process. Finding operational funding is more difficult than finding startup funding. Community meetings to emphasize the importance of clients completing forms and to explain services and benefits is an essential continuous process. Adding a new role (CHW) to the staff mix may be more successful with new staff, instead of by converting existing staff.

Organization Name		Regional Health Care Clinic Inc.	
Organization Information			
Grant Number		Organization Type	
D04RH31794		Federally Qualified Health Center (FQHC)	
Organization Website			
www.katytrailcommunityhealth.org			
Address		City	State
821 Westwood Dr.		Sedalia	Missouri
			ZIP Code
			65301
Primary Contact Information for Project			
Name		Phone	Email
Chris Stewart		660-851-7756	cstewart@katyhealth.org
Focus Area(s)			
<input checked="" type="checkbox"/>	Behavioral/Mental Health		Oral Health
<input type="checkbox"/>	Cancer Care Management		Pediatric Care
<input type="checkbox"/>	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
<input type="checkbox"/>	Case Management	<input checked="" type="checkbox"/>	Primary Care Services
<input type="checkbox"/>	Chronic Disease Management		Population Health
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
<input type="checkbox"/>	Community-based Care Coordination		Substance Abuse Treatment and/or Education
<input type="checkbox"/>	Diabetes Care Management		Telehealth/Telemedicine
<input type="checkbox"/>	Health Education/Promotion and Disease Prevention	<input checked="" type="checkbox"/>	Transitions of Care
<input type="checkbox"/>	Health Improvement Special Project (HISP)		Women's Health
<input type="checkbox"/>	Health Screenings	<input checked="" type="checkbox"/>	Other: Suicide Prevention
<input type="checkbox"/>	HIV/AIDS		Other:
<input type="checkbox"/>	Maternal and Child Health		Other:
Area(s) Served			
This grant served a four-county region in West Central Missouri: Saline, Pettis, Benton, and Morgan counties			
Target Population(s)/Need Addressed			
People living in households under 200% of the federal poverty level, as well as people identified either in primary care, in an emergency room, or in a school setting for having a risk of suicidality.			

Consortium/Network Partners

Regional Health Care Clinic, dba Katy Trail Community Health (KTCH); Bothwell Regional Health Center (regional hospital); Burrell Behavioral Health; Compass Health Network (community mental health center); Sedalia 200 School District; and DeFeet (community education and support group for Suicide Prevention)

Project Goals

1. Improve screening and assessment in the school and primary care settings to identify individuals at risk for suicide so that early intervention and treatment can lead to improved outcomes.
2. Build workforce competencies in suicide prevention in the West Central Missouri region through awareness, training, and education.

Evidence-Based Model(s)/Promising Practice(s)

Zero Suicide model: Zero Suicide is based on the realization that people experiencing suicidal thoughts and urges often fall through the cracks in a sometimes fragmented and distracted health care system. Studies have shown the vast majority of people who died by suicide saw a health care provider in the year prior to their deaths. There is an opportunity for health care systems to make a real difference by transforming how patients are screened and the care they receive. Information regarding the model can be found at <https://zerosuicide.edc.org/>.

Services and Activities

1. Katy Trail Community Health provided training on the seven components of the Zero Suicide Model to our organization including our board of directors, staff, and providers. We began implementation at our four clinics in January 2019 and completed implementation in December 2019.
2. We created the Zero Suicide Coalition (ZSC) to collaborate with partners to implement model in the Sedalia 200 school district, the Bothwell Regional Health Center (BRHC) emergency department, and the BRHC family practice clinic.
3. We collected data on the numbers of screenings we completed, the number of safety plans we put in place, the number of patients referred for therapy, and the number of caring contacts we made.
4. The ZSC hosted two community events on suicide prevention and two virtual events on managing mental health during the pandemic.
5. The ZSC implemented a care transition specialist to provide “warm handoffs” in the emergency room, school and BRHC family practice.

Outcomes

1. There were 12 primary care providers (physicians and nurse practitioner) trained, and 520 employees of KTCH, Burrell, Compass, BRHC, and Sedalia 200 were trained on the Zero Suicide Model.
2. There were 59,564 screenings completed. 3266 Columbia Suicidal Risk Assessment were completed, and 308 people had safety plans completed during the project period.
3. There were 1,328 students/patients screened and referred for behavioral health services.
4. Five workflows were developed by the ZSC to implement the program in the partner locations.
5. All but one coalition partner has completed all the steps for the Zero Suicide Model.

Sustained Impacts

The Zero Suicide Model will continue to be delivered at all four KTCH primary care delivery sites. In addition, we will continue expanding the model in the school districts for which KTCH is delivering services. The project will continue to work with Sedalia 200 to screen students at least twice per year. Our goal is to screen them quarterly.

The consortium will also continue to provide community and health professional education regarding suicide prevention through our partnership with DeFeet.

Lessons Learned and Considerations for Program Replication

Implementing the Zero Suicide Model was seamless in an FQHC and a community mental health environment. It was much more challenging in a hospital emergency room and a hospital primary care environment.

The learning about suicide and suicide prevention was invaluable to the ZSC, especially the primary care providers and the school district staff. The idea that suicide can be prevented was a novel idea to our communities.

It is also recommended that instead of administrative leaders as members of the ZSC, people actually responsible for implementation would be a better fit.

Ongoing education in the community is imperative. Most often, education and community discussion only happen after a tragedy (someone dying by suicide). The coalition has made a commitment to community education events at least twice per year, and in our clinics at least once per year.

Organization Name		Rehoboth McKinley Christian Health Care Services Inc.	
Organization Information			
Grant Number		Organization Type	
D04RH31645		Hospital (non-CAH)	
Organization Website			
https://www.rmch.org/			
Address		City	State
1901 Red Rock Dr.		Gallup	New Mexico
			ZIP Code
			87301
Primary Contact Information for Project			
Name		Phone	Email
Beth Landon		503-705-2955	blandon@rmchcs.org
Focus Area(s)			
	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
✓	Diabetes Care Management		Telehealth/Telemedicine
	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)	✓	Women's Health
	Health Screenings		Other:
	HIV/AIDS		Other:
	Maternal and Child Health		Other:
Area(s) Served			
McKinley and Cibola counties, New Mexico			
Target Population(s)/Need Addressed			
<p>This project served the Navajo people of the isolated Ramah Navajo Chapter House, and some non-Natives that also reside in the community. The community is located 60 miles from the nearest Indian Health Services facility. Addressed needs twice monthly:</p> <ol style="list-style-type: none"> 1. Women's health: Focused on women 14 years and older, services are provided by board-certified obstetrician/gynecologists. 2. Diabetes management: A licensed podiatrist provided diabetic foot checks and foot care while a technician provided retinal screens evaluated by a licensed optometrist. 3. Wellness education: Two community health representatives (CHRs) provided wellness education and fresh produce. 			

Consortium/Network Partners

Pine Hill Health Center (PHHC): This P.L. 93-638 health center is owned and operated by the Ramah Navajo School Board. Per Public Law 93-638, PHHC contracted with the Indian Health Service to provide primary health care services to Ramah Navajos, including family medicine, dental, and behavioral health. Community Outreach and Patient Empowerment (COPE): This Native-controlled nonprofit organization based in Gallup worked to promote healthy, prosperous and empowered American Indian communities in a patient-focused approach to community transformation. Rehoboth McKinley Christian Health Care Services (RMCHCS): Based in Gallup.

Project Goals

Building from the hypothesis that expanding local health care services while concurrently empowering community members to make more informed health care decisions will improve wellness, the following goals framed all program activities:

1. By the close of April 2021, at least 150 eligible individuals in the Navajo Ramah Chapter House community would be up to date on women's health and diabetic management services, specifically podiatry services and retinal eye exams. Native Americans will comprise the majority of service beneficiaries. All patients receive a bag of fresh produce.
2. To support care coordination and warm handoffs, records for these services and corresponding lab and pharmacy services would be stored and retrievable from the RMCHCS and the PHHC electronic health records systems; this ensured that wherever a patient seeks care, appropriate background information was available.
3. Effective February 2021, provided Family Wellness education to at least 50% of the patients receiving services in this program.
4. By May 2021, completed and reported a community health needs assessment (CHNA) with the Navajo Ramah Chapter House community. Report was presented to community members and intentionally organized to inform planning of sustainable and appropriate health care and community social services.

Evidence-Based Model(s)/Promising Practice(s)

1. Wellness education: COPE provides the training and tools to local CHRs.
2. Women's health: Well-women's exams, prenatal care, cancer screening all provided by board-certified OB/GYNs
3. Diabetes management: Diabetic foot checks by a licensed podiatrist, retinal screens evaluated by a licensed optometrist.

Promising practice:

Implementation of a community health needs assessment that employed established qualitative research methods and university and federally developed interview questions, grounded in a community-driven process.

Services and Activities

1. Wellness education: COPE provides the training and tools to local CHRs.
2. Provision of produce gift bag to each patient.
3. Women's health: Well-women's exams, prenatal care, cancer screening all provided by board-certified OB/GYNs.
4. Diabetes management: diabetic foot checks by a licensed podiatrist, retinal screens evaluated by a licensed optometrist.
5. Care continuity: Because clinical notes and lab results were manually shared between RMCHCS and PHHC, and because the RMCHCS clinicians were on-site every two weeks, patient follow-up and appropriate referrals were tightly managed.

Outcomes

The Navajo Rural Health Outreach Program achieved the following outcomes:

1. By March 3, 2021, RMCHCS conducted 14 clinical trips to PHHC, providing women's health care to 61 patients, diabetic foot checks to 95 patients and diabetic retinopathy screens to 79 patients. Visits were scheduled four days per month through 2021. All patients received a produce gift bag.
2. By March 3, 2021, RMCHCS and PHHC provided wellness education to 49 patients, a service which started in February.
3. Executed service contracts with EyePACS and Eye Associates of New Mexico for retinopathy screens, and executed an improved memorandum of understanding with PHHC.
4. In collaboration with COPE, RMCHCS developed and administered in-person patient satisfaction surveys with 85% of patients from December through January. Because of the overwhelming patient requests for Optometry services, PHHC has interviewed clinicians to provide this service. Due to the consistent interest in wellness and nutrition education, COPE proceeded in training PHHC-based CHRs to provide this service in conjunction with clinical services.
5. All clinical notes were loaded into the RMCHCS electronic health records system and securely transmitted manually to PHHC soon thereafter. Likewise, all laboratory results were loaded into the PHHC system and securely transmitted manually to RMCHCS. This manual process will continue until RMCHCS converts to a new system, at which time an HL7 interface intends to replace the manual effort.
6. In February, PHHC formed a community steering committee to oversee the community health needs assessment (CHNA). As of early March, that committee has convened twice and finalized their assessment goals, selected the research and determined the data collection methods.

Sustained Impacts

Wellness education: Because locally employed CHRs provided the wellness education and now have a variety of tools and models to enhance the education, this service will continue.

Women's health and diabetic foot checks: These services are expected to continue at the close of funding because the cost of the clinician time is below the reimbursement rate for the majority of patients.

Traveling clinicians/additional services: Developing the internal systems to meaningfully collaborate with external clinicians now enables other clinicians to serve patients at Pine Hill more simply. Data-sharing, referrals, ordering of labs and pharmaceuticals all happens with increasing ease.

Enduring partnerships: PHHC, COPE, and RMCHCS will identify new opportunities for collaboration in the future. As the partnership continues to learn each other's strengths and capacities, the work can expand beyond the grant-funded initiative.

Lessons Learned and Considerations for Program Replication

COVID-19 brought challenges and opportunities to this program. It forced work to cease entirely for over six months and continued to compromise the pace of project resumption. COVID-19 also enabled partners to seek new opportunities to serve remote Navajo people in crisis. In addition to the resource scarcity endemic to the Navajo people and exacerbated in isolated Navajo communities such as Ramah/Pine Hill, COVID-19 threw a spotlight on the community as a food desert suffering a staggering prevalence of diabetes. Geography remains a persistent barrier; curfews heightened the barrier, limiting the ability of residents to travel for food beyond what exists at the local gas station convenience store.

Perhaps the biggest lesson learned flows from common sense: listen more than you speak. Further, do not hesitate to listen to a variety of voices, not just the loudest or most powerful ones. For example, patients literally call from home to thank the team for the produce gift bags; CHRs edited the bag contents. PHHC staff charm patients with Navajo humor, better enabling RMCHCS services to flow gracefully. It takes a village.

Organization Name		Richland Medical Center Inc.	
Organization Information			
Grant Number		Organization Type	
D04RH31795		Federally Qualified Health Center (FQHC)	
Organization Website			
www.centralozarks.org			
Address		City	State
304 W. Washington		Richland	Missouri
			ZIP Code
			65556
Primary Contact Information for Project			
Name		Phone	Email
DawnElyn Schneider		573-337-8668	dschneider@centralozarks.org
Focus Area(s)			
<input checked="" type="checkbox"/>	Behavioral/Mental Health		Oral Health
<input type="checkbox"/>	Cancer Care Management		Pediatric Care
<input type="checkbox"/>	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
<input type="checkbox"/>	Case Management		Primary Care Services
<input type="checkbox"/>	Chronic Disease Management		Population Health
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
<input type="checkbox"/>	Community-based Care Coordination		Substance Abuse Treatment and/or Education
<input type="checkbox"/>	Diabetes Care Management		Telehealth/Telemedicine
<input type="checkbox"/>	Health Education/Promotion and Disease Prevention		Transitions of Care
<input type="checkbox"/>	Health Improvement Special Project (HISP)		Women's Health
<input type="checkbox"/>	Health Screenings	<input checked="" type="checkbox"/>	Other: Trauma Informed Care
<input type="checkbox"/>	HIV/AIDS		Other:
<input type="checkbox"/>	Maternal and Child Health		Other:
Area(s) Served			
Pulaski, Camden, and Miller counties			
Target Population(s)/Need Addressed			
The target population was students in partnering school districts who were in need of trauma-informed behavioral health supports and therapy. In addition to students, school district staff was supported through trainings focused on becoming more trauma informed to implement best practices within their districts and with their students.			

Consortium/Network Partners

There were five health care partners in this coalition that included Richland Medical Center Inc. dba Central Ozarks Medical Center (FQHC), Lake Regional Health System (hospital), Camden County Health Department (public health department), Miller County Health Department (public health department), and Pulaski County Health Department (public health department). There were also eight original school district partners to include Camdenton R-III, Waynesville R-VI, School of the Osage, Eldon R-1, Richland R-IV, Crocker R-II, Laquey R-V, and Plato R-V.

Project Goals

The overarching, long-term goal for the project is improved mental health status and increased trauma informed approach for school districts where our focus populations reside. The more specific goals include engaging schools and communities throughout the three counties served in Central Missouri in trauma awareness training, connecting students to behavioral health services through access to school-based therapists and to connect individuals facing health inequities to community health workers to address underlying social determinants of health. The goal number of behavioral health school-based patient visits in Year 1 was 219, Year 2 was 1,954, and Year 3 was 2,793. The goal number of community health worker (CHW) visits in Year 1 was 110, Year 2 was 977, and Year 3 was 1,397.

Evidence-Based Model(s)/Promising Practice(s)

Evidence-based practices to be utilized include trauma-informed care and Trauma Screening Tool (ACEs). Promising practices include the use of community health workers and the use of rural school districts as community sites for mental health services.

Services and Activities

On-site access to mental, emotional, and behavioral health services was implemented in partner districts and a referral process was developed to support the connection to these resources. In addition to these services, two partner districts can utilize a community health worker to support students and staff in addressing social determinants of health and assist in case management. Ongoing case management is provided to families identified as needing additional supportive services and reduces the impact on the schools who normally must work to provide these services or find a community agency who will help in the effort. Through work with a consultant who provided training to participating schools on Trauma Awareness. Trauma Awareness training was offered in multiple formats and forums (such as professional development days for individual districts and district groups).

Outcomes

Primary Goals achieved:

1. Therapists were placed in nine school districts and provided 32,140 behavioral health visits over the last three years.
2. Community health workers provided 3,437 encounters with families to address social determinants of health and provide resources.
3. Trauma-informed care training and resources were provided to all partner school districts.

Sustained Impacts

Access to mental, emotional, and behavioral (MEB) health services will have ongoing lasting impacts. Through a strategic planning process, schools and communities found a high level of need with very limited resources to address concerns. Research tells us that MEB disorders have strong roots in childhood and adolescent years and have a direct correlation to lower academic achievement. In addition to these factors, the cost of such disorders is spread widely in several services areas to include health care, schools, social service organizations, and government (state and federal). With this base of knowledge, students who have been connected to such resources early will have better outcomes. In addition, the support provided by the community health workers to families with social determinants of health (SDOH) needs there has been and will continue to be a cost savings to schools due to removing the burden of such activities from school nurses, counselors, teachers and even administrators. It is broadly recognized that addressing SDOH will improve short-term and long-term health outcomes.

Lessons Learned and Considerations for Program Replication

One early identified barrier to replication across school districts was referral pathways. Some schools preferred a more open access model that the therapist could then screen the student to identify that the needs met the intention of the school-based program. Other districts had more reserved access with a formal referral process that only allowed referrals from counselors. Although, COMC recommends having a referral process in place, a caution would be to ensure it is not so restrictive as to prevent access to students where needed and not so broad that the therapist panel is filled with students who are able to access community resources opposed to limited school-based resources. In addition to referral processes across districts it is important to have a process for how to address staff needs and who will provide those services.

It would be beneficial for any school-based programs for any service line to have strong school relationships that can openly and clearly discuss successes as well as opportunities for improvement. Creating those open lines of communication with a single access point allows for promptness in addressing queries as well as common messaging.

Organization Name		Rural Alabama Prevention Center	
Organization Information			
Grant Number		Organization Type	
D04RH31646		Nonprofit Organization	
Organization Website			
www.ruralalabamaprevention.org			
Address		City	State
301 Prairie Ave.		Eutaw	Alabama
			ZIP Code
			35462
Primary Contact Information for Project			
Name		Phone	Email
Loretta W. Wilson		205-496-0562	lowwebb9@aol.com
Focus Area(s)			
	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
✓	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
✓	Health Education/Promotion and Disease Prevention		Transitions of Care
✓	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	✓	Other: Cardiovascular Disease Prevention
	HIV/AIDS		Other:
	Maternal and Child Health		Other:
Area(s) Served			
Greene, Hale, and Sumter counties of Alabama			
Target Population(s)/Need Addressed			
The target population included African American churchgoers (aged 30-55) residing in the targeted counties, with no history of cardiovascular disease (CVD). Ninety participants, meeting the criteria for participation, were recruited. Sixty-four have been retained and completed the program as of April 2021.			

Consortium/Network Partners

Each consortium member was significantly involved ensuring the effective implementation of the Tri-County Health Improvement Special Project (TCHISP). Partners included Rural Alabama Prevention Center, (RAPC), Lead Agency, Community-Based Organization, Greene County; Hill Hospital of Sumter County, Rural Hospital, Sumter County; Community Health Resource and Education Center (CHEAR) Community-Based Organization, Sumter County; New Generation Community Outreach Center (NGCOC), Faith-Based Organization, Greene County; Abundant Life Wellness Center, Health and Wellness Clinic, Hale County; and Eutaw Housing Authority, Eutaw.

Project Goals

The overarching goal of the Tri-County Health Improvement Special Project (TCHISP) is to integrate community health workers (CHWs) into churches in Greene, Hale, and Sumter to support churchgoers, with no history of heart disease, in making healthy lifestyle choices to prevent or reduce the onset of CVD. The overall objective of the TCHISP is to increase knowledge of churchgoers regarding the risks associated with cardiovascular disease, while reducing their chances of acquiring CVD. The use of the Heart Age Calculator and trained CHWs are the primary reason why the project's goal and objectives were accomplished, which is demonstrated by data showing no participants acquired CVD while enrolled in the project.

Evidence-Based Model(s)/Promising Practice(s)

The evidence-based models used in during the implementation of the Tri-County Health Improvement Special Project (TCHISP) were:

The Centers for Disease Control (CDC) Heart Age Calculator designed to help people find out more about their risk for heart disease.

The Community Health Worker Health Disparities Initiative (CHWI) designed by the National Heart, Lung, and Blood Institute (NHLBI) to improve health in minority and underserved communities by translating evidence derived from scientific studies and included in clinical practice guidelines into community practice.

In Year 1, the model for addressing CVD associated Smoking/Tobacco Use was eliminated because *With Every Heartbeat Is Life, Community Health Worker's Manual for African Americans* had an entire section of smoking sensation that worked perfectly with the tobacco using population.

Services and Activities

The Centers for Disease Control and Prevention Heart Age Calculator provided health information to help participants visualize how important is to work toward improving the age of their heart and thereby lower their risk for experiencing a CVD event. Trained CHWs were placed in each county (three per county) and paired with 15 participants (five per CHW) to implement strategies and curriculum sessions geared toward CVD prevention. Participants were also engaged in the following activities:

1. Games relative to heart health, heart anatomy with all parts of the heart, and role play on when to call 911.
2. Designed personal Emergency Cards in case of an emergency.
3. Signs to look for if a person is showing signs of a heart attack and or stroke.
4. Weekly pledges geared toward quitting or decreasing the amount of tobacco used daily.
5. Participation in hands on activities detailing the importance of keeping cholesterol, blood.
6. Pre-COVID-19, participants took part in physical activities, e.g., line dancing.
7. Instructions on how to read food labels.

Outcomes

Data was collected on 64 of the participants over the three-year project period:

1. Ten percent maintained a hemoglobin A1c was less than 7%.
2. Twenty-two percent maintained a blood pressure less than 130/80.
3. Five percent maintained a cholesterol less than 100mg/dl.
4. Twenty-two percent maintained a fasting blood sugar within normal range of 70 to 120.
5. One hundred percent increased their consumption of fresh fruits and vegetables.
6. One hundred percent increased their physical activity.
 - a. Fourteen of 64 participants reported gaining an average of 5% body weight.
 - b. Fifty of 64 participants reported losing an average of 5% of body weight.
7. None of the participants acquired CVD during the project implementation.
8. Five percent of the biometric data abstracted from the use of the Heart Age Calculator revealed that heart age aligned with their age.
9. All participants were screened for smoking. Only five participants were smokers. None have quit but have decreased the number of cigarettes smoked daily.
10. Twenty percent of patients aged 30-55 who were referred to their primary care doctor for abnormal blood pressure and A1c levels.
11. Five percent of participants referred for tobacco intervention.
12. Nine CHWs were trained and six were employed for this project.
13. Eighty-five percent of the participants were recruited from churches.
14. Nearly one in seven (14.15%) of the participants was recruited from housing authorities.
15. Sixty-four participants completed all sessions of the curriculum.
16. Among each county, nearly 15% of the participants were from the same household.
17. All participants reported their knowledge increased relative to CVD.
18. All participants reported an improvement in their overall health outcome.

Sustained Impacts

As a result of this project, there are trained CHWs who live in the communities and are valuable members of health care teams. They are critical to the long-term sustained impact of the project and can share their knowledge in other rural settings with similar health care focus. The trust among the consortium members will also impact sustainability of services. While the project may not be able to fund these agencies, they are equipped with knowledge, educational materials, and a network of other agencies who can assist them in extending services to their communities. Project participants provided a Fit-bit at completion of project as a constant reminder to continue be physically active. Participant's knowledge of heart disease risk factors and prevention strategies increased. As a result, they are now advocating for good heart health in their homes and community.

Lessons Learned and Considerations for Program Replication

One of the lessons learned is that data collection can be challenging, especially during a pandemic when everything is virtual. When participants self-report health data, there may be inconsistency in data and inability to track participant biometric and behavioral changes. Another lesson learned is that offering incentives is vital to recruitment and retention of participants. During the project participants were provided gas cards for travel, Fitbits, and prizes during for attendance at sessions, improved biometrics, and participation in daily physical activities. In addition to the above incentives, we learned the following aided in retention:

1. Highlight program participants utilizing all media outlets when necessary
2. Schedule classes in areas accessible for participants if church space is not available
3. Conduct classes virtually
4. Provide outings to activities geared to improving health or disease prevention
5. Conduct a graduation ceremony at the end of Year 3.

When tracking participants over time, impacts are more achievable when the program enrollment is smaller, enabling more focus on participants across the years.

Organization Name		Rural Health Access Corp.	
Organization Information			
Grant Number		Organization Type	
D04RH31796		Federally Qualified Health Center (FQHC)	
Organization Website			
www.coalfieldhealth.com			
Address		City	State
386 Airport Rd.		Chapmanville	West Virginia
			ZIP Code
			25508
Primary Contact Information for Project			
Name		Phone	Email
Kristin Dial		304-855-1200	kdial@coalfieldhealth.com
Focus Area(s)			
Behavioral/Mental Health		Oral Health	
Cancer Care Management		Pediatric Care	
Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance	
Case Management	✓	Primary Care Services	
Chronic Disease Management		Population Health	
Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination	
Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services	
Community-based Care Coordination		Substance Abuse Treatment and/or Education	
Diabetes Care Management		Telehealth/Telemedicine	
Health Education/Promotion and Disease Prevention		Transitions of Care	
Health Improvement Special Project (HISP)		Women's Health	
Health Screenings		Other:	
HIV/AIDS		Other:	
Maternal and Child Health		Other:	
Area(s) Served			
The areas served by the program included rural Logan, Mingo, McDowell, Roane, and Wyoming counties, West Virginia.			
Target Population(s)/Need Addressed			
The targeted population for the Rural Consortium of Rapid Addiction Intervention and Coordination program fell within the rural region of West Virginia that, according to the Centers for Disease Control and Prevention (CDC), had a nearly 80% higher substance abuse-related mortality and viral infection rates than the rest of the country. The targeted population continuously ranked within the top 10 highest infectious counties in the state of West Virginia and has experienced a 90% increase in overdose deaths just in the last decade.			

Consortium/Network Partners

The Rural Consortium of Rapid Addiction Intervention and Coordination program was a collaborative effort between nonprofit health clinics and hospitals that serve the rural communities of southern West Virginia. The partners included Rural Health Access Corp. (d/b/a Coalfield Health Center), West Virginia Health Right, Charleston Area Medical Center, Welch Community Hospital and Roane General Hospital.

Project Goals

The overarching goal of the program was to expand public awareness of the depth and breadth of the substance abuse and the merits of harm reduction in the hardest hit areas of rural West Virginia. The major goals of the program included providing comprehensive harm-reduction services in the program service area and provided outreach activities to educate and increase awareness of harm reduction. The objectives of the program were to reduce the number of drug overdose deaths and drug-related infection rates for HIV and hepatitis C.

*Due to the outbreak of COVID-19, the program partners had to create additional objectives that include providing COVID-19 rapid testing and vaccinations to at-risk populations throughout southern West Virginia and provided information pertaining to CDC and West Virginia Department of Health and Human Resources (WVDHHR) guidelines and resources.

Evidence-Based Model(s)/Promising Practice(s)

This program was based on an evidence-based practice model that is used throughout West Virginia, the Screening Brief Intervention and Referral to Treatment (WVSBIRT). This plan worked to quickly process and treat those affected by substance use disorder (SUD) and other disorders related to substance abuse. The SBIRT plan has been prominent in metropolitan areas and while it did include referral to treatments such as rehabilitation and MAT, it did not offer needle exchange or Naloxone education and distribution. To advance the best practice model developed by SBIRT, this program offered a mobile unit designed to set up operation and offered services directly to the rural target population modeled by the National Harm Reduction Coalition best practice model.

Services and Activities

The direct services offered with the mobile harm-reduction program included rapid HIV and hepatitis C screening, hepatitis A and flu vaccines, naloxone distribution and education by a PharmD representative, condoms, access to behavioral health expert on site and a peer recovery coach and clean needle exchange where allowed. As COVID-19 spread, additional services included rapid screening, hand washing and sanitizing stations, mask distribution and educational material on CDC safety guidelines to prevent the spread of COVID-19. The indirect services provided by the program included referrals to rehabilitation and recovery programs for those individuals ready to seek treatment, free or low-cost health clinics to address adverse health issues related to intravenous drug use, telemedicine and tele-behavioral health sites and an inclusive wraparound health referral resource list.

Outcomes

Evaluating the outcomes of the program during the funding period was limited. The COVID-19 pandemic has made it difficult to offer a mobile harm-reduction program in the rural program area on a consistent basis. The following outcomes listed were for the period of June 2018 to December 2020.

1. Provided rapid HIV and hepatitis C screenings to approximately 350 unduplicated individuals in the service area.
2. Provided Naloxone kits and instructions to approximately 160 unduplicated individuals in the service area.
3. Provided approximately 90 referrals for behavioral health and primary care.
4. Administered 95 hepatitis A and 35 flu vaccinations.
5. Increased harm reduction awareness in the service area by 12% (original goal was 20% in three years).
6. Conducted 13 harm reduction and substance use disorder educational events throughout the service area.

Sustained Impacts

The original objectives of the Rural Consortium of Rapid Addiction Intervention and Coordination were in line with the Healthy People 2020 initiatives which included a 20% decrease in both drug overdose deaths and drug-related infectious rates in rural communities across West Virginia. According to the most recent data (2019) there was a 12% decrease in overdose deaths and a 22% decrease in drug-related hepatitis C cases. Another objective of the program was to increase the awareness of harm reduction in the service area by 20%. When comparing the base Harm Reduction Community survey to the most recent survey (April 2020) there was a 23% increase in awareness in the five counties included in the program. This increase in awareness has aided in the growth of similar programs and collaboration with various organizations dedicated to the health and well-being of those individuals suffering with SUD.

Lessons Learned and Considerations for Program Replication

The most impactful lesson learned during the three years of the funding period was awareness and acceptance from the community and stakeholders as the most important aspect of treating individuals effected by substance use disorder and providing controversial services such as Naloxone distribution and needle exchange programs. In rural Appalachia, there is a stigma related to drug addiction that is not easily overcome. For more than a decade, the opioid epidemic was largely ignored or downplayed by nearly everyone not directly involved in the treatment of SUD. By 2018 the number of overdose deaths reached a climax as West Virginia was ranked in the top 5 in overdose deaths in the nation and Wyoming County, W.Va., ranked first in overdose deaths per 100,000. This stigma initially created roadblocks in expanding harm reduction into the five rural counties included in the grant funded program. Gaining support from local politicians, health care providers and other influential stakeholders in the represented communities has been key to the program's success.

Organization Name		Southwest District Health	
Organization Information			
Grant Number		Organization Type	
D04RH31647		Other: Regional Public Health District	
Organization Website			
https://phd3.idaho.gov			
Address		City	State
13307 Miami Ln.		Caldwell	Idaho
			ZIP Code
			83607
Primary Contact Information for Project			
Name		Phone	Email
Charlene Cariou		208-455-5364	Charlene.Cariou@phd3.idaho.gov
Focus Area(s)			
<input checked="" type="checkbox"/>	Behavioral/Mental Health		Oral Health
<input type="checkbox"/>	Cancer Care Management		Pediatric Care
<input type="checkbox"/>	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
<input type="checkbox"/>	Case Management	<input checked="" type="checkbox"/>	Primary Care Services
<input type="checkbox"/>	Chronic Disease Management		Population Health
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
<input type="checkbox"/>	Community-based Care Coordination		Substance Abuse Treatment and/or Education
<input type="checkbox"/>	Diabetes Care Management		Telehealth/Telemedicine
<input type="checkbox"/>	Health Education/Promotion and Disease Prevention		Transitions of Care
<input type="checkbox"/>	Health Improvement Special Project (HISP)		Women's Health
<input type="checkbox"/>	Health Screenings		Other:
<input type="checkbox"/>	HIV/AIDS		Other:
<input type="checkbox"/>	Maternal and Child Health		Other:
Area(s) Served			
The service are Gem, Payette, Adams, Valley, Elmore, Washington, Owyhee, and Boise counties.			
Target Population(s)/Need Addressed			
Target population will be patients (adolescents and adults) served in the primary care clinics operated by Valley Family Health Care in Region 3 of Southern Idaho, primarily in Payette, Gem, and Washington counties with some patients residing in Malheur County, Ore. Targeted intervention population will be patients with a comorbid chronic condition that are identified as needing brief behavioral health intervention due to their difficulty managing their chronic condition or making lifestyle changes recommended by their provider.			

Consortium/Network Partners

Southwest District Health (SWHD), Central District Health, Valley Family Health Care, and YNot Innovators (consultant), Cornerstone Whole Healthcare Organization Inc. (nonprofit), Saltzer Health, and Valor Health.

Project Goals

To build the existing Idaho Integrated Behavioral Health Network into an enduring structure for a set of three regional hubs that serve as capacity-building platforms for the systematic integration of behavioral health into rural primary care clinics and practices.

Project objectives:

1. Create a workforce development program to train regional behavioral health consultants to support the integration of evidence-based behavioral health techniques and team-based care in rural primary care settings
2. Train a cadre of local content experts to provide technical assistance for regional primary care providers on evidence-based and best practices for clinical and administrative integration of behavioral health services
3. Develop a regionwide Behavioral Health Internship program to recruit and train social workers, community health workers, and other allied health students to provide brief behavioral health interventions and services in primary care settings
4. Design and implement a robust Learning Collaborative for each of the three regional hubs, utilizing the RIBHNN model.

Evidence-Based Model(s)/Promising Practice(s)

The overall delivery model is based on the Chronic Care Model (CCM) because it is designed to help practices improve patient health outcomes by changing the routine delivery of ambulatory care through six interrelated system changes meant to make patient-centered, evidence-based care easier to accomplish. The aim of the CCM is to transform the daily care for patients with chronic illnesses from acute and reactive to proactive, planned, and population based.

Complimentary to CCM is the Primary Care Behavioral Health (PCBH) Model. PCBH provides strategies for clinical interventions for integrated behavioral health providers and the model is flexible to support patients in low resource, isolated, rural, medically underserved areas. PCBH provides vital behavioral health resources to patients with limited access, who struggle with behavioral health and chronic health conditions.

Services and Activities

Overall Goal: To build the existing Idaho Integrated Behavioral Health Network into an enduring structure for a set of three regional hubs that serve as capacity-building platforms for the systematic integration of behavioral health into rural primary care clinics and practices.

Objectives:

1. Create a workforce development program to train regional behavioral health consultants to support the integration of evidence-based behavioral health techniques and team-based care in rural primary care settings.
2. Train a cadre of local content experts to provide technical assistance (TA) for regional primary care providers on evidence-based and best practices for clinical and administrative integration of behavioral health services.
3. Develop a statewide behavioral health internship program to recruit and train social workers, community health workers, and other allied health students to provide brief behavioral health interventions and services in primary care settings.
4. Design and implement a robust learning collaborative for each of the three regional hubs.

Outcomes

To date, the RIBHHN consortium has achieved strong success in the primary goal “To build the existing Idaho Integrated Behavioral Health Network into an enduring structure for a set of three regional hubs that serve as capacity-building platforms for the systematic integration of behavioral health into rural primary care clinics and practices.” Key successes include training facilitation and engagement in both the clinical and operations focus areas, accelerated pace in internship infrastructure development and program launch, and strong consortium participation. The consortium has continued to observe strong external interest in RIBHHN assets and TA both at the local level (as demonstrated by training attendance and participation in planning activities) and at the regional level (based on networking discussions to identify TA leads). Due to COVID-19 in the second year of the grant the internships were stopped because the interns were prohibited to be on site at clinics and academic institutions placed a moratorium on internships. Based on the slow recruitment and the unfortunate suspension of internships due to COVID-19, the consortium anticipates potential challenges to recruit students to the rural service sites in the fall 2020 semester.

Sustained Impacts

Sustainability continues to remain at the forefront of RIBHHN project priorities. Key activities to promote sustainability have included the development of internship manuals (internal and external), retention of training materials, and statewide network development. As previously noted, as internship materials have been identified they have been adapted to serve the need of clinics across the state. Remote attendance options have been provided to enhance access to training opportunities for clinics throughout Idaho and the primary care teams are leveraging this training to support their operations but also serve as a TA lead in years 2 and 3. The RIBHHN project team will continue building out a sustainable TA hub infrastructure with VFHC (demo clinic) based on a trainer-the-trainer model, VFHC has indicated in-house BHCs to participate in this process. The RIBHHN consortium is currently developing the sustainability plan as indicated in the RIBHHN Strategic Plan. Finally, the RIBHHN consortium has begun to outreach clinics across the state as potential TA sites and service sites to benefit from TA.

Lessons Learned and Considerations for Program Replication

1. On-site trainings and internships were extremely difficult or nonexistent due to COVID-19 restrictions but we learned that teleconference and video conference were great alternatives to provide trainings.
2. BHCs had difficult time transitioning the PCBH model to video or teleconferencing workflow because the PCBH model is very dependent on in person interaction with the care team.
3. Southwest District Health (SWDH) the fiscal agent learned that they are unable to sustain the project. Consideration for program replication and sustainability, they decided to transition all work to Cornerstone Whole Healthcare Organization Inc. (private nonprofit) the fiscal agent for IIBHN. This decision will ensure sustainability of the RIBHHN work but also ongoing replication and support to other states.
4. The project team did not realize how much impact the RIBHHN project would have to promote and educate Idaho on integrated behavioral health. We have been approached by regional directors for HRSA, SAMHSA, CMS, and OASH to be included in the RIBHHN and IIBHN conference collaboration. They will be presenting in the September IIBHN conference.

Organization Name

Spokane Tribal Network

Organization Information

Grant Number

D04RH31697

Organization Type

Nonprofit Organization

Organization Website

www.spokanetribe.org

Address

PO Box 390 | 6270 Ford Wellpinit Rd.

City

Wellpinit

State

Washington

ZIP Code

99040

Primary Contact Information for Project

Name

Penny Spencer

Phone

509-258-4535

Email

pennys@spokanetribe.org

Focus Area(s)

✓	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	✓	Other: Trauma Informed Training
	HIV/AIDS	✓	Other: Peer Support Specialist
	Maternal and Child Health		Other:

Area(s) Served

Spokane Tribal Reservation (Stevens County, Wash.) and Wellpinit School District (Stevens County, Wash.).

Target Population(s)/Need Addressed

This project focused on Wellpinit School District (K–12) students and families who are primarily Native American from Spokane, and other Tribes. Family structure varied from two parents, single parent, relative placement, grandparent and foster homes. The initial focus was on creating a trauma-informed school and community to increase school attendance and student success in the classroom. The project pivoted to connect students and families to resources for social emotional needs that supported successful return to classrooms post-pandemic. Spokane Tribal Network (STN) continued to deliver healing centered training to teachers, staff, and community, which included trauma-informed practices.

Consortium/Network Partners

The primary project partner was Wellpinit School District, which is a K–12 public school located in the center of the Spokane Reservation. Other partners included Indian Health Services-Wellpinit, a medical clinic providing services to eligible Native Americans living on the reservation and service area boundaries; the Spokane Tribal Business Council as the governing authority for the Spokane Tribe of Indians; Empire Health Foundation, a private health foundation in Spokane County that has provided support to STN and its projects; and the National Native Children’s Trauma Center, a training and technical assistance center based out of Missoula, Mont.

Project Goals

The initial goals of the project were to reduce the incidences of trauma-related disorders by creating public health and education systems capable of providing trauma-informed care to school-age children and their families on the Spokane Tribe Reservation. The objectives set out to reach this goal changed slightly over time, as a result of the COVID-19 pandemic. The project grew into healing centered engagement, which contained a trauma-informed focus, but also allowed for culture, spirituality, and civic engagement as healing from collective and individual traumas. The project also made a pivot in response to school and community needs resulting from the COVID-19 pandemic by moving toward supporting students’ and families’ social and emotional needs as they re-entered the school setting after months of virtual learning. Thus, the support provided to school partners gravitated toward surveying social emotional needs of students and families as well as professional development with teachers beginning with the Gathering of Native Americans (GONA) theme of belonging. Prior to the pandemic, the project had already started working with plants and social emotional lessons with the classroom goal of connecting students to tribal ways of learning from all relatives in the natural world as well as from human teachers. The project also facilitated one staff member to get certified as a peer support specialist to work directly with students and families to access resources to increase student success in the classroom and beyond. STN also received funding from partners to assess peer support specialist training for use in tribal communities. Prior to school closure due to the pandemic, the project provided school staff and teachers with trauma-informed professional development.

Evidence-Based Model(s)/Promising Practice(s)

Evidence-based and promising practice models normed in rural and Native American communities are rare. GONA was the first choice for a promising practice across tiers 1 and 2 of the Multi-Tiered Systems of Support. The project included topics of interest to the population into GONA activities (plants, ribbon skirts, leadership) into the themes of belonging, mastery, interdependence, and generosity. Likewise, the Medicine Wheel approach to health and well-being was used for Tier 3 interactions. The concept of HCE was eventually adopted into the project’s approach when talking about the concept of trauma-informed due to HCE’s capacity to hold space for culture, spirituality, and civic engagement as healing from collective and individual traumas.

Other models/practices incorporated into this project included Positive Behavioral Intervention and Supports, Botvin Life Skills, Social Emotional Lessons, and Restorative Practices.

Services and Activities

The primary activities of the grant project were three Building Resilience and Hope through HCE community events for providers from schools (preschool to K–12), health clinic, behavioral health, and all community members; community and school training around Multi-Tiered Systems of Support (MTSS), positive discipline, plant knowledge and more; classroom, community, and small group lessons, activities and supports; GONA workshops for school, community, and youth and Tribal leadership; professional development for staff and teachers at Wellpinit schools around MTSS, GONA and self-care; dissemination of programming, projects, and lessons learned to broader community support for caregivers, and preventive care for compassionate/pandemic fatigue; advocacy for educational justice for Native students; engagement with peer support specialist training for use in native communities; advocacy, organization, and support of Tribal Food Sovereignty through community gardening, and traditional plant gathering.

Each of these activities were meant to instill Spokane Tribal values and ways, and foster connection to self, others, nature, and all things.

Outcomes

The primary outcomes of the Outreach Program grant project were:

1. Provided various trauma-informed and healing centered trainings to over 366 individuals in the community.
2. Built working partnerships with the Wellpinit School District, the Indian Health Service clinic, Tribal leadership, Empire Health Foundation, and the National Native Children's Trauma Center at the University of Montana during the project.
3. Held at least eight GONA workshops featuring themes of belonging, mastery, interdependence, and generosity.
4. Invited by Wellpinit School to create yearlong GONA activities for school and community, to partner in teaching science and civics lessons, to intervene with small student groups to combat bullying among the students, to create a universal screening tool for assessing social emotional needs of students and families upon return to the classroom after virtual learning only, provide guidance for student leadership cohort, and incorporate plant knowledge into healing spaces in schools.
5. Pivoted in response to school, student, family, and community needs during the pandemic by shifting focus from student and family counseling for behavior problems in the classroom into peer support specialist services for students and families to support access to resources for classroom success upon return to school.
6. Incorporated concepts of "trauma-informed" into HCE, which accounts for the unique needs and sensitivities of our Tribal community to culture, spirituality, and the added healing mechanism of civic engagement as an empowering response to collective and individual traumas.
7. Increased the number of students and families receiving wraparound services and support for school and pandemic-related social emotional needs through a certified peer support specialist.
8. Added peer support specialist space to meet with families, and if needed step up telehealth services.

Sustained Impacts

This project started a yearlong community GONA in partnership with Wellpinit School District, Indian Health Services and Spokane Tribe. The yearlong GONA will incorporate HCE and tribal values, Social Emotional Healing, civic action and plant knowledge. Getting to this point of hope and healing within three years is a major accomplishment for the Spokane Tribe's people and community. The project created a peer support specialist position, which provides support and resources to students and families. This enables STN to bill the state for services. The project hopes to establish a contract with the local clinic for reimbursement through Indian Health Services as STN expands the peer support specialist role in the community. Worth more than the monetary value, STN is finding ways to provide a more collective healing experience for the community. Providing further GONA activities in the community, and surrounding Tribal communities, will bring further funding opportunities along with fostering well-being and collaboration among communities. Building a sense of belonging, mastery, interdependence, and generosity in more communities will benefit many.

Lessons Learned and Considerations for Program Replication

The experience in this project required everyone to look deeper at concepts like "trauma-informed." Implementation of trauma-informed programming was met with skepticism in the community. The project found HCE inclusive of all that is trauma-informed, while accounting for culture and spirituality, which are very important for the people served. HCE also advances civic engagement as a healing mechanism for people who have lived experiences with trauma. Another learning was that in a time of escalating national political uncertainty, it became difficult to work across systems in this rural setting. Finite resources, sharing limited clientele, or adding labor to already burdensome processes, became barriers. The year 2020 impacted the tribal community in ways everyone is still clarifying. Thus, in the COVID pandemic, the project pivoted in response to the needs of the community. In collaboration with community partners, and support of the funder and technical assistance provider, the project created a new pathway to help students and families get culturally aligned resources and support to succeed in the classroom and meet social emotional needs.

Organization Name		St. John's Lutheran Hospital Inc.	
Organization Information			
Grant Number		Organization Type	
D04RH31798		Critical Access Hospital (CAH)	
Organization Website			
https://www.cabinetpeaks.org/			
Address		City	State
350 Louisiana Ave.		Libby	Montana
			ZIP Code
			59923
Primary Contact Information for Project			
Name		Phone	Email
Jessica Brown		406-283-7000	jdrak@cabinetpeaks.org
Focus Area(s)			
<input checked="" type="checkbox"/>	Behavioral/Mental Health		Oral Health
<input type="checkbox"/>	Cancer Care Management		Pediatric Care
<input type="checkbox"/>	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
<input type="checkbox"/>	Case Management	<input checked="" type="checkbox"/>	Primary Care Services
<input type="checkbox"/>	Chronic Disease Management		Population Health
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
<input type="checkbox"/>	Community-based Care Coordination		Substance Abuse Treatment and/or Education
<input type="checkbox"/>	Diabetes Care Management		Telehealth/Telemedicine
<input type="checkbox"/>	Health Education/Promotion and Disease Prevention		Transitions of Care
<input type="checkbox"/>	Health Improvement Special Project (HISP)		Women's Health
<input type="checkbox"/>	Health Screenings	<input checked="" type="checkbox"/>	Other: Health Information Technology
<input type="checkbox"/>	HIV/AIDS		Other:
<input type="checkbox"/>	Maternal and Child Health		Other:
Area(s) Served			
Lincoln County.			
Target Population(s)/Need Addressed			
Target population: Patient needing behavioral health and physical health services. Need addressed: Two significant health gaps were addressed:			
<ol style="list-style-type: none"> 1. Lack of resources and coordination in the community to address mental health issues; and 2. Lack of interoperability between the disparate electronic health records (EHRs) affecting transition of care. The need for integrated behavioral health program and interoperability between the EHRs with health care providers to improve inefficiencies which impacts quality and safety of patient care. 			

Consortium/Network Partners

Cabinet Peaks Medical Center, Northwest Community Health Center (FQHC), Centers for Asbestos Related Disease (specialty asbestos pulmonary clinic), Kalispell Regional Healthcare (tertiary hospital), and Libby Care Center of Cascadia.

Project Goals

Project goals to address behavioral health issues:

1. Improve patient access to behavioral health services in Lincoln County with implementation of a brand-new service using an evidence-based practice model.
2. Improve population health in Lincoln County with improvements in health outcomes for patients with behavioral health issues.
3. Increase provider access to patient information to improve patient care by utilizing health information technology.
4. Increase the efficiency of the health systems by aligning resources and strategies through a rural health network.
5. Reduce the per capita cost of health care by implementing alternative payment models to sustain needed services through the use of collaboration and coordination of services.

Project goals to address health communication and HIT issues:

1. Supporting shared decision-making between patients and providers through a formal care coordination efforts
2. Providing personalized self-management tools and resources
3. Building social support networks
4. Delivering accurate, accessible, and actionable health information that is targeted and tailored
5. Facilitating the meaningful use of HIT and the exchange of health information among health care and public health professionals

Evidence-Based Model(s)/Promising Practice(s)

Behavioral Health Integration: Project initially started with Collaborative Care Model (CoCM) but discovered it was cost prohibitive for rural areas and switched to a psychiatric consultation model in conjunction with the Primary Care Behavioral Health Model and Team-based care based on Ed Wagner's Chronic Care Model. For HC/HIT, this project utilized the Evidence-Based Toolkits for Rural Community Health from the Rural Health Information Hub are Services Integration Toolkit and Rural Care Coordination Toolkit.

Services and Activities

1. Integrated Behavioral Health (IBH) education and training: Provide trainings to primary care and care team on clinical and operational implementation on Primary Care Behavioral Health (PCBH) and team-based care.
2. Access to integrated behavioral health care: Contract with psychiatrist and hire or identify a behavioral health consultant to provide PCBH services.
3. Identify and implement health integration technology: CPMC's EHR called Meditech would connect to Big Sky Connect, Montana's health information exchange (HIE), and with Common Well and CareEquality to receive Admissions/Discharges/Transitions (ADT) alert function as well as provider portal that can share transition of care documentation.
4. Increase behavioral health screening: Implement and deploy behavioral health screenings to identify and treat behavioral health patients.
5. Provide for continuity of care documents: Add new members to consortium.
6. Utilize reimbursable services for IBH: CMPC would develop billing model for psychiatric consultation and IBH to sustain the program.

Outcomes

1. Provided in-person and webinar workshops on PCBH model to 50 primary care, behavioral health, and community providers over two years. Participated in a regional integration conference with national experts on IBH clinical and operational experience.
2. Access to integrated behavioral health care: CPMC hired a full-time behavioral health consultant and contracted part time with a psychiatrist for psychiatric consultation and NWCHC provided three to four mental health counselors to provide one full-time equivalent behavioral health consultant service.
3. Identify and implement health integration technology: Project has successfully connected with Big Sky Care Connect but still working on CommonWell and CareEquality for ADT feeds. The HIE process is complex and various issues continue to arise, but the team is actively optimizing and problem solving the issues.
4. Increase behavioral health screening: PHQ9 (depression) and GAD7 (anxiety) screenings have been implemented in both CPMC and NWCHC. PHQ4 (abbreviated PHQ9 and GAF7) has been implemented in the CMPC emergency department.
5. Provide for continuity of care documents: Consortium did add new members from the original stakeholders and added Libby Care Center and are working towards direct secure messaging.
6. Utilize reimbursable services for IBH: CPMC and NWCHC have successfully developed codes in their charge master to bill for behavioral health services.

Sustained Impacts

1. Implementation of a sustainable IBH and team-based care model for rural primary care;
2. Increased access to behavioral health services by integration behavioral health in primary care;
3. Implementation of health integration technology to state health information exchange;
4. Increased behavioral health screenings for depression and anxiety in primary care and emergency department;
5. Sustainable consortium; and
6. Implementation of reimbursable IBH services.

Lessons Learned and Considerations for Program Replication

1. CoCM model was not the best fit because it was cost prohibitive. Need to consider using PCBH model because it is cost-effective and flexible for rural areas.
2. Provider engagement for IBH can be difficult if care team does not understand team-based care. Future consideration, primary care needs education on team-based care first prior to implementing IBH.
3. COVID-19 highlighted the importance of remote access and direct to consumer health intervention. HIT objective was directionally correct due to the pandemic.
4. Recruitment and retention of Behavioral Health providers are very difficult to manage, especially in rural areas. Future consideration, take the time and be intentional in hiring for “fit” in regard to model fidelity and longevity in the community.

Organization Name		Stephenson County Health Department	
Organization Information			
Grant Number		Organization Type	
D04RH31648		Health Department	
Organization Website			
Address		City	State
10 W. Linden St.		Freeport	Illinois
			ZIP Code
			61032
Primary Contact Information for Project			
Name		Phone	Email
Craig Beintema		815-235-8353	cbeintema@stephensoncountyil.gov
Focus Area(s)			
	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
✓	Health Education/Promotion and Disease Prevention		Transitions of Care
✓	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	Other:	
	HIV/AIDS	Other:	
	Maternal and Child Health	Other:	
Area(s) Served			
Stephenson and Carroll counties in northwest Illinois			
Target Population(s)/Need Addressed			
<p>Win with Wellness (WWW), a Health Improvement Special Project (HISP), targeted eligible adults aged 30-74 in Stephenson and Carroll counties to engage in community or worksite-based interventions to address their personal cardiovascular disease (CVD) risk factors identified during enrollment screenings. A significant proportion of the population in both counties is overweight or obese. In Stephenson County, 73.5% of adults are obese and in Carroll County, the percentage is 72.6%. The CVD mortality rates in Carroll County (202 per 100,000) and Stephenson County (148.6 per 100,000) are markedly higher than the state rate of 144.4 per 100,000.</p>			

Consortium/Network Partners

The WWW partnership included the following eight organizations: (1) Stephenson County Health Department (SCHD, local health department), (2) Carroll County Health Department (CCHD, local health department), (3) FHN Health System (health system and hospital), (4) Monroe Clinic Health System (health system), (5) United Way of Northwest Illinois (social service organization), (6) Saint Anthony College of Nursing (academic institution), (7) Greater Freeport Area Partnership (economic development organization), and (8) University of Illinois College of Medicine Rockford (academic institution).

Project Goals

The overall goal of WWW was to reduce the burden of cardiovascular disease (CVD) in adults in Stephenson and Carroll counties by promoting healthy lifestyles and reducing obesity and chronic disease. Partnership/consortium objectives: (1) Expand the WWW partnership from six to 10 partners by the end of three years to plan, implement, and sustain WWW programs. (2) Within the first six months of the project, recruit a cohort of 325 adults aged 30-74 to participate in the HISP interventions and evaluation. (3) Plan for the sustainability of successful components of WWW. HISP cohort objectives: (4) By the end of three years, decrease the CDC Heart Age calculated in the HISP cohort by addressing modifiable CVD risk factors. (5) Increase the proportion of HISP participants who meet the recommended Physical Activity Guidelines for Americans for aerobic physical activity (PA) by the end of three years. (6) Decrease body mass index (BMI) among overweight and obese HISP cohort participants by 6% at the end of three years. (7) Increase self-efficacy for PA and healthy eating among HISP participants in Stephenson and Carroll counties by the end of three years. (8) Over the three-year project, sustain the 17 current Take Off Pounds Sensibly (TOPS) groups, 10 new TOPS groups, and five work-site Heart-to-Heart (HH) programs with at least 325 participants in the HISP cohort. Community/Policy Level Objectives: (9) Complete an assessment of the food environment in towns/neighborhoods within Stephenson and Carroll counties, and develop an action plan to improve the food environment by the end of three years. (10) Complete a physical activity environment assessment to improve and promote the PA environment in towns/neighborhoods within Stephenson and Carroll counties and develop an action plan to improve the PA environment, by the end of three years.

Evidence-Based Model(s)/Promising Practice(s)

1. The following highlights the primary models implemented as part of this project. WWW participants were required to participate in either Taking Off Pounds Sensibly (TOPS) or Heart-to-Heart (HH).
2. TOPS: a weekly weight-loss support group for adults
3. Heart-to-Heart (HH): health promotion sessions conducted by health educators for worksites and community groups. Online HH curriculum modules were also available
4. Text-4-Wellness (T4W): text-messaging program in which participants received information and motivational messages
5. Step-4-Wellness (S4W): physical activity monitor program in which participants could track their daily steps
6. Communitywide physical activity and nutrition environment assessments were conducted in four towns using the Town-Wide Assessment (TWA), Program and Policy Assessment (PPA), and Street Segment Assessment (SSA) components of Rural Active Living Assessment (RALA) and the Nutrition Environment Measures Survey (NEMS-S)

Services and Activities

WWW participants were required to sign up for TOPS or HH. TOPS participants received TOPS membership through WWW. Weekly TOPS sessions were held in a variety of settings and included weigh-ins and informational programs on nutrition, exercise, and healthy lifestyles. HH presentations were offered in community, worksite, and online platforms and emphasized small, practical changes to reduce CVD risk. T4W was an optional program. Enrolled participants received motivational/informational text messages about healthy eating and physical activities. Participants received three messages per week for 16 weeks with the option to re-enroll. S4W was an optional program. Enrolled participants received a physical activity tracker and agreed to “sync” their daily physical activity with the tracker’s app and an online platform. Participants received monthly physical activity goals based on their prior activity levels. Communitywide physical activity assessments were completed in four communities and physical activity resources maps were created for each town. Food environment assessments have been initiated in the same communities.

Outcomes

Partnership/consortium: (1) WWW consortium members increased from seven to eight. (2) Enrolled 188 participants: 138 (73.4%) eligible for HISP, 50 (26.6%) engaged in WWW but not HISP-eligible due to age or prior cardiac event, 114 (60.6%) enrolled in TOPS, 74 (39.4%) enrolled in HH, 121 (64.4%) enrolled in S4W, 100 (53.2%) enrolled in T4W, and 20 (10.6%) participants completed 55 HH online sessions. (3) WWW Facebook page: Posted at least five posts per week. Increased fans by 195 from June 2018 to March 2021 (n = 505 fans).

WWW/HISP cohort: (4) 122 (64.9%) of participants completed one-year follow-up, 38 (20.2%) completed two-year follow-up. (5) Among HISP participants (n = 88), n = 36 (40.9%) decreased CVD risk, n = 51 (58.%) had no change, and n = 1 (1.1%) increased risk. (6) WWW participants (n = 74) decreased daily time spent in sedentary activity (M = 44.5 minutes, SD = 168.8, p = .027, and HISP participants (n = 58) decreased in daily time spent in sedentary activity (M = 43.1 minutes, SD = 167.5, p = .055). (7) WWW participants (n = 125) increased daily vegetable intake (M = 0.2 cups, SD = 1.3, p = .086), HISP participants (n = 91) increased daily vegetable intake (M = 0.3 cups, SD = 1.3, p = .018). (8) Weight loss among WWW participants with a baseline BMI of 25-plus (n = 114, M = 2.8 pounds, SD = 12.1, p = .014), weight loss among HISP participants with a baseline BMI of 25-plus (n = 81, M = 3.6 pounds, SD = 13, p = .014). (9) BMI decrease in WWW participants with a baseline BMI of 25-plus (n = 114, M = 0.5, SD = 2.4, p = .04), BMI decrease in HISP-eligible participants with a baseline BMI of 25-plus (n = 81, M = 0.7, SD = 2.4, p = .01).

Community/Policy Level: (10) Completed four assessments of the PA environment (Freeport and Lena in Stephenson County; Mont. Carroll and Savanna in Carroll County). Used assessments to create online PA resource maps. Page visits: Freeport: 585; Lena: 1295; Mount Carroll: 424; Savanna: 239.

Sustained Impacts

WWW partnership: Over the course of six years, the WWW partnership has expanded to include other key organizations and become a vibrant, active partnership that strives to offer innovative, collaborative, community-based programs. Technology: WWW has successfully integrated multiple technology components (i.e., text messaging, physical activity monitors, web-based health promotion, physical activity maps, Facebook) to enhance our interventions and increase our reach. Training and support from WWW health educators allowed participants to successfully navigate technology components. Program capacity: Increased the capacity of SCHD/CCHD to address communitywide CVD risk via multiple interventions. Strategies like social media, web-based health promotion, and physical activity maps can be sustained at little to no cost, thus, are not dependent on grant funds. Research/evaluation capacity: Increased the research/evaluation capacity in the region through partnerships with local medical and nursing colleges. Students have engaged in research projects in support of WWW initiatives and additional research projects, such as a COVID-19 vaccine hesitancy study.

Lessons Learned and Considerations for Program Replication

A key factor to successful replication of community-based partnerships and health programs is to involve people/organizations from multiple sectors during the planning and development stages. Incorporating individuals from sectors not directly related to health can bring a new perspective to the group. WWW held annual meetings with participants to provide them feedback on the data and to celebrate their successes. It was also an opportunity to hear participant perspectives on the current program as well as get their ideas for future efforts. Using multiple strategies to reach people where they are at is important for participants to be successful. There is not a one-size-fits-all approach. Creating a mix of activities and options, which are customizable to individual goals, motivations, and situational needs and preferences, is essential for keeping people engaged and motivated. Encouraging small steps instead of major changes will provide more consistent follow-through and increasing self-empowerment through small successes which will add up to big results over time.

Organization Name		Strength in Peers Inc.	
Organization Information			
Grant Number		Organization Type	
D04RH31799		Nonprofit Organization	
Organization Website			
www.strengthenpeers.org			
Address		City	State
9560 S. Congress St.		New Market	Virginia
			ZIP Code
			22844
Primary Contact Information for Project			
Name		Phone	Email
Nicky Fadley		540-217-0869	nicky@strengthenpeers.org
Focus Area(s)			
✓	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management	✓	Telehealth/Telemedicine
	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	✓	Other: Peer Recovery Support
	HIV/AIDS		Other:
	Maternal and Child Health		Other:
Area(s) Served			
Shenandoah and Page counties, Virginia			
Target Population(s)/Need Addressed			
<p>The project targeted adults with substance use and co-occurring substance use and mental health challenges who are uninsured or under insured and have incomes under 200% of the federal poverty level. These individuals struggle to access behavioral health services due to barriers that include lack of knowledge about where to get help, limited-service capacity, cost, transportation, and real or perceived cultural stigma. Many lose hope that they can overcome their challenges, get their life back on track, and live a life in recovery. This project focused on outreach and developing a behavioral health program model that removes barriers to recovery support services.</p>			

Consortium/Network Partners

The primary project partners were the Harrisonburg Center for Relational Health (a private outpatient therapy practice that specializes in culturally sensitive, trauma-informed, attachment focused, and strength-based services) and the University of Virginia (UVA) Department of Psychiatry and Neurobehavioral Sciences (a public teaching hospital that provides outpatient psychiatric services and is a leader in expanding telemedicine across Virginia).

Project Goals

The goal of the project was to increase access to behavioral health services and improve recovery outcomes among adults with substance use and co-occurring substance use and mental health challenges. The project had three strategies. The first was to develop peer recovery services that included individual and group sessions. Individual peer support services were designed to be primarily mobile, with peer recovery specialists meeting participants in their home or community to remove transportation barriers. Group sessions were provided virtually via secure video conference software. The second was to incorporate counseling and psychiatry services to the program via telemedicine through consortium partners. These services were provided in close coordination with peer support. Peer recovery specialists also were able to deliver Internet-connected tablets to participants who did not have personal devices. The third strategy was to use peer recovery specialists to conduct regular, targeted outreach in jails, homeless shelters and camps, food pantries, and other locations to reach high-need individuals facing the greatest barriers to accessing recovery support services.

Evidence-Based Model(s)/Promising Practice(s)

The project was primarily based on the evidence-based Consumer Operated Services Model that has been shown to facilitate recovery and reduce health care costs. The majority of services were provided by peer recovery specialists who are in recovery from substance use challenges and trained through the state certification program, Motivational Interviewing, cultural competence, trauma-informed care, verbal de-escalation, and service navigation. They provided outreach, peer mentoring, resource connections, and recovery groups. The recovery groups provided were evidence-based interventions. Wellness Recovery Action Plan (WRAP) is a group workshop to help people with mental health challenges manage their symptoms. Self-Management and Recovery Training (SMART) Recovery is a peer support group that is built on cognitive behavioral therapy and Motivational Interviewing practices. The project complemented peer recovery services with clinical treatment, including therapy and psychiatry.

Services and Activities

The project developed a new recovery program focused on rural underserved populations. It established and modified the strategies, policies, and procedures to overcome obstacles, including sustaining outreach and services through the coronavirus pandemic. Peer recovery specialists conducted significant outreach to recruit participants, including having weekly office hours at a homeless day shelter and food pantry; visiting homeless encampments; providing weekly peer support groups at local jail; presenting to key referral agencies including probation/parole, social services, behavioral health providers, and nonprofit organizations; participating in community events; and marketing via social media. Peer recovery specialists provided enrolled participants individual peer support services that were primarily home-based, as well as weekly WRAP and SMART Recovery groups held virtually. Resident counselors with the Harrisonburg Center for Relational Health provided participants behavioral health therapy via telemedicine. Resident psychiatrists at UVA provided participants psychiatry via telemedicine. The treatment team met weekly to coordinate care and ensure quality of services.

Outcomes

To date (July 2018-February 2021):

1. Four hundred forty-four individuals reached through all outreach activities.
2. Two hundred fifty individuals reached through jail outreach activities alone with 973 total jail outreach sessions.
3. One hundred participants enrolled in the program.
4. Ninety participants received a total of 1,208 individual peer support sessions with an average of 13.4 sessions per person.
5. Twenty-three participants received a total of 225 group peer support sessions with an average of 9.8 sessions per person.
6. Sixteen participants received a total of 141 individual therapy sessions with an average of 8.8 sessions per person.
7. Twenty-one participants received a total of 56 individual psychiatric sessions with an average of 2.7 sessions per person.

At the end of Year 2 (July 2018-June 2020):

1. Twenty-seven participants had engaged in the program for at least six months and completed follow-up assessments.
2. Eighty-one percent of participants showed a decrease in alcohol or drug use in the prior 30 days.
3. Seventy percent of participants indicated that they were bothered by psychological or emotional problems only slightly or not at all or showed an improvement.
4. Seventy-four percent of participants were in permanent housing and 26% were in temporary housing (living with family or friends).
5. Forty-eight percent of participants received some form of income (employment or disability benefits).
6. Participants experienced a 14-point (out of 152) increase in their self-rated recovery per the Recovery Assessment Scale-Domains and Stages with substantial increased in the domains for mastery over my illness and connecting and belonging.

Sustained Impacts

The project increased access to quality substance use and mental health services for high-need, underserved individuals. Typically, substance use and mental health treatment facilities serve individuals who seek care. They often experience high demand for services and have limited capacity to engage in outreach to underserved populations. High-need individuals often do not seek care due to a variety of barriers and instead fall frequently into cycles of homelessness and incarceration. The project improved equity in access to treatment services by conducting outreach directly to individuals who were incarcerated, homeless, and engaged with social services or probation or parole. Peer recovery specialists were able to engage hard-to-reach populations because they have personal experience overcoming similar challenges and are able to develop trusting relationships based on connection and mutuality. They also were able to help participants engage effectively in clinical and peer recovery services, including learning how to better communicate with service providers, advocating for their needs and preferences, and following through with recommendations and instructions.

Lessons Learned and Considerations for Program Replication

The project represents a cost-effective model for serving high-need populations. Peer recovery specialists are paraprofessionals and economical to employ. They proved to be successful at recruiting and engaging the target population; facilitating participants' access to telecounseling and telepsychiatry services; and helping participants to access public benefits and community services for housing, employment, health care, and other needs. They also improved efficiencies by vetting potential participants and making sure they were motivated to engage in the program before enrolling them and connecting them to clinical services. The project also created efficiencies by using telemedicine to deliver counseling and psychiatric services from providers located outside the area thereby expanding service capacity. Bringing Internet-connected tablets to participants' homes proved an essential strategy to ensure access to telemedicine. The project is replicable in rural communities with capable peer-run organizations. However, most peer-run organizations are ineligible for insurance reimbursement despite evidence indicating that peer recovery services have the capacity to reduce costs.

Organization Name		Summit Medical Fitness Center	
Organization Information			
Grant Number		Organization Type	
D04RH31800		Nonprofit Organization	
Organization Website			
https://www.krh.org/summit/			
Address		City	State
205 Sunnyview Lane		Kalispell	Montana
			ZIP Code
			59901
Primary Contact Information for Project			
Name		Phone	Email
Brad A. Roy, Ph.D., FACSM		406-751-4512	broy@krmc.org
Focus Area(s)			
	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
✓	Chronic Disease Management	✓	Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
✓	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
✓	Health Screenings		Other:
	HIV/AIDS		Other:
	Maternal and Child Health		Other:
Area(s) Served			
<ol style="list-style-type: none"> 1. Glacier County, Mont.; Northern Rockies Medical Center, Cut Bank. 2. Sanders County, Mont.; Clark Fork Valley Hospital, Plains. 3. Flathead County, Mont.; The Summit Medical Fitness Center, Kalispell. 			
Target Population(s)/Need Addressed			
<p>The target population consisted of two rural medically underserved areas in Montana, each served by a Critical Access Hospital. Glacier County has the highest diabetes prevalence in Montana with 35% of the population obese and over 30% physically inactive and smokers. Sanders County has primary health concerns that include (1) substance and alcohol abuse, (2) adult obesity (25%), and (3) physical inactivity (20%) and cancer. Both communities had identified health and wellness as a top priority.</p>			

Consortium/Network Partners

The Montana Journey to Wellness Consortium consisted of the following organizations:

1. The Summit Medical Fitness Center (SMFC), a 114,800 square foot medically integrated fitness center located in Kalispell (Flathead County), and part of the Kalispell Regional Healthcare System.
2. Northern Rockies Medical Center, a 20-bed Critical Access Hospital located in Cut Bank (Glacier County).
3. Clark Fork Valley Hospital, a 16-bed Critical Access Hospital located in Plains (Sanders County).

Project Goals

The primary objective was to replicate components of the SMFC's Journey to Wellness (JTW) Program to deliver a mobile screening and lifestyle intervention program to two geographically isolated communities using a traveling team of professionals, telehealth technology and training of local staff to conduct and sustain an ongoing program. Specific goals included:

1. Improving health outcomes by providing community access to wellness screening services and primary prevention
2. Utilize the framework of the SMFC JTW Program to train local staff, develop/implement/refine the Montana Journey to Wellness (MJTW) model in each rural community in order to improve participant health behaviors (physical activity, nutritional intake, smoking cessation, sleep, psychosocial factors) and the CDC Heart Age Score and other health indicators (BMI, BP, blood lipids and glucose)
3. Offer a variety of health promotion and fitness activities to raise awareness regarding health risk factors and provide information on the MJTW program
4. Foster relationships with local medical providers to raise awareness of the MJTW program and connect adults without a specific source of ongoing care to local medical providers
5. Support and augment the local MJTW programs with mobile van delivery of screening services and support from SMFC professional staff.

Evidence-Based Model(s)/Promising Practice(s)

The core of MJTW is Engle and Romana's biopsychosocial model (BPS) of disease outcomes. The BPS connects disease outcomes to complex interactions between psychological and social determinants in addition to traditional biological pathology. In particular, the Transtheoretical Model (TTM) of behavior change, and adaptation of BPS, is the evidence-based practice model for MJTW. This includes methods of participant interaction with a health/wellness coach using the principles of Motivational Interviewing, appreciative inquiry, and positive psychology to encourage sustainable health/lifestyle behaviors. The relationship between a coach and client offers a profound level of support, guidance and encouragement to make changes without being judgmental and enables change by focusing on a client's stated needs, values, vision, and goals. The MJTW use of TTM with the health/wellness coach approach provides a masterful relationship for clients that promotes growth mindsets and outcome achievements.

Services and Activities

Services and activities for MJTW included the following:

1. Implementation of a mobile screening and lifestyle intervention program utilizing a traveling team of professional staff to provide health and wellness screening, health and wellness coaching sessions (individual and group), and nutrition counseling services
2. Implement, operate, and refine the MJTW program at each rural site by training local staff, providing wellness screenings, health coaching, physical activity sessions, and other health-promotion activities
3. Provide ongoing support for local sites via telemedicine for health/wellness coaching, nutrition counseling, cooking demonstration classes, and other health-related educational sessions
4. Connect program participants to local medical providers as indicated
5. Develop a MJTW training manual for site staff training and ongoing support
6. Develop and implement an electronic platform for data management and collection of survey-related data that will assist in refinement of the MJTW program and provide future support for program expansion and reimbursement.

Outcomes

Goals 1-6: A total of six cohorts were initiated in Cut Bank, Mont., encompassing 98 participants and six cohorts in Plains, Mont., encompassing 62 participants for a total of 160 participants completing the initial assessment and beginning the MJTW program. The average age of the participants was 52.8 years, with 85.3% being female. At three months significant improvements were noted in weight, resting HR, total sit to stands, total steps per minute, waist and hip circumference and a number of other psychological variables. For participants completing the one-year assessment the most prominent results demonstrated improved scores in motivation for physical activity (pre 9.2; post 12.3), reduced anxiety (pre 5.4; post 3.4) and depression (pre 5.3; post 4.1). Goals 1, 2, and 3: Participants completing the three-month program questionnaire reported being extremely satisfied with their experience in the MJTW program. Participants rated the program as very to extremely effective at helping them set health improvement goals (84.4%), adopt healthier behaviors (80.4%) and improve quality of life (77%). Additionally, cohorts in Year 3 indicated that the time spent meeting with their health and wellness coach was helpful in developing a personal vision of wellness (93%), setting goals (89%), increasing self-motivation (93%) and making healthier eating and exercise choices (88%). Goals 1-5: Throughout the project a combined site total of 7,129 unique individuals received services as part of 669 activities, including individual and group coaching by site coaches that were live, telephonic, or virtual or telemedicine. Nutrition coaching, cooking demonstrations, and education was provided by a dietitian both virtually and in-person through the mobile van unit. Additionally, a variety of health and wellness-related educational sessions were delivered that provided education and knowledge to participants, many of which did not have prior access to such activities and events.

Sustained Impacts

Positive impacts have been generated due to strong collaboration between coalition partners including:

1. Mobile van implementation provides ongoing ability to support sites with equipment, staff and MJTW services. Support includes assessment and data analysis, coaching and dietitian assistance, local event attendance and screenings, staff training, and other site needs.
2. Site specific implementation of MJTW and support of local medical providers and health care administrators.
3. Electronic platform for data management and collection which improved process efficiency, accuracy, and quality.
4. Key equipment acquisition, positioning sites for a sustainable post-grant period.
5. Telemedicine capabilities: allow delivery of education and cooking classes, remote coaching and ongoing training/support.
6. MJTW training manual creation, site training and ongoing support via mobile visits and virtual/telephonic meetings.
7. COVID-19 pivots to provide telemedicine and virtual services for assessments, coaching and education. The pandemic experience emphasizes the importance of technology and program and program nimbleness. Mental health and other COVID-19 challenges may make MJTW even more relevant.

Lessons Learned and Considerations for Program Replication

Lessons learned and addressed include (1) the importance of a *certified* health coach at sites; (2) the importance of having a well-defined program manual for consistency within and among sites; (3) the value of technology — Qualtrics database for outcomes; (4) the value of choosing the right site partners/coaches with a finger on the pulse of the community, passion, investment, and a belief that the program will improve community health; (5) the value of increased community appeal via events, collaboration with county events and public schools, and outreach to social groups within the community; and (6) the value of having a dietitian come onsite with recipes and cooking demos of common Montana foods.

Considerations for replication: (1) Rural challenges (weather/travel, money, time) suggest a solid wellness platform that has appealing session documentation, participant chat, video/phone consult, and the ability to push content through chat. (2) Write grant with flexibility of equipment purchase options. Anticipate needs, as what would work best for the grant demographic and address needs in a timely manner. (3) Alcohol consumption in the demographic is culturally acceptable but challenging for coaching health lifestyle behaviors and nutrition management, need additional strategies to address

Organization Name		Tri-County Health Network	
Organization Information			
Grant Number		Organization Type	
D04RH31649		Nonprofit Organization	
Organization Website			
www.tchnetwork.org			
Address		City	State
238 E. Colorado Ave., Suite 8		Telluride	Colorado
			ZIP Code
			81435
Primary Contact Information for Project			
Name		Phone	Email
Lynn Borup		719-480-3822	lynn@telluridefoundation.org
Focus Area(s)			
✓	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
✓	Chronic Disease Management	✓	Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management	✓	Telehealth/Telemedicine
✓	Health Education/Promotion and Disease Prevention		Transitions of Care
✓	Health Improvement Special Project (HISP)		Women's Health
✓	Health Screenings	✓	Other: Social Determinants of Health
	HIV/AIDS	✓	Other: Community Health Workers
	Maternal and Child Health		Other:
Area(s) Served			
Delta, Montrose, Ouray, and San Miguel counties in Colorado.			
Target Population(s)/Need Addressed			
<p>The population targeted by Tri-County Health Network (TCHNetwork) included people in the region between the ages of 30 and 74 with no history of cardiovascular disease (CVD), as well as those outside of this age group who experienced barriers to accessing health care services. The primary needs experienced by the population include poverty and low incomes, lack of health care coverage, food insecurity, a lack of Spanish speaking and Latinx health care providers, and rural barriers to accessing health and social services. Risk factors for CVD and diabetes, particularly modifiable risk factors like tobacco use and inactivity, trend higher in the region compared to across the state of Colorado.</p>			

Consortium/Network Partners

Consortium members include Basin Clinic (a Rural Health Clinic), River Valley Family Health Center (Federally Qualified Health Center (FQHC)), Telluride Medical Center (community primary care clinic and 24/7 emergency center), Uncompahgre Medical Center (FQHC and dental clinic), The Center for Mental Health (regional community mental health center), Montrose Memorial Hospital (nonprofit, community-based hospital), Mountain Medical Center (full-service primary care clinic), Pediatric Associates (medical home for children), and Telluride Foundation (community foundation).

Project Goals

The goals of the Community Health Workers Coordinating Assessments, Resources, & Education to Improve Heart Health (CHWs CARE) project included:

1. Using community health workers (CHWs) throughout the region to improve population health and help reduce CVD risk utilizing the Centers for Disease Control and Prevention Heart Age Calculator. The project will partner with employers and screen employees to promote the ability to track the same cohort of individuals during the three-year grant period;
2. Expanding the delivery of health care services by promoting self-management and prevention of CVD, hypertension, and diabetes through evidence-based programs; and
3. Identifying and prioritizing social determinants of health (SDH) needs in the region and implementing action steps to address SDH using a collaborative approach.

Evidence-Based Model(s)/Promising Practice(s)

TCHNetwork utilized the following evidence-based/promising practices in the CHWs CARE Program:

1. Colorado Heart Health Solutions: CHWs were embedded throughout communities and provided health screenings, education, and referrals to community resources to reduce the burden of cardiovascular disease and diabetes
2. Cooking Matters: Six-week evidence-based course that empowers participants to cook healthy on a limited budget
3. Diabetic Retinopathy Telescreening (DRT): CHWs were certified to take diabetic retinopathy images and use store-and-forward technology to send the photos to ophthalmologists/optometrists in another location for review
4. Screening for behavioral health and social determinants of health and providing referrals to meet identified needs: By identifying and addressing behavioral health and social determinant of health needs for clients, the project was able to proactively break down barriers to care and support the whole person health of our partners' patients

Services and Activities

The primary activities implemented through the CHWs CARE Program included:

1. Partnering with businesses to provide wellness screenings to employees and offering wellness screenings to other community members facing barriers to accessing health services. Screenings included determining risk factors associated with CVD and diabetes, SDH, and behavioral health screenings. CHWs walked each client through the results and provided self-management tools and peer support to help clients set and achieve manageable goals to improve overall health
2. Offering Cooking Matters courses that helped graduates cook healthy on a budget. As CHWs conducted wellness screenings and identified individuals looking to eat healthier or those experiencing food insecurity, the CHWs referred clients to local Cooking Matters classes. Courses were offered in-person pre-COVID and virtually post-COVID
3. Offering diabetic retinopathy tele screenings on-site at local clinics to break down barriers to this critical screening
4. Supporting clients to understand and monitor their blood pressure at home
5. Creating a cross-sector partnership to assess regional SDH needs

Outcomes

Outcomes achieved to date as a result of our funded project include:

1. Provided 1,383 wellness screenings to 1,133 individuals throughout this rural region. Of those who received more than one screening, 41% decreased their overall risk of having a heart attack or stroke in the next 10 years, 36% decreased their body mass index, 42% decreased their LDL, and 48% decreased their blood pressure after their first screening. Of those with diabetes who were screened more than once, 40% decreased their A1c levels
2. Partnered with 49 businesses to break down barriers to care by offering services on-site to their employees
3. Screened 490 individuals for behavioral health needs using validated assessments and offering referrals to clients who screened positive for stress or depression
4. Screened 184 people for SDH needs and providing referrals when needs were identified. A lack of support was the most commonly identified need, with 28% of respondents stating that they would have nobody to turn to with help with a sudden crisis. Many of these responses were given pre-COVID, therefore it is anticipated that this need has only intensified
5. Offered 10 in-person Cooking Matters courses, reaching 119 people. Ninety-eight percent of graduates stated they were “more confident” they could cook healthy meals on a budget after completing the course
6. Offered 36 virtual Cooking Matters classes reaching 326 people. Eighty-five percent of those who completed a post-course survey stated that the course increased their knowledge of how to cook healthy on a budget
7. The CHW team became certified to take retinal images and conducted 286 diabetic retinopathy tele screenings at seven clinical sites
8. Convened an SDH Action Consortium comprised of clinical partners and community-based organizations throughout the region. The consortium reviewed data from SDH screenings and connected on different resources to address SDH for our region’s population. About 12 partners regularly attend the monthly meetings

Sustained Impacts

Sustained impacts include longer-term improvements in the health status of community members as CHWs empower residents to understand their health indicators and how different behaviors, social determinants of health, and mental health impact their overall health and well-being. Clients became familiar with and connected to local tools and resources to support healthy lifestyle changes, including Cooking Matters, health care coverage, and ongoing peer support from CHWs, that can further contribute to sustained, positive, healthy changes. Further, by offering DRT, the project is providing screenings to individuals that have never had and may never get this critical retinopathy screening. This may lead to a decrease in blindness caused by diabetic retinopathy in our region. Since the beginning of the COVID-19 crisis in our region, TCHNetwork began offering Cooking Matters classes virtually. The project found that some community members preferred the virtual setup of the courses over in-person. While it is expected to go back to in-person courses when it is safe, it is anticipated that virtual courses may also be a regularly offered option in these communities moving forward.

Lessons Learned and Considerations for Program Replication

Lessons learned and considerations for program replication include:

1. Using CHWs from the communities where they work is a must. CHWs who are culturally knowledgeable and seen as a trusted member of their respective community is key for conducting community outreach and effectively engaging with clients
2. Proactive and continual training is necessary for CHWs to feel confident when screening for SDH/behavioral health needs. CHWs were still hesitant as the questions related to SDH and behavioral health were more personal than their traditional health screening questions. TCHNetwork offered ongoing training related to the connection of SDH/behavioral health and heart health, as well as regular training on community resources available to address identified SDH and behavioral health needs to help CHWs feel more confident in their screenings
3. Community partners and clinics were eager to collaborate and learn about the resources available in the community to address SDH. While the project started by discussing prioritized SDH needs, it was found that the partners were more interested in taking a broader approach to learn about resources to address different SDH needs

Organization Name		University of South Dakota	
Organization Information			
Grant Number		Organization Type	
D04RH28389		Nonprofit Organization	
Organization Website			
Address		City	State
414 East Clark 120 East Hall		Vermillion	South Dakota
			ZIP Code
			57069
Primary Contact Information for Project			
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Tasha Wendel		605-658-5967	tasha.wendel@usd.edu
Focus Area(s)			
Behavioral/Mental Health	<input checked="" type="checkbox"/>	Oral Health	
Cancer Care Management	<input type="checkbox"/>	Pediatric Care	
Cardiovascular Disease (CVD) Care Management	<input type="checkbox"/>	Pharmacy Assistance	
Case Management	<input type="checkbox"/>	Primary Care Services	
Chronic Disease Management	<input type="checkbox"/>	Population Health	
Chronic Obstructive Pulmonary Disease (COPD) Prevention	<input type="checkbox"/>	School Based Care Coordination	
Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management	<input type="checkbox"/>	Specialty Care Services	
Community-based Care Coordination	<input type="checkbox"/>	Substance Abuse Treatment and/or Education	
Diabetes Care Management	<input type="checkbox"/>	Telehealth/Telemedicine	
Health Education/Promotion and Disease Prevention	<input type="checkbox"/>	Transitions of Care	
Health Improvement Special Project (HISP)	<input type="checkbox"/>	Women's Health	
Health Screenings	<input type="checkbox"/>	Other:	
HIV/AIDS	<input type="checkbox"/>	Other:	
Maternal and Child Health	<input type="checkbox"/>	Other:	
Area(s) Served			
The Rural Dental Health Service Program provided oral health services to rural, underserved children, senior citizens, and veterans in 29 different rural locations in southeast South Dakota.			
Target Population(s)/Need Addressed			
The small rural communities required residents to travel great distances for dental care and many times a provider who will accept Medicaid payments was difficult to find. Veterans' dental benefits were limited, and senior citizens have limited income; both populations may have transportation difficulties. Reaching children, senior citizens and Veterans in their own communities was an effective way to provide dental services. Individuals in the hospital were often in critical condition; providing basic oral hygiene services potentially minimized length of hospital stays and improved patient health.			

Consortium/Network Partners

The consortium was made up of the University of South Dakota (USD) Dental Hygiene Program director, coordinators, dentist, and 21 school administrators, three senior citizens administrators, four nursing home administrators, and one hospital administrator.

Project Goals

1. Increased access to preventive and restorative dental services for high-risk children, senior citizens, and Veterans who are low-income, Medicaid-eligible, uninsured, or immobile living in southeastern South Dakota without a dental home.
2. Provided evidence-based oral care to patients in the hospital.

Evidence-Based Model(s)/Promising Practice(s)

The program was based on the success of several evidence-based models. These included the RAC Corp.'s school-based model, the School-based Dental Sealant Program, Preventing Dental Caries: School-based Dental Sealant Delivery Program, Comprehensive School-Based Program Initiative Model, Patient Aligned Care Team model, Elder Smiles, Bedside Oral Exam, and the Barrow Oral Care Protocol.

Services and Activities

Services included dental screenings, dental exams, fluoride varnish, dental cleanings, X-rays, dental sealants, oral cancer screening, oral prosthesis adjustments/relines, limited restorative procedures, as well as oral health, tobacco and nutritional education. In the hospital, screening and oral health education was provided to patients in the hospital.

Services were provided by the use of portable dental equipment. Senior dental hygiene students who were supervised by faculty performed these services.

Outcomes

1. Because of this program, many people in South Dakota had an increased access to oral health care. USD has seen almost 1,500 children, almost 250 people in senior centers or nursing homes, and over 100 patients in the hospital. The value of these services is over \$300,000.
2. Surveys have shown that most of the participants would participate in this program again. Many reported from the surveys that without this program, they may not have been able to receive dental care for a length of time; this is especially true for those individuals in the nursing home. Overall, patients were satisfied with the program.
3. Because of the success of the program, most consortium members continued to be a part of the program. Also, many more people are aware of the importance of oral health.

Sustained Impacts

The largest impact made on the communities served through this outreach is oral health awareness. The number of individuals with unmet dental needs that were referred to a dental home accompanied with the knowledge regarding the importance of oral health stands out as the most significant impact that this program has made on these rural communities. Having the partnership with a hospital was groundbreaking in South Dakota and could create changes to the dental practice act allowing dental hygienists to be employed by a hospital or other entity. Because of this program, USD significantly increased the confidence and competence of dental hygiene students working with various populations, in nontraditional settings, and with portable equipment. The health of individuals was the most invaluable sustained impact this program made in many rural South Dakota communities. The people in these communities are now aware of the importance of oral health as it relates to overall health.

Lessons Learned and Considerations for Program Replication

The success of this program became known to many in South Dakota and more recently to other states. When the program was first beginning, USD reached out to communities to see where services could be provided. USD now has people making direct contact, asking if services can be provided in their community. A nursing home in Nebraska reached out to see if USD could provide services. We needed to consider the growth and expansion of this program to include licensure in border states (Iowa and Nebraska). We also need to continually seek out financial sustainability to continue this program. This should include having the University of South Dakota help contribute to this financially by paying for the salary of the faculty member involved. Connections with area dentists for referrals was also key to our success. Over the years, USD tried to maintain good relationships with the dentists, but more work in this area is needed. Teledentistry was being explored to help with issues with access to care and ensure people received the care they need, especially considering the impact of the recent pandemic.

Organization Name		Valley Heights School District 498	
Organization Information			
Grant Number		Organization Type	
D04RH31650		School District	
Organization Website			
Address		City	State
121 East Commercial P.O. Box 89		Waterville	Kansas
			ZIP Code
			66548
Primary Contact Information for Project			
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Philisha Stallbaumer		785-292-4453	philishas@bluevalley.net
Focus Area(s)			
✓	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
✓	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
✓	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	Other:	
	HIV/AIDS	Other:	
	Maternal and Child Health	Other:	
Area(s) Served			
The area served by the Schools That Care expansion project included the rural counties of Marshall and Nemaha located in Northeast Kansas.			
Target Population(s)/Need Addressed			
The target population served by the Schools That Care expansion project included prekindergarten students, Parents as Teachers families, and K–12th grade families within USD 498 Valley Heights and USD 380 Vermillion. The primary needs addressed in serving the aforementioned populations were categorized into three different focus areas: mental health climate and culture (e.g., school district family advocate, written mental health school policies), mental health activities and services (e.g., evidence-based mental health curriculum/programs, mental health media campaign), and mental health mobilization and empowerment (e.g., Mobile Family Resource Center, mental health stigma).			

Consortium/Network Partners

Primary project partners of the Schools That Care expansion project included a health consortium comprised of the following five organizations: USD 498 Valley Heights (school district), USD 380 Vermillion (school district), Pawnee Mental Health Services (community mental health center), the School-Business Educational Consortium (nonprofit organization); and Blue Valley Tele-Communications (nonprofit business). All of these partners reside within either Marshall or Nemaha counties in Northeast Kansas.

Project Goals

Ultimately, the Schools That Care expansion project strengthened the mental health support network for students and their families by providing concrete resources that built protective factors and optimized success. This included using the evidence-based Kansas Multi-Tier System of Supports (MTSS) model to provide programs and activities that benefited partners and the communities served by the project to increase access to mental health services and resources while improving the health status of rural residents. Specific goals for the Schools That Care initiative follow:

- Goal 1: To promote quality, comprehensive and streamlined school mental health services to students and their families beginning in early childhood.
- Goal 2: To engage, educate, and support students and their families to improve their mental health status and ensure access to appropriate services.
- Goal 3: To connect schools with business and community partners to help mobilize mental health resources for students and families resulting in a removal of barriers to learning.

Evidence-Based Model(s)/Promising Practice(s)

As mentioned previously in the “Project Goals” section, the overall framework of the Schools That Care expansion project was built on the evidence-based model, the Kansas MTSS. Specific evidence-based programs and services integrated into the initiative included Second Step’s Bullying Prevention Unit and Second Step’s Child Protection Unit which were administered to preschool students. Other programs and activities incorporated within the MTSS framework included professional development for preschool and Parent As Teachers instructors; special events for mental health awareness; the development and implementation of a Mobile Family Resource Center (MFRC); targeted group interventions for early childhood programs and families; and individual assessment-based referrals.

Services and Activities

This Schools That Care project expanded services to prekindergarten students, Parents as Teachers’ families, and school district families within USD 498 Valley Heights and USD 380 Vermillion. The goals and objectives of this expansion initiative were fulfilled by acquiring a family advocate to serve the two school districts; offering professional development to school staff; providing MTSS evidence-based programs/activities to students, family, and communities; utilizing mental health media promotion to educate the public; and creating, developing, and implementing an MFRC to empower families and strengthen connections between schools and communities. During the first year of the grant, the focus of the project consisted mainly of planning for future programs/activities along with some early stages of implementation (i.e., employment of the family advocate to provide outreach and access to mental health services). During years 2-3 of the grant, the focus then shifted to the implementation of evidence-based curriculum in the preschool setting, the MFRC, mental health activities/special events and sustainability.

Outcomes

Accomplishments through March 15, 2021, of the Schools That Care expansion project demonstrated that partner school sites and their communities experienced many positive outcomes. (It is important to note that Year 3 data was still being collected at the time of this submission.) Primary outcome results achieved through project implementation as of March 15, 2021, included the following:

1. There were 3,363 unique individuals who participated in health education and counseling activities offered to the public.
2. Eight hundred thirty-two unique individuals and 291 families received direct services mental or behavioral health through the family advocate.
3. Two hundred sixty-nine preschool students received the Second Step Bullying Prevention Curriculum, and 213 preschool students received the Second Step Child Protection Curriculum.
4. Eleven successful donation drives were conducted throughout our partner schools and communities of USD 498 and USD 380 that included the following: winter wear, blankets and towels, diapers and wipes, school supplies, soaps and suds (cleaning and hygiene items), boots and blankets, shorts, socks and underwear, and cleaning supplies.
5. High levels of community collaboration took place between grant partners and external community organizations.

Collaborative efforts included, but were not limited to, the following: Habitat for Humanity, Lincoln Center, Pony Express Partnership for Children, Harvesters Community Food Network, and Marshall County Vaping Task Force, and so on. In addition to the positive hard data results, constructive outcomes also occurred in both school and community settings. For example, school affiliated groups worked with the family advocate to collect donations for the MFRC. In addition, local businesses, churches, and public entities also volunteered their assistance and space to serve as “drop-off” points for donation collections.

Sustained Impacts

1. Improved service models: Implementation of an MFRC to provide direct services at multiple locations and various settings. Preschool instructors trained in bullying prevention and child protection mental health curricula.
2. Increased capacity in local systems: The employment of a family advocate to provide mental health services to students and their families both in schools and on the MFRC. Implementation of mental health curricula that can be integrated into preschool classrooms.
3. New policies: The implementation of written policies and procedures to guide the MFRC. Mental health policies and procedures at preschool sites that are consistently enforced and updated regularly.
4. Changes in knowledge, attitudes, and behaviors: Preschool instructors approach their teaching instruction in a new way and recognize the benefits and significance of mental health activities and services within the school setting. Preschool staff, student, family, and community awareness on the importance of addressing mental health issues and basic needs has increased due to training, outreach, and the MFRC.

Lessons Learned and Considerations for Program Replication

Major lessons learned from implementing the Schools That Care project include, but are not limited to the following:

1. At the beginning of the project, the creation of an MFRC was challenging because there were very few models to help with the process. Research, visitation to resource centers (nonmobile), and local expertise assisted in the innovative development.
2. Despite offering professional development and training to project and school staff, not everyone involved in the initiative still had the same level of expertise or experience with mental health issues. Specific individuals were still more “equipped” or felt more confident and comfortable addressing mental health issues with students and families.
3. Creating a cohesive social services unit within multiple schools was difficult when so many players were involved. Putting policies and procedures into place that ensured constructive and effective communication flow was essential.
4. Community needs changed throughout the grant period. For example, the unimaginable COVID-19 pandemic directly influenced and impacted the types of student and family needs. Always expect the unexpected.

Organization Name		Westchester-Ellenville Hospital Inc.	
Organization Information			
Grant Number		Organization Type	
D04RH31651		Critical Access Hospital (CAH)	
Organization Website			
https://erhny.org/			
Address		City	State
10 Healthy Way		Ellenville	New York
			ZIP Code
			12428
Primary Contact Information for Project			
Name		Phone	Email
Victoria Reid		845-647-6400	vreid@erhny.org
Focus Area(s)			
	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
✓	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
✓	Health Education/Promotion and Disease Prevention		Transitions of Care
✓	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	Other:	
	HIV/AIDS	Other:	
	Maternal and Child Health	Other:	
Area(s) Served			
Our primary service area was the Wawarsing region of Ulster County, N.Y. However, our service area included all of the following ZIP codes (which include rural parts of Orange and Sullivan counties as well): 12428, 12446, 12458, 12404, 12566, 12489, 12740, 12788, 12789, 12790.			
Target Population(s)/Need Addressed			
This project served residents living in the rural and medically underserved region of Wawarsing, N.Y., with a population of 13,157, of which 4,135 reside within the village of Ellenville. This project specifically targeted residents of Wawarsing between 30 to 74 years old who had no history of cardiovascular disease (CVD) (e.g., heart attack, stroke, peripheral artery disease, or heart failure) that had certain risk factors associated with onset of CVD.			

Consortium/Network Partners

Our consortium consists of the following groups: Ellenville Regional Hospital (Critical Access Hospital), the Institute for Family Health (Federally Qualified Health Center), and the Ulster County Department of Health and Mental Health (county health department). In addition, the network has the following partners: Cornell Cooperative Extension of Ulster County (land grant institution), the Wawarsing Youth Commission (youth commission), the Ellenville Central School District (public school), Planned Parenthood of Greater New York (health education facility), and the Rondout Valley Growers Association (other).

Project Goals

Our goal for the HRSA Outreach: Health Improvement Special Project (HISP) was to use evidence-based community outreach and clinical improvement strategies to reduce the 10-year cardiovascular risk amongst a cohort of at-risk members of the Wawarsing community. The program had three concentration areas, first, creating and expanding the Wawarsing Healthy Hearts Consortium, second, recruiting cohort participants and providing them with health education and activities to lower cardiovascular risk, as well as engaging the larger community in a similar manner, and third, improving clinical service delivery and availability of community resources.

Evidence-Based Model(s)/Promising Practice(s)

This project employed the evidence-based Community Health Worker–Health Educator Model as well as the CDC Heart Age screening protocol in an effort to decrease the risk of cardiovascular disease incidence in our service area. The community health worker (CHW) model aims to engage community members in their own health behavior change by developing individualized goals and action plans to address specific risk factors associated with CVD and other chronic diseases while connecting participants to additional community services when necessary. As part of their job, the CHW also utilizes the CDC’s heart age calculator to determine cohort member risk of CVD development, as well as to determine measurable change over the course of time spent with the CHW along with other clinical measures.

Services and Activities

1. Hold monthly consortium meetings to promote coordination of service provision, review planned and completed project activities, and address challenges to project implementation.
2. Train staff on best practices (e.g., Mental Health First Aid, Million Hearts Campaign, rural health office toolkits, cultural competency/health literacy Motivational Interviewing, Blue Print for Health Equity, referrals).
3. Engage at-risk population through community screenings, and physical activity/health education programs (e.g., pharmacy, weekday walkers, nutrition support group) in the community, as well as primary care offices.
4. Enroll patients into the Wawarsing Healthy Hearts project cohort.
5. Develop integrated workflows between clinical staff at the Ellenville Regional Hospital and health center to jointly address patients at high CVD risk.

Outcomes

1. Enrolled 165 community members at risk of developing CVD into the Healthy Hearts cohort.
2. Held monthly consortium meetings with partner organizations monthly over a three-year grant period to discuss project activities, and implementation efforts.
3. Engaged over 300 residents in ongoing community programming including food distribution stands, health education classes, nutrition education classes, and physical activity programs.
4. Trained 15 clinical staff members on best practices (e.g., Mental Health First Aid, Million Hearts Campaign, rural health office toolkits, cultural competency/health literacy Motivational Interviewing, Blue Print for Health Equity, referrals).
5. Created three integrated workflows between Ellenville Regional Hospital staff and clinical staff at the Institute for Family Health to jointly address patients at high risk of CVD.

Sustained Impacts

The Healthy Hearts program had a multitude of sustained impacts on program participants as well as on both the services provided to area residents, and the programmatic efforts of the Rural Health Network. Through the Health Improvement Special Project, the Rural Health Network consortium was able to build a network of rural providers who were ready and able to supply a plethora of social and health-related services to community residents. Through these partnerships, the network has been able to secure further funding to support additional projects aimed at decreased both CVD as well as other chronic diseases, such as obesity. Projects supported by this grant, as well as others improved access to health services, health knowledge, healthy food options, and social/emotional supports to cohort members and the broader public, by providing over 400 free programs over the 36-month grant period. Moreover, through project objectives, the network began and sustained joint processes between the Ellenville Family Health Center and the hospital to support continued care coordination of at-risk patients.

Lessons Learned and Considerations for Program Replication

During planning and implementation of our Outreach Program project, our team identified areas in which our desired outcome was not met, and therefore our methodology had to be adjusted and reworked to best suit the project objectives. For example, our initial process for recruiting at-risk individuals was through cold calling clients based on electronic health records (EHR) data that highlighted an increased risk for CVD. While this process seemed streamlined in theory, in practice, it was not received well by individuals who were both confused by our ability to obtain their PII as well as concerned by our blunt approach to recruitment. For this reason, we changed our referral process to partner with outside agencies and clinical staff to refer to us directly. Additional lessons learned include the necessity of using data to track programmatic efforts, the broader impact seen through family inclusion in health behavior change, as well the benefit of including nontraditional partners in your network of providers. Further, it is always beneficial to be creative when considering best practices for health improvement project interventions.

Organization Name		Williamson Health and Wellness Center	
Organization Information			
Grant Number		Organization Type	
D04RH31652		Federally Qualified Health Center (FQHC)	
Organization Website			
www.williamsonhealthwellness.com			
Address		City	State
184 E. 2nd Ave.		Williamson	West Virginia
			ZIP Code
			25661
Primary Contact Information for Project			
Name		Phone	Email
Jennifer Hudson		304-235-3400	jhudson@williamsonhealthwellness.com
Focus Area(s)			
	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
✓	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
✓	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
	Health Education/Promotion and Disease Prevention		Transitions of Care
✓	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	Other:	
	HIV/AIDS	Other:	
	Maternal and Child Health	Other:	
Area(s) Served			
Mingo County, W.Va.			
Target Population(s)/Need Addressed			
As heart disease prevalence in Mingo County is nearly double the national rate, and the county also experiences high rates of obesity and diabetes, ranking 54th out of 55 West Virginia counties in the 2017 County Health Rankings for health outcomes, the Healthy Lives, Healthy Hearts team employs a community health worker (CHW) model with linkages to social services including smoking cessation, healthy eating, and active living resources and programs.			

Consortium/Network Partners

The Healthy Lives, Healthy Hearts consortium consists of three partners: Williamson Health and Wellness Center (lead applicant), Appalachian Regional Hospital, and Marshall University John C. Edwards School of Medicine.

Project Goals

The Healthy Lives, Healthy Hearts initiative in Mingo County is an integrated health care delivery system that focuses on cardiovascular disease prevention and treatment in a rural community struggling with some of the worst heart health outcomes in the nation.

- Goal 1: To implement a CHW care coordination model that is fully integrated into service delivery and care teams at WHWC to reduce the risk of cardiovascular disease and other chronic diseases (diabetes, COPD) in Mingo County.
- Goal 2: To ensure the financial viability of cardiovascular disease prevention based CHW care coordination activities by promoting third party payment in West Virginia.
- Goal 3: To promote care coordination best practices and evidence-based learning that supports regional and national expansion of CHW model.

Evidence-Based Model(s)/Promising Practice(s)

The consortium implemented an evidence-based model called Cardiovascular Disease: Interventions Engaging Community Health Workers as well as evidence-based Nutrition Prescriptions and Walk with Ease programs.

Services and Activities

As Williamson Health and Wellness Center (WHWC) implemented a care coordination model, integration activities involved building care plans into EClinical works to improve health information technology (HIT) and communication among care coordination teams. Making changes to HIT and establishing workflows prepared the existing clinic and support staff to hire and train new CHWs. More than 200 patients were enrolled in the program and engaged in care coordination activities to prevent and treat chronic disease. Care coordination teams screened patients to understand social needs and provided linkages to social services and healthy eating and active living opportunities within the community. Providers connected via ECHO telehealth with specialty care experts at Marshall University to address difficult issues with co-occurring disorders. Third-party payers met with project partners to establish new payment models. Process and outcome measures were shared with other health centers and parties interested in value-based care and payment reform.

Outcomes

1. Improved quality of care is demonstrated through health outcome data from the program and claims data provided by third-party payers. Health outcome data shows reduced A1c and improved blood pressure control. Claims data demonstrates reduced health care utilization costs. Qualitative stories shared by CHWs and their patients reflect improved quality of life because of changed behaviors to manage and prevent chronic disease. We know from care coordination teams that patients enrolled in the program improved medication adherence. From the claims data, we can deduce that no-show rates for primary and specialty care appointments decreased as patients became more engaged in a journey to improve their health over the first six months of enrollment.
2. A reimbursement code established via third-party payers helps to sustain CHW services in addressing chronic disease. Evidence of improved health outcomes and quality of care motivated Aetna Better Health to establish a billing code for CHW services. The billing code was established to generate revenue for care coordination services delivered by CHWs and care coordination teams. These billable activities delivered by the care coordination teams have an impact on patient outcomes and therefore also generate an annual return on investment through value-based payments. Commitments from third-party payers contribute to the sustainability of care coordination activities and serve as a testament to intervention effectiveness.
3. Spread of the CHW care coordination intervention occurs in two ways:
 - a. Sharing the service model with other health centers and practitioners
 - b. Showcasing the payment model with additional payers, including both philanthropic institutions and private insurance companies. A long-standing partnership with Marshall University to support expansion of CHW care coordination services engages health insurance payers and health centers from West Virginia, Kentucky, and Ohio.

Sustained Impacts

An improved service model was established as CHWs became integrated at the adult medicine clinic to serve as part of a chronic disease prevention team at the health center. In prior years, care coordination services had been primarily provided for individuals with chronic conditions and co-occurring disorders (type 2 diabetes, COPD, CHF). The care coordination teams were able to provide services with individuals at risk of heart disease. Care coordination teams utilized Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) to identify and address social determinants of health and social barriers to care. Transportation costs for care coordination were reduced from prior years as the CHWs became part of the clinical setting. Utilizing a tiered approach, home-based care coordination services were reserved for the highest utilizers of health care services, while care delivered to individuals at risk for chronic disease occurred at the clinic.

Lessons Learned and Considerations for Program Replication

CHW care coordination results in reduced health care utilization and costs among patients with chronic conditions and co-occurring disorders. As such, value-based payment models are designed to equitably distribute financial payments to promote the continuation of services, especially when those services have the result of reducing overutilization of the emergency room and hospitalization. The distribution of savings between payers and providers depends crucially on good data, outcomes that are trusted by the payer. At WHWC, the care coordination team and the third-party payer utilize data reports from the payer systems to track verifiable cost-savings, and the most obvious savings are captured by the reduced emergency room visits and hospital stays. In many cases, primary and specialty care visits and pharmacy claims increase within the first six months of enrollment for patients as they improve management of health conditions. While increased costs from doctor appointments and the pharmacy are expected, the cost-savings and value-based payments are related more to reductions in claims for ER and hospitalization.

Organization Name		Yakima Valley Farm Workers Clinic	
Organization Information			
Grant Number		Organization Type	
D04RH31803		Federally Qualified Health Center (FQHC)	
Organization Website			
www.YVFWC.com			
Address		City	State
510 West First Ave. P.O. Box 190		Toppenish	Washington
			ZIP Code
			98948
Primary Contact Information for Project			
Name		Phone	Email
Maria Benavides		509-248-3334	mariaben@yvfwc.org
Focus Area(s)			
	Behavioral/Mental Health		Oral Health
	Cancer Care Management		Pediatric Care
	Cardiovascular Disease (CVD) Care Management		Pharmacy Assistance
	Case Management		Primary Care Services
	Chronic Disease Management		Population Health
	Chronic Obstructive Pulmonary Disease (COPD) Prevention		School Based Care Coordination
	Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management		Specialty Care Services
✓	Community-based Care Coordination		Substance Abuse Treatment and/or Education
	Diabetes Care Management		Telehealth/Telemedicine
	Health Education/Promotion and Disease Prevention		Transitions of Care
	Health Improvement Special Project (HISP)		Women's Health
	Health Screenings	✓	Other: Children with Special Health Care
	HIV/AIDS		Other:
	Maternal and Child Health		Other:
Area(s) Served			
Rural Yakima County, Wash. Includes these places in Yakima County: Buena, Grandview, Granger, Mabton, Outlook, Sunnyside, Toppenish, White Swan, and Zillah.			
Target Population(s)/Need Addressed			
The target population was rural children with special health care needs (CSHCN) and their families. The majority of these children are Hispanic, from mono-lingual Spanish families, with limited education.			
The bilingual and bicultural patient navigators and public health nurse provided these families information to understand their children's health care needs and how to access the services to address these health care needs.			

Consortium/Network Partners

Three Children's Village consortium partners are involved with this project: Yakima Valley Memorial Hospital (previously Virginia Mason Memorial Hospital), Yakima Memorial Foundation (nonprofit community foundation, and Yakima Valley Farm Workers Clinic (FQHC).

Project Goals

1. Children's Village will leverage partnerships, programs, and technology to decrease persistent disparities in access and outcomes for Hispanic CSHCN and their families.
2. Children's Village will overcome barriers to pediatric specialty care, and mental health and nutrition counseling for underserved CSHCN in rural areas.
3. Children's Village will facilitate timely access to pediatric specialty care, and mental health and nutrition counseling, for rural CSHCN who have been referred to Children's Village.
4. Children's Village will improve coordination of care along the health care continuum including health, education, social service, and public health to provide comprehensive and coordinated care for rural CSHCN.

Evidence-Based Model(s)/Promising Practice(s)

Two evidenced based, promising practice models were utilized in this project: (1) Harold P. Freeman's Patient Navigation program, a nationally recognized, community-based health care service delivery model conceived by Dr. Freeman in 1990 as a strategy to improve timely screening, diagnosis, and treatment of cancer in vulnerable, underserved populations. The program focuses on the critical window of opportunity (from a suspicious finding or diagnosis to the point of treatment) by eliminating barriers to care. (2) Oregon CaCoon (Care Coordination) Program, a community-based, care coordination promising practice administered in every Oregon county for over 20 years by the Oregon Center for Children and Youth with Special Health Care Needs (OCCYSHN) and Oregon's Title V (CYSHCN). In partnership with local health districts and pediatric specialists, the program has a network of PHNs that work directly with families to determine needs and develop a care plan.

Services and Activities

1. Two bilingual, bicultural patient navigators and a public health nurse were hired and received training. Training received was documented by patient navigators and public health nurse and shared with project evaluator.
2. The project director with the patient navigators developed process workflows for behavioral health and therapies (speech and language, occupational, and physical). In addition, process workflows were developed for selected Pediatric Specialties with relatively high no-show rates.
3. Patient navigators made contact (telephone, letter) with families referred for the targeted services. Provided home or office visits as needed/requested by families. Made referrals to community support agencies and parent organizations. Assisted families with completion of paperwork/instruments needed for visits. Reminder phone calls to families for provider visits.
4. Public health nurse provided post-provider follow-up with patients, as requested by the provider.
5. All contacts were documented in spreadsheet and electronic medical record.
6. Monthly meetings of the project team provided regular updates and discussion.
7. Project evaluator collects, summarizes project data.

Outcomes

1. Patient navigators and public health nurse increased knowledge and skills by participating in training through Washington State Department of Health, YVFWC department of outreach, and Children's Village targeted programs.
2. Increased appointments scheduled for Behavioral Health, Nutrition, and Pediatric Specialties.
3. Decreased time between referral and scheduled Pediatric Specialties appointment.
4. Decreased no-shows for scheduled Pediatric Specialties appointments.
5. Increased referrals by patient navigators to Parent to Parent (CV group), early intervention, and community and state resources (transportation, Washington State Developmental Disabilities Association, Washington State Department of Social and Health Services, Partnerships for Action, Voices of Empowerment, Behavioral Health Services).
6. Improved family understanding of their child's needs and how evaluation and treatment can assist the family and child.

Sustained Impacts

1. Leverage partnerships, training, and technology to decrease disparities in access and outcomes for rural, Hispanic children.
2. Overcome barriers to pediatric specialty care for rural, low-income Hispanic children with special health care needs and their families.
3. Facilitate timely access to evaluation and treatment for rural, Hispanic children with special health care needs and their families.
4. Improve coordination of care across the health care continuum; to include health, education, social services and public health by providing comprehensive coordinated care for rural children with special health care needs.

Lessons Learned and Considerations for Program Replication

1. Children's Village (where our project is based) operates on three different electronic medical records, one was installed the first year of this grant. Data for the therapies (speech and language, occupational, and physical) were only available from this new electronic medical record. Patients had unique (not consistent with our other data systems) medical identifying numbers in this system. As a result, the therapies appointment completion rate was calculated for the period of the project and compared to the period before the project. For the therapies, we are not able to separately evaluate the patients who received our intervention.
2. The COVID outbreak in 2020, caused the closure of our offices and limited in-person visits to our clinics toward the end of March 2020. Patient navigator contacts from February to August 2020 were on hold. The public health nurse was able to continue follow-up with parents by telephone. The patient navigators returned to work in September 2020 and contacted referred patient's families by telephone. In-home visits by the patient navigators and public health nurse, have not occurred since early February 2020.

Appendix

Grantees by State

State	Organization Name
Alabama	Rural Alabama Prevention Center
Arizona	Mariposa Community Health Center Inc.
Arkansas	ARcare
	Arkansas Rural Health Partnership
Colorado	Health Care Partners Foundation Inc.
	Tri-County Health Network
Hawaii	Lana'i Community Health Center
Idaho	Family Health Services Corp.
	Southwest District Health
Illinois	Mercer, County of
	Stephenson County Health Department
Indiana	Indiana Rural Health Association
Iowa	Monroe County Hospital
	North Central Iowa Mental Health Center
Kansas	Valley Heights School District 498
Kentucky	Lake Cumberland District Health Department
	Mountain Comprehensive Care Center Inc.
	Pennyroyal Healthcare Service Inc.
Louisiana	Innis Community Health Center Inc.
Maine	Aroostook County Action Program
Maryland	Garrett County Memorial Hospital
Michigan	District Health Department # 10
	Harbor Beach Community Hospital Inc.
Minnesota	CentraCare Health System
	Mississippi Headwaters Area Dental Health Center
Mississippi	Delta Health Alliance Inc.
	Greater Meridian Health Clinic Inc.
Missouri	Missouri Bootheel Regional Consortium Inc.
	Regional Health Care Clinic Inc.
	Richland Medical Center Inc.
Montana	St. John's Lutheran Hospital Inc.
	Summit Medical Fitness Center
Nevada	Healthy Communities Coalition of Lyon and Storey Counties
New Hampshire	Bi-State Primary Care Association Inc.
	North Country Health Consortium
New Mexico	El Centro Family Health
	Miners' Colfax Medical Center

	Rehoboth McKinley Christian Health Care Services Inc.
New York	Mary Imogene Bassett Hospital
	Westchester-Ellenville Hospital Inc.
North Carolina	Firsthealth of the Carolinas Inc.
	City County Health District
Ohio	Hopewell Health Centers Inc.
	Ohio University
Oregon	Mid-Valley Healthcare Inc.
	Northeast Oregon Network
	Peacehealth
Pennsylvania	Butler Healthcare Providers
South Dakota	University Of South Dakota
Texas	Plainview Foundation for Rural Health Advancement Inc.
Virginia	Bay Rivers Telehealth Alliance
	Strength in Peers Inc.
Washington	Adams County Public Hospital District #2
	Inspire Development Centers
	Spokane Tribal Network
	Yakima Valley Farm Workers Clinic
West Virginia	Community Care of West Virginia Inc.
	Rural Health Access Corp.
	Williamson Health and Wellness Center

Grantees by Organization Type

Organization Name	Area Health Education Center	Critical Access Hospital	Federally Qualified Health Center	Health Department	Hospital (non-CAH)	Mental Health Provider	Nonprofit Organization	Rural Health Clinic	School District	Other
CentraCare Health System		✓								
Harbor Beach Community Hospital Inc.		✓								
Mid-Valley Healthcare Inc.		✓								
Miners' Colfax Medical Center		✓								
Monroe County Hospital		✓								
Peacehealth		✓								
St. John's Lutheran Hospital Inc.		✓								
Westchester-Ellenville Hospital Inc.		✓								
ARcare			✓							
Community Care of West Virginia Inc.			✓							
El Centro Family Health			✓							
Family Health Services Corp.			✓							
Hopewell Health Centers Inc.			✓							
Innis Community Health Center Inc.			✓							
Lana'i Community Health Center			✓							
Mariposa Community Health Center Inc.			✓							
Mountain Comprehensive Care Center Inc.			✓							
Pennyroyal Healthcare Service Inc.			✓							
Regional Health Care Clinic Inc.			✓							
Richland Medical Center Inc.			✓							
Rural Health Access Corp.			✓							
Williamson Health and Wellness Center			✓							
Yakima Valley Farm Workers Clinic			✓							
City County Health District				✓						
Butler Healthcare Providers					✓					
Firsthealth of the Carolinas Inc.					✓					
Garrett County Memorial Hospital					✓					
Mary Imogene Bassett Hospital					✓					

Organization Name	Area Health Education Center	Critical Access Hospital	Federally Qualified Health Center	Health Department	Hospital (non-CAH)	Mental Health Provider	Nonprofit Organization	Rural Health Clinic	School District	Other
Rehoboth McKinley Christian Health Care Services Inc.					✓					
North Central Iowa Mental Health Center						✓				
Arkansas Rural Health Partnership							✓			
Aroostook County Action Program							✓			
Bay Rivers Telehealth Alliance							✓			
Bi-State Primary Care Association Inc.							✓			
Delta Health Alliance Inc.							✓			
Health Care Partners Foundation Inc.							✓			
Healthy Communities Coalition of Lyon and Storey Counties							✓			
Inspire Development Centers							✓			
Mercer, County of							✓			
Mississippi Headwaters Area Dental Health Center							✓			
Missouri Bootheel Regional Consortium Inc.							✓			
North Country Health Consortium							✓			
Northeast Oregon Network							✓			
Ohio University							✓			
Plainview Foundation for Rural Health Advancement Inc.							✓			
Rural Alabama Prevention Center							✓			
Spokane Tribal Network							✓			
Strength in Peers Inc.							✓			
Summit Medical Fitness Center							✓			
University Of South Dakota							✓			
Tri-County Health Network							✓			
Greater Meridian Health Clinic Inc.								✓		
Valley Heights School District 498									✓	
Adams County Public Hospital District #2										✓
District Health Department # 10										✓
Indiana Rural Health Association										✓
Lake Cumberland District Health Department										✓
Southwest District Health										✓
Stephenson County Health Department										✓
Total	0	8	15	1	5	1	21	1	1	6

Grantees by Focus Areas

Organization Name	Behavioral/Mental Health	Cancer Care Management	Cardiovascular Disease Care Management	Case Management	Chronic Disease Management	Chronic Obstructive Pulmonary Disease Prevention	Chronic Obstructive Pulmonary Disease Treatment and Management	Community-based Care Coordination	Diabetes Care Management	Health Education/Promotion and Disease Prevention	Health Improvement Special Project	Health Screenings	HIV/AIDS	Maternal and Child Health	Oral Health	Pediatric Care	Pharmacy Assistance	Primary Care Services	Population Health	School Based Care Coordination	Specialty Care Services	Substance Abuse Treatment and/or Education	Telehealth/Telemedicine	Transitions of Care	Women' s Health	Other
Adams County Public Hospital District #2			✓		✓			✓																		
ARcare	✓																					✓				
Arkansas Rural Health Partnership	✓									✓													✓			
Aroostook County Action Program									✓	✓		✓											✓			
Bay Rivers Telehealth Alliance	✓		✓	✓	✓				✓	✓								✓					✓			
Bi-State Primary Care Association	✓							✓										✓	✓							
Butler Healthcare Providers			✓		✓			✓		✓																
CentraCare Health System																					✓		✓			
City County Health District										✓									✓							✓
Community Care of West Virginia	✓																									
Delta Health Alliance Inc.	✓			✓																		✓				
District Health Department # 10			✓		✓				✓	✓	✓	✓														
El Centro Family Health																										✓

Organization Name	Behavioral/Mental Health	Cancer Care Management	Cardiovascular Disease Care Management	Case Management	Chronic Disease Management	Chronic Obstructive Pulmonary Disease Prevention	Chronic Obstructive Pulmonary Disease Treatment and Management	Community-based Care Coordination	Diabetes Care Management	Health Education/Promotion and Disease Prevention	Health Improvement Special Project	Health Screenings	HIV/AIDS	Maternal and Child Health	Oral Health	Pediatric Care	Pharmacy Assistance	Primary Care Services	Population Health	School Based Care Coordination	Specialty Care Services	Substance Abuse Treatment and/or Education	Telehealth/Telemedicine	Transitions of Care	Women's Health	Other
Family Health Services Corp.	✓							✓		✓							✓	✓				✓				
Firsthealth of the Carolinas Inc.																						✓				
Garrett County Memorial Hospital	✓																									
Greater Meridian Health Clinic Inc.	✓		✓						✓														✓			
Harbor Beach Community Hospital	✓																						✓			
Health Care Partners Foundation	✓			✓				✓														✓	✓	✓		
Healthy Communities Coalition of Lyon and Storey Counties								✓							✓					✓						✓
Hopewell Health Centers Inc.	✓																					✓				
Indiana Rural Health Association				✓				✓		✓		✓		✓									✓			
Innis Community Health Center Inc.				✓											✓											
Inspire Development Centers																										✓
Lake Cumberland District Health Department										✓	✓	✓														✓
Lana'i Community Health Center	✓		✓						✓					✓		✓					✓					✓
Mariposa Community Health Center	✓								✓	✓																✓
Mary Imogene Bassett Hospital					✓				✓																	✓
Mercer, County of	✓			✓						✓												✓				

Organization Name	Behavioral/Mental Health	Cancer Care Management	Cardiovascular Disease Care Management	Case Management	Chronic Disease Management	Chronic Obstructive Pulmonary Disease Prevention	Chronic Obstructive Pulmonary Disease Treatment and Management	Community-based Care Coordination	Diabetes Care Management	Health Education/Promotion and Disease Prevention	Health Improvement Special Project	Health Screenings	HIV/AIDS	Maternal and Child Health	Oral Health	Pediatric Care	Pharmacy Assistance	Primary Care Services	Population Health	School Based Care Coordination	Specialty Care Services	Substance Abuse Treatment and/or Education	Telehealth/Telemedicine	Transitions of Care	Women's Health	Other
Mid-Valley Healthcare Inc.	✓																					✓				
Miners' Colfax Medical Center												✓									✓		✓			✓
Mississippi Headwaters Area Dental Health Center	✓																									
Missouri Bootheel Regional Consortium										✓				✓												
Monroe County Hospital																										✓
Mountain Comprehensive Care Center				✓																						
North Central Iowa Mental Health Center	✓		✓								✓															
North Country Health Consortium								✓																		
Northeast Oregon Network	✓				✓			✓		✓		✓						✓	✓	✓		✓				
Ohio University					✓				✓																	
Peacehealth	✓									✓										✓			✓			
Pennyroyal Healthcare Service			✓		✓						✓															
Plainview Foundation for Rural Health Advancement Inc.	✓														✓	✓		✓					✓			✓
Regional Health Care Clinic Inc.	✓																	✓						✓		✓

Organization Name	Behavioral/Mental Health	Cancer Care Management	Cardiovascular Disease Care Management	Case Management	Chronic Disease Management	Chronic Obstructive Pulmonary Disease Prevention	Chronic Obstructive Pulmonary Disease Treatment and	Community-based Care Coordination	Diabetes Care Management	Health Education/Promotion and Disease Prevention	Health Improvement Special Project	Health Screenings	HIV/AIDS	Maternal and Child Health	Oral Health	Pediatric Care	Pharmacy Assistance	Primary Care Services	Population Health	School Based Care Coordination	Specialty Care Services	Substance Abuse Treatment and/or Education	Telehealth/Telemedicine	Transitions of Care	Women's Health	Other
Rehoboth McKinley Christian Health Care Services Inc.									✓																✓	
Richland Medical Center Inc.	✓																									✓
Rural Alabama Prevention Center			✓							✓	✓															✓
Rural Health Access Corp.				✓																						
Southwest District Health	✓																	✓								
Spokane Tribal Network	✓																									✓
St. John's Lutheran Hospital Inc.	✓																	✓								✓
Stephenson County Health Department										✓	✓															
Strength in Peers Inc.	✓																									✓
Summit Medical Fitness Center					✓					✓		✓							✓							
University Of South Dakota															✓											
Tri-County Health Network	✓				✓					✓	✓	✓							✓							✓
Valley Heights School District 498	✓			✓						✓																
Westchester-Ellenville Hospital Inc.			✓							✓	✓															
Williamson Health and Wellness Center			✓		✓						✓															
Yakima Valley Farm Workers Clinic								✓																		✓
Total	29	0	11	9	11	0	0	10	6	22	10	8	0	3	4	2	1	8	5	3	3	10	14	2	1	19

Maps of Areas Served by State

Alabama

Rural Alabama Prevention Center



Arizona

Mariposa Community Health Center



Arkansas

ARcare

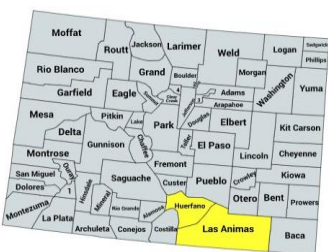


Arkansas Rural Health Partnership



Colorado

Health Care Partners Foundation

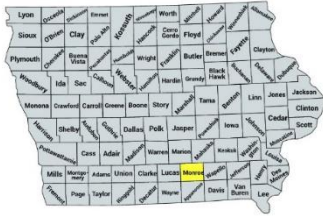


Tri-County Health Network

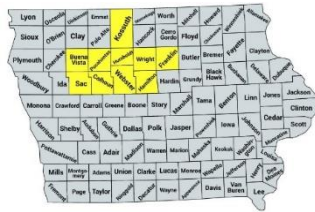


Iowa

Monroe County Hospital

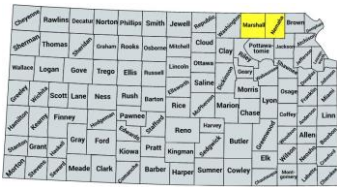


North Central Iowa Mental Health Center



Kansas

Valley Heights School District 498

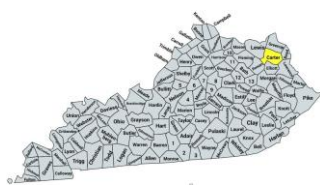


Kentucky

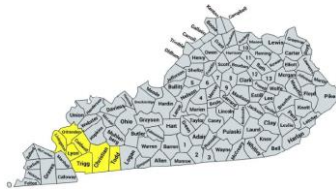
Lake Cumberland District Health Department



Mountain Comprehensive Care Center

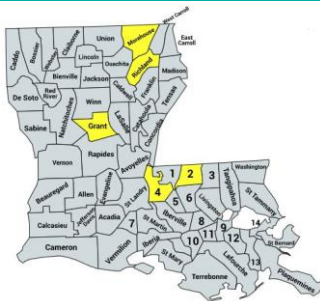


Pennyroyal Healthcare Service



Louisiana

Innis Community Health Center



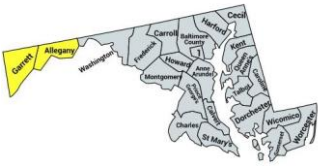
Maine

Aroostook County Action Program



Maryland

Garrett County Memorial Hospital



Michigan

District Health Department # 10

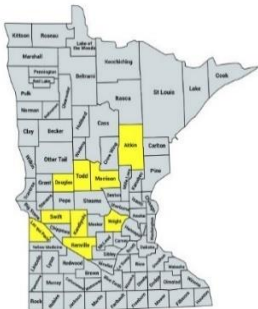


Harbor Beach Community Hospital



Minnesota

CentraCare Health System

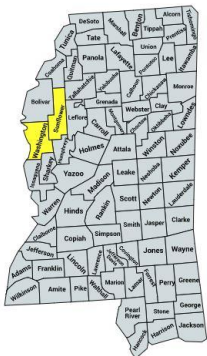


Mississippi Headwaters Area Dental Health Center

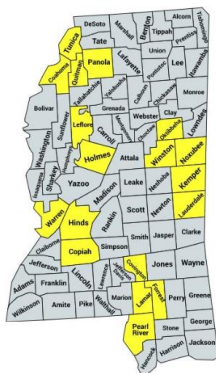


Mississippi

Delta Health Alliance



Greater Meridian Health Clinic



Missouri

Missouri Bootheel Regional Consortium Inc.



Regional Health Care Clinic



Richland Medical Center



Montana

Miners' Colfax Medical Center



St. John's Lutheran Hospital



Summit Medical Fitness Center



Nevada

Healthy Communities Coalition of Lyon and Storey Counties



New Hampshire

North Country Health Consortium



New Mexico

El Centro Family Health



Health Care Partners Foundation



Rehoboth McKinley Christian Health Care Services



New York

Mary Imogene Bassett Hospital



Westchester-Ellenville Hospital



North Carolina

Firsthealth of the Carolinas



North Dakota

City County Health District



Mississippi Headwaters Area Dental Health Center (ND)



Ohio

Hopewell Health Centers



Ohio University



Vermont

Bi-State Primary Care Association



Virginia

Bay Rivers Telehealth Alliance



Strength in Peers



Washington

Adams County Public Hospital District #2



Inspire Development Centers



Spokane Tribal Network



Yakima Valley Farm Workers Clinic

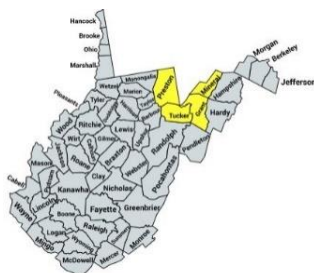


West Virginia

Community Care of West Virginia



Garrett County Memorial Hospital



Rural Health Access Corp.



Williamson Health and Wellness Center



Wyoming

Miners' Colfax Medical Center



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

