

Grantee Directory

Rural Health Network Development Grant Program: 2017 – 2020

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NATIONAL RURAL HEALTH RESOURCE CENTER

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RURAL HEALTH DEVELOPMENT NETWORK PROGRAM

BACKGROUND

The purpose of the Rural Health Network Development Grant Program (RHND) is to assist health-focused networks in developing and maintaining sustainable networks with self-generating revenue streams. These networks provide activities that benefit both network partners and the communities served by the network to increase access and quality of rural health care and ultimately improve the health status of rural residents.

This grant program supports health care organizations that wish to further ongoing collaborative relationships to integrate systems of care administratively, clinically and financially. As a result, the rural health care delivery system will be strengthened by: 1) solidifying the relationships and collaborations between local health oriented organizations, 2) improving the capabilities of individual providers in the network and/or 3) improving the delivery of care to people served by the network.

The RHND Grant Program is authorized under the Public Health Service Act, Section 330A (f) (42 U.S.C. 254(c)(f), as amended to: 1) achieve efficiencies, 2) expand access to, coordinate, and improve the quality of essential health care services, and 3) strengthen the rural healthcare system. Programs that address these charges can benefit rural health care providers in acclimating to the evolving health care environment by addressing relevant topics of the health care environment as identified by the rural community. Identified areas of focus by the 2017 – 2020.

Network Development cohort include: telehealth, health information technology, care coordination and integration, workforce training, health care enrollment and health and wellness.

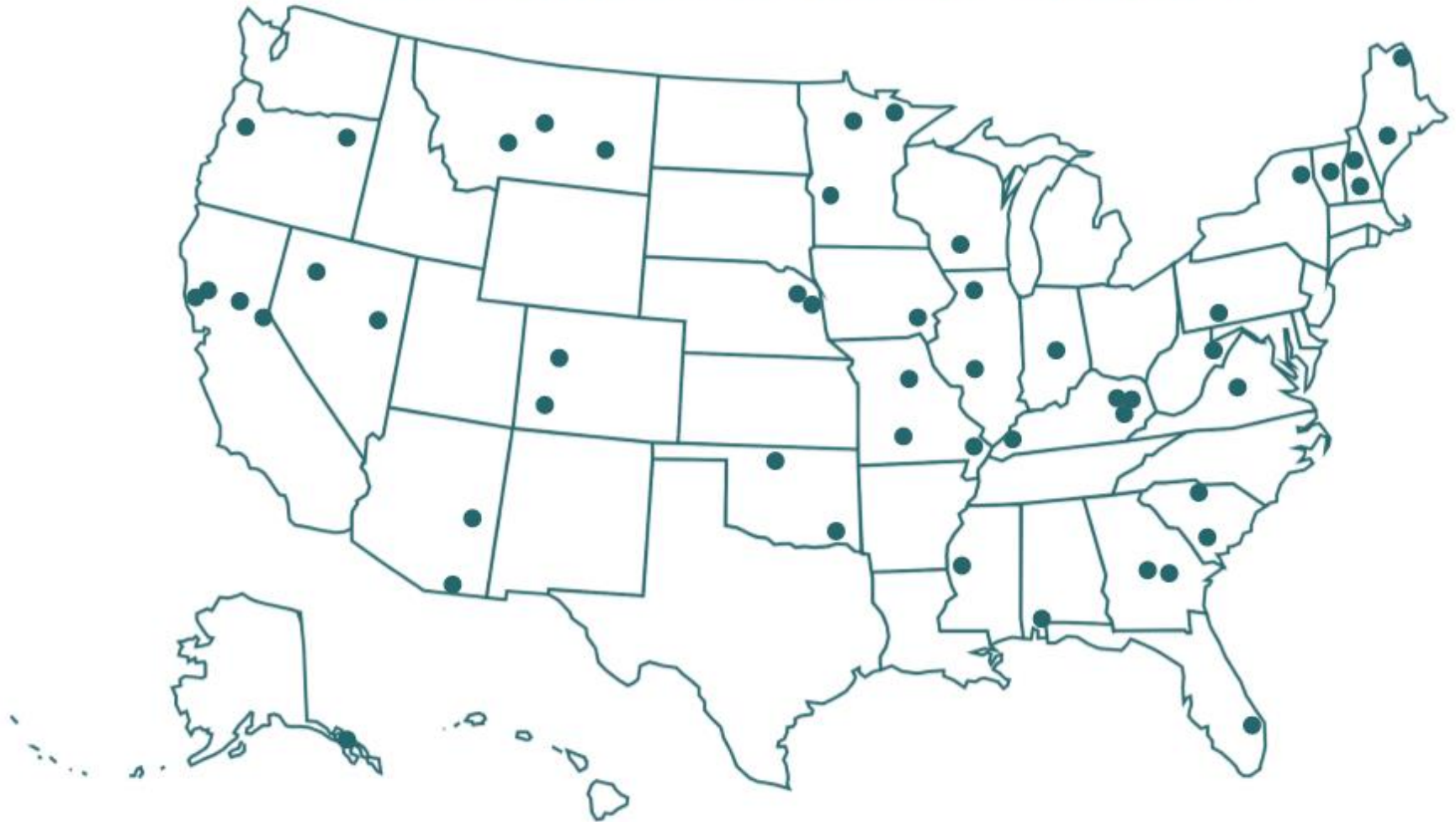
Some anticipated outcomes of supporting the development of rural health networks include:

- achieving economies of scale and cost efficiencies of certain administrative functions such as billing and
- collections, claims management, information management systems integration, shared staffing and
- purchasing;
- increasing the financial viability of network members;
- sharing of staff and expertise across network members;
- enhancing the continuum of care in rural communities;
- providing services to the under- and uninsured in rural communities;
- ensuring continuous quality improvement of the care provided by network members;
- enhancing workforce recruitment and retention efforts;
- improving access to capital and new technologies; and
- enhancing the ability of network members to respond positively to rapid and fundamental changes in the
- health care environment, such as managed care, prospective payment systems, bioterrorism or the
- Health Insurance Portability and Accountability Act requirements.

This directory provides contact information and a brief overview of the 51 initiatives funded under the Rural Health Network Development Grant Program in the 2017 - 2020 funding cycle.

GRANTEES BY STATE (MAP)

2017 NETWORK DEVELOPMENT GRANTEES



GRANTEES BY STATE (LIST)

Alaska

[Prince of Wales Island Health Network](#)

Alabama

[North Baldwin Rural Health Network \(NBRHN\)](#)

Arizona (2)

[Network for Improved Outcomes in Rural Emergency Care](#)

[Santa Cruz County Adolescent Wellness Network](#)

California (4)

[Community Mental and Behavioral Health Cooperative](#)

[Health Leadership Network](#)

[Mendonoma Health Alliance \(MHA\)](#)

[Nevada County Health Collaborative](#)

Colorado (2)

[Community Care Alliance](#)

[Tri-County Health Network](#)

Florida

[Lake Okeechobee Community – Integrated Rural Health Network](#)

Georgia (2)

[South Georgia Regional Prevention Coalition Rural Health Network
Development Initiative](#)

[Southeast Georgia Rural Community Network; Meadows Regional Center
Care Coordination and Telemedicine Program](#)

Iowa

[Healthy Henry County Communities](#)

Illinois (2)

[Illinois Telehealth Network](#)

[Right Care, Right Place, Right Time](#)

Indiana

[ASPIN Health Improvement Program 2.0](#)

Kentucky (4)

[Appalachian Kentucky Health Care Access Network Community Health Worker](#)

[Integrated Primary Care/Behavioral Health Telehealth Project](#)

[Northeast Kentucky Regional Health Information Organization \(NeKY RHIO\)](#)

[Purchase Area Health Connections](#)

Maryland

[Mountain Health Alliance](#)

Maine (2)

[Aroostook County Health Network](#)

[Northern New England ECHO-CARES HUB](#)

Minnesota (3)

[Ely Behavioral Health Network](#)

[Lac qui Parle Behavioral Health Network](#)

[Sandford One Connect Behavioral Health](#)

Missouri (3)

[Bootheel Health Alliance](#)

[Missouri Ozarks Rural Health Network](#)

[Rural Mental Health Network](#)

Mississippi

[Deer Creek Behavioral Health Network](#)

Montana (3)

[Montana GME Network](#)

[Montana Health Network](#)

[Northcentral Montana Hospital \(NMHA\); Enhancing Behavioral Healthcare Access through Technology \(EBAT\)](#)

Nebraska (2)

[Mercy Health Network – Siouxland’s Tele-Behavioral Health Program](#)
[Partnering for Behavioral Health in Rural Northeast and North-Central Nebraska](#)

New Hampshire (2)

[Controlled Substance Management Network \(CSMN\)](#)

[Ways2Wellness Connect](#)

Nevada (2)

[Humboldt General Hospital District](#)

[NRHP Population Health Management Program](#)

New York

[Northern County Value Based Payment Readiness Project](#)

Oklahoma (2)

[Tele-Behavioral Health Integration](#)

[Tri-County Health Improvement Organization \(Tri-CHIO\)](#)

Oregon (2)

[Coast to the Cascades Culinary Health Education and Fitness \(CHEF\) Project](#)

[Northeast Oregon Network \(NEON\)](#)

South Carolina (2)

[South Carolina Behavioral Health Telehealth Network](#)

[Upper Midlands Rural Health](#)

Virginia

[Amherst-Nelson Behavioral Health Network](#)

Vermont

[Vermont Care Network Rural Health Network Development](#)

Wisconsin

[Rural Wisconsin Health Cooperative \(RHWC Primary Care Outcomes Improvement Network\)](#)

West Virginia

[Strength in Peers](#)

GRANTEES BY FOCUS AREA

Alternative Payment Models

- [Community Care Alliance](#)
- [Illinois Telehealth Network](#)
- [Integrated Primary Care/Behavioral Health Telehealth Project](#)
- [Northern New England ECHO-CARES HUB](#)
- [Lac qui Parle Behavioral Health Network](#)
- [Northern County Value Based Payment Readiness Project](#)
- [Northeast Oregon Network \(NEON\)](#)
- [Vermont Care Network Rural Health Network Development](#)

Behavioral/Mental Health

- [Prince of Wales Health Network](#)
- [Network for Improved Outcome in Rural Emergency Care](#)
- [Santa Cruz County Adolescent Wellness Network](#)
- [Community Mental and Behavioral Health Cooperative](#)
- [Nevada County Health Collaborative](#)
- [Tri-County Health Network](#)
- [South Georgia Regional Prevention Coalition Rural Health Network Development Initiative](#)
- [Southeast Georgia Rural Community Network; Meadows Regional Medical Center Care Coordination and Telemedicine Program](#)
- [Illinois Telehealth Network](#)
- [ASPIN Health Improvement Program 2.0](#)
- [Appalachian Kentucky Health Care Access Network Community](#)
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- [South Carolina Behavioral Health Telehealth Network](#)
- [Amherst-Nelson Behavioral Health Network](#)
- [Vermont Care Network Rural Health Network Development](#)
- [Strength in Peers](#)

Chronic Disease Management

- [North Baldwin Rural Health Network \(NBRHN\)](#)
- [Network for Improved Outcome in Rural Emergency Care](#)
- [Health Leadership Network](#)
- [Mendonoma Health Alliance \(MHA\)](#)
- [Nevada County Health Collaborative](#)
- [Community Care Alliance](#)
- [Lake Okeechobee Community-Integrated Rural Health Network](#)
- [Healthy Henry County Communities](#)
- [Illinois Telehealth Network](#)
- [ASPIN Health Improvement Program 2.0](#)
- [Appalachian Kentucky Health Care Access Network Community](#)
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- [Montana Health Network](#)
- [Controlled Substance Management Network \(CSMN\)](#)
- [Ways2Wellness Connect](#)
- [Tri-County Health Improvement Organization \(Tri-CHIO\)](#)
- [Coast to the Cascades Culinary Health Education and Fitness](#)
- [Northeast Oregon Network \(NEON\)](#)
- [Upper Midlands Rural Health Network](#)

- [Rural Wisconsin Health Cooperative \(RHWC\) Primary Care Outcomes Improvement Network](#)

Clinical Based Care Coordination

- [Network for Improved Outcome in Rural Emergency Care](#)
- [Community Mental and Behavioral Health Cooperative](#)
- [Nevada County Health Collaborative](#)
- [Community Care Alliance](#)
- [Tri-County Health Network](#)
- [Southeast Georgia Rural Community Network; Meadows Regional Medical Center Care Coordination and Telemedicine Program](#)
- [Right Care, Right Place, Right Time](#)
- [Integrated Primary Care/Behavioral Health Telehealth Project](#)
- [Aroostook County Health Network](#)
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Clinical Care Integration

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Health Care Access

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- [Rural Mental Health Network](#)
- [Deer Creek Behavioral Health Network](#)
- [Montana GME Network](#)
- [Northcentral Montana Hospital \(NMHA\) Enhancing Behavioral Healthcare Access through Technology](#)
- [Controlled Substance Management Network \(CSMN\)](#)
- [Ways2Wellness Connect](#)
- [Tri-County Health Improvement Organization \(Tri-CHIO\)](#)
- [Northeast Oregon Network \(NEON\)](#)

Health Promotion and Disease Prevention

- [Prince of Wales Health Network](#)
- [North Baldwin Rural Health Network \(NBRHN\)](#)
- [Health Leadership Network](#)
- [Mendonoma Health Alliance \(MHA\)](#)
- [Nevada County Health Collaborative](#)
- [South Georgia Regional Prevention Coalition Rural Health Network Development Initiative](#)
- [Southeast Georgia Rural Community Network; Meadows Regional Medical Center Care Coordination and Telemedicine Program](#)
- [Healthy Henry County Communities](#)
- [Appalachian Kentucky Health Care Access Network Community](#)
- [Purchase Area Health Connections](#)
- [Northern New England ECHO-CARES HUB](#)
- [Lac qui Parle Behavioral Health Network](#)

- [Bootheel Health Alliance](#)
- [Missouri Ozarks Rural Health Network](#)
- [Rural Mental Health Network](#)
- [Montana Health Network](#)
- [Ways2Wellness Connect](#)
- [Humboldt General Hospital District](#)
- [Tri-County Health Improvement Organization \(Tri-CHIO\)](#)
- [Northeast Oregon Network \(NEON\)](#)
- [Rural Wisconsin Health Cooperative \(RHWC\) Primary Care Outcomes Improvement Network](#)

HIT Infrastructure

- [Network for Improved Outcome in Rural Emergency Care](#)
- [Community Mental and Behavioral Health Cooperative](#)
- [Health Leadership Network](#)
- [Missouri Ozarks Rural Health Network](#)
- [Rural Mental Health Network](#)
- [Ways2Wellness Connect](#)
- [Northern County Value Based Payment Readiness Project](#)
- [Vermont Care Network Rural Health Network Development](#)

Integration of Patient Health Information

- [North Baldwin Rural Health Network \(NBRHN\)](#)
- [Community Mental and Behavioral Health Cooperative](#)
- [Southeast Georgia Rural Community Network; Meadows Regional Medical Center Care Coordination and Telemedicine Program](#)
- [Purchase Area Health Connections](#)
- [Aroostook County Health Network](#)
- [Bootheel Health Alliance](#)
- [Missouri Ozarks Rural Health Network](#)
- [Controlled Substance Management Network \(CSMN\)](#)
- [Amherst-Nelson Behavioral Health Network](#)
- [Vermont Care Network Rural Health Network Development](#)

Oral Health

- [South Georgia Regional Prevention Coalition Rural Health Network Development Initiative](#)
- [Mountain Health Alliance](#)

- [Missouri Ozarks Rural Health Network](#)

Population Health

- [Prince of Wales Health Network](#)
- [Network for Improved Outcome in Rural Emergency Care](#)
- [Health Leadership Network](#)
- [Nevada County Health Collaborative](#)
- [Community Care Alliance](#)
- [Tri-County Health Network](#)
- [Lake Okeechobee Community-Integrated Rural Health Network](#)
- [Southeast Georgia Rural Community Network; Meadows Regional Medical Center Care Coordination and Telemedicine Program](#)
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Quality Improvement (QI)

- [Health Leadership Network](#)
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- [Tri-County Health Improvement Organization \(Tri-CHIO\)](#)
- [Vermont Care Network Rural Health Network Development](#)
- [Rural Wisconsin Health Cooperative \(RHWC\) Primary Care Outcomes Improvement Network](#)

Quality Reporting

- [Community Care Alliance](#)
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- [Missouri Ozarks Rural Health Network](#)
- [Northern County Value Based Payment Readiness Project](#)
- [Northeast Oregon Network \(NEON\)](#)
- [Vermont Care Network Rural Health Network Development](#)
- [Rural Wisconsin Health Cooperative \(RHWC\) Primary Care Outcomes Improvement Network](#)

Recruitment and/or Retention

- [South Georgia Regional Prevention Coalition Rural Health Network Development Initiative](#)
- [Montana GME Network](#)
- [Partnering for Behavioral Health in Rural Northeast and Northcentral Nebraska](#)
- [Ways2Wellness Connect](#)

School Based Care Coordination

- [Community Mental and Behavioral Health Cooperative](#)
- [Tri-County Health Network](#)
- [South Georgia Regional Prevention Coalition Rural Health Network Development Initiative](#)
- [Missouri Ozarks Rural Health Network](#)
- [Strength in Peers](#)

Transitions of Care

- [North Baldwin Rural Health Network \(NBRHN\)](#)
- [Network for Improved Outcome in Rural Emergency Care](#)
- [Community Mental and Behavioral Health Cooperative](#)
- [Mendonoma Health Alliance \(MHA\)](#)
- [Nevada County Health Collaborative](#)
- [Tri-County Health Network](#)
- [Illinois Telehealth Network](#)
- [Integrated Primary Care/Behavioral Health Telehealth Project](#)
- [Purchase Area Health Connections](#)
- [Aroostook County Health Network](#)
- [Ely Behavioral Health Network](#)
- [Northern County Value Based Payment Readiness Project](#)
- [Upper Midlands Rural Health Network](#)

Other:

- [Prince of Wales Health Network](#): We aim to increase prevention activities for youth by developing a peer-driven leadership program to support and prevent youth in adversity and build resiliency. We also aim to increase knowledge island wide about ACE's.
- [Santa Cruz County Adolescent Wellness Network](#): Capacity Building, Youth Peer Community Health Workers
- [Nevada County Health Collaborative](#): Addressing social factors impacting health
- [Lake Okeechobee Community-Integrated Rural Health Network](#): Health Literacy and Patient Empowerment, Care Coordination, Resources and Referrals
- [Right Care, Right Place, Right Time](#): Pediatric Medical Home
- [Mountain Health Alliance](#): Practice transformation utilizing non-clinical extenders
- [Lac qui Parle Behavioral Health Network](#): Develop system efficiencies that lead to integrated behavioral health and primary care and shared cost savings in the Lac qui Parle Health Network (LqPHN) region. To reduce the stigma associated with seeking behavioral health wellness, prevention and treatment services and increase community awareness and understanding of behavioral health issues and resources available in the community.

- [Humboldt General Hospital District](#): Our evidence based activities to be expanded to new population service areas include Basic Life Support Obstetrics Course (BLSO®), Advanced Life Support Obstetrics Course (ALSO®), and Project ECHO (Extension for Community Healthcare Outcomes). New innovations involve modification of the Screening, Brief Intervention and Referral to Treatment Course (SBIRT) to address opioid dependence and development of new courses: (1) Basic Sports Safety Training Course (SSTC©), (2) Medical Flight Curriculum, and (3) Clinical Health Assessment and Promotion Program (CHaPP) for individuals with intellectual disabilities. To expand oversight of rural resident physicians in training and develop physician faculty at the rural sites, we will pilot virtual precepting of teaching encounters by primary care and specialty physicians. To investigate potential expansion of residency sites, we will engage in formalized assessment of critical access hospitals for educational and financial viability.
- [Coast to the Cascades Culinary Health Education and Fitness](#): Obesity
- [Northeast Oregon Network \(NEON\)](#): Service area geographic expansion and sustainable funding
- [South Carolina Behavioral Health Telehealth Network](#): Build telehealth network among behavioral health clinics
- [Rural Wisconsin Health Cooperative \(RHWC\) Primary Care Outcomes Improvement Network](#): Primary focus is MIPS compliance and quality improvement associated with diabetes and hypertension on care
- [Strength in Peers](#): Trauma-informed care awareness and policy development

GRANTEES' CONTACT INFORMATION

ALASKA

Prince of Wales Health Network
Southeast Alaska Regional Health Consortium (SEARHC)
Juneau, AK
www.searhc.org

Network Director:

Heidi Young
907-254-2904
info@powhealthnetwork.org

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Health Promotion Disease Prevention
- Population Health
- Other: We aim to increase prevention activities for youth by developing a peer-driven leadership program to support and prevent youth in adversity and build resiliency. We also aim to increase knowledge island wide about ACE's.

Grant Activities:

1) Establish and integrate youth leadership to lead and cultivate behavioral change relating to suicide, alcohol and substance abuse, domestic violence, and bullying; 2) Increase community awareness and support, and build resiliency in youth and families; and 3) Develop programming sustainability through the Network members.

Project Officer:

Michele Gibson
301-443-7320
mgibson@hrsa.gov

ALABAMA

North Baldwin Rural Health Network (NBRHN)

Gulf Health Hospitals, Inc.

Bay Minette, AL

Network Director:

Tracy McDowell

251-580-1776

tracy.mcdowell@infirmarhealth.org

Focus Area(s) of the Development Project:

- Chronic Disease Management
- Clinical Care Integration
- Community Based Care Coordination
- Health Care Access
- Health Promotion and Disease Prevention
- Integration of Patient Health Information
- Transitions of Care

Grant Activities:

To strengthen the rural healthcare system and improve upon the social determinants of health and health equity in rural Alabama through: Increasing the Network's Capacity as an Organization; Providing Targeted Healthcare Services to the Effectively Manage High-Risk Patients Using Best Practices; and to Strengthen the NBRHN's Position in its Service Area.

To achieve its strategic goals the NBRHN will expand upon its current infrastructure to allow for the expansion of service delivery using technology (health dashboard) and collaboration to provide needed educational and outreach to the rural communities we serve.

Project Officer:

Marcia Colburn

301-443-3261

mbolburn@hrsa.gov

ARIZONA (2)

Network for Improved Outcomes in Rural Emergency Care

Summit Healthcare Association

Show Low, AZ

www.summithealthcare.net

Network Director:

Kristi Iannucci

928-537-6397

kiannucci@summithealthcare.net

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Chronic Disease Management
- Clinical Based Care Coordination
- Community Based Care Coordination
- Health Care Access
- HIT infrastructure
- Population Health
- Transitions of Care

Grant Activities:

To provide the personnel, equipment, training, outreach, and supplies necessary to establish and implement a mature, sustainable network that employs Telemedicine (TM) to bridge EMS providers in the field with emergency department physicians, behavioral health professionals and Summit Healthcare medical staff. Enabling improved evaluation and management of critical patients by allowing EMS to provide more advanced care, both on-scene and en-route and enabling the healthcare facility to treat the patients immediately upon their arrival reducing delays in treatment. Establishing an EMS Treat & Refer program to alleviate unnecessary transports to the ED and connecting patients with the right level of care at the right time and in the right place. Expanding care coordination and remote patient monitoring efforts in partnership with EMS and identifying chronic patients who would benefit from follow-up care that focuses on self-management of their conditions to reduce repeat EMS calls and/or readmissions.

Project Officer:

Jayne Berube

301-443-4281

jberube@hrsa.gov

Santa Cruz County Adolescent Wellness Network
Mariposa Community Health Center, Inc.
Nogales, AZ
www.adolescentwellness.net

Network Director:

Cassalyn David
520-375-6050 x 1370
cdavid@mariposachc.net

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Clinical Care Integration
- Community-Based Services Integration
- Other: Capacity Building, Youth Peer Community Health Workers

Grant Activities:

Goal 1 – improve access to and the quality of behavioral health services for county adolescents as an integral part of overall health and wellness.
Goal 2 – increase the capacity of adolescents, parents, and teachers to promote resiliency, identify risk and utilize resources to promote and improve behavioral health.

Project Officer:

Jayne Berube
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CALIFORNIA (4)

Community Mental and Behavioral Health Cooperative

Barton Healthcare System

South Lake Tahoe, CA

www.bartonhealth.org

Network Director:

Michael Ward

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Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Clinical Based Care Coordination
- Clinical Care Integration
- Community Based Care Coordination
- Health Care Access
- HIT Infrastructure
- Integration of Patient Health Information
- School Based Care Coordination
- Transitions of Care

Grant Activities:

- (1) Develop, implement and refine uniform referral and data sharing protocols to improve coordination of primary, mental health and behavioral health services;
- (2) Design and develop a technology-assisted infrastructure for communicating with patients and across participating network providers and services;
- (3) Facilitate and support targeted training and navigation resources to bolster the skills and capacity of care coordinators currently employed by network organizations;
- (4) Provide expertise and framework to guide data capture and data analysis for quality improvement focused on mental health and behavioral health services and network coordination;
- (5) Strengthen the rural health care system as a whole by implementing evidence-based approaches to integrate primary and behavioral health services and mitigate provider shortages in greater South Lake Tahoe.

Project Officer:

Michele Gibson

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Health Leadership Network
Redwood Mednet, Inc.
Ukiah, CA
www.healthleadershipnetwork.org

Executive Director:

Susan Jen
707-279-8827
s.jen@mchsi.com

Focus Area(s) of the Development Project:

- Chronic Disease Management
- Community Based Care Coordination
- Health Promotion and Disease Prevention
- HIT Infrastructure
- Population Health
- Quality Improvement (QI)

Grant Activities:

(1) to utilize Health Information Exchange to implement a Population Health Management protocol based on results from the Staying Healthy Assessment. This continues to build on HLN efforts to work with partners on accessing real-time local health data to shape a Wellness Roadmap based on priority health needs and recommendations as a framework for collaboration in addressing our poor county health profile, and
(2) to work collaboratively to implement a Wellness Response protocol that puts in motion meaningful use of data exchange and coordinated services to reduce the frequency of 911 calls as healthcare in Lake County, California.

The Wellness Response Protocol is based on a community paramedics approach. We will link Emergency Responders with a Community Health Worker to conduct home visit follow-up to selected patients post-discharge from the ED. Local Emergency Responders have identified heart disease and Chronic Obstructive Pulmonary Disease as two main causes for repeat use of 911 as healthcare. The Protocol utilizes a set of screenings to address these conditions through blood pressure checks, tobacco use, Activities of Daily Living, as well as safety and behavioral health issues. The screening will identify priority needs and engage the coordinated services to address identified needs. The Protocol will close the communication gap between the EDs and Emergency Responders through shared data exchange and increase meaningful use of shared data among HLN members.

Project Officer:

Cassandra Phililps
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cphillips1@hrsa.gov

Mendonoma Health Alliance (MHA)
Redwood Coast Medical Services Inc. (RCMS)
Gualala, CA
www.mendonomahealth.org
www.rcms-healthcare.org

Network Director:

Bonnie Noble
707-884-9728
bonnie@mendonomahealth.org

Focus Area(s) of the Development Project:

- Chronic Disease Management
- Clinical Care Integration
- Community Based Care Coordination
- Health Care Access
- Health Promotion and Disease Prevention
- Transitions of Care

Grant Activities:

1. Integrate emergency medical services (EMS) in hospital settings;
2. Improve the quality and safety of health care by improving care transitions from the hospital to other settings and reducing hospital readmissions;
3. Improve coordination of services;
4. Implement telehealth services including remote monitoring, interactive telehealth services, store and forward telehealth, imaging services, and specialist and primary care consultation;
5. Implement Health IT activities including electronic transmission of patient care summaries, patient access to self-management tools, and a patient-centered HIE;
6. Expand access to outpatient specialty care services, such as cardiology; and
7. Address population health needs and social determinants of health in our community.

Project Officer:

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Nevada County Health Collaborative
Sierra Nevada Memorial Hospital Foundation Inc.
Grass Valley, CA
<https://supportsierranevada.org/>

Program Director:

Stephanie Kreiter
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Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Chronic Disease Management
- Clinical Based Care Coordination
- Clinical Care Integration
- Community Based Care Coordination
- Health Care Access
- Health Promotion and Disease Prevention
- Other: addressing social factors impacting health
- Population Health
- Transitions of Care

Grant Activities:

We believe that an expanded Care Transition Integration program and increased care management will be a dynamic influence in improving the health of our patients and improving the health of the system as a whole. The grant proposes a solution by increasing care coordinators in the hospital's emergency department for behavioral health, increasing coordination with the primary care providers, increasing telehealth access, increasing inter-agency referrals, increasing care transition intervention, and increasing chronic disease self-management.

Project Officer:

Cassandra Phillips
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COLORADO (2)

Community Care Alliance
Valley View Hospital Association
Glenwood Springs, CO
www.communitycarealliance.com

Project Director:

Marguerite Tuthill
970-986-3677
Marguerite.tuthill@communitycarealliance.com

Focus Area(s) of the Development Project:

- Alternative Payment Models
- Clinical Based Care Coordination
- Chronic Disease Management
- Population Health
- Quality Reporting
- Quality Improvement (QI)

Grant Activities:

1. Increase the quality and transparency of care provided by Network member organizations.
2. Improve the quality and safety of healthcare provided through the greater coordination of services provided by Network member organizations
3. Improve the health information technology capabilities and functionalities of Network member organizations
4. Transition the two MSSP ACOs from Track 1 (no risk) to Track +1 or Track 2 MSSP ACOs (assume risk).

Project Officer:

Jayne Berube
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Tri-County Health Network
Tri-County Health Network
Telluride, CO
www.tchnetwork.org

Network Director:

Lynn Borup
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lynn@telluridefoundation.org

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Clinical Based Care Coordination
- Health Care Access
- Population Health
- School Based Care Coordination
- Transitions of Care

Grant Activities:

Specific initiatives include:

- launching teletherapy services throughout the region,
- replicating peer support programs for those who have a loved one with a mental illness and those living with a mental illness,
- offering Mental Health First Aid and Youth Mental Health First Aid training workshops, training local organizations in trauma-informed care,
- piloting the Communities That Care framework to reduce and prevent youth substance use,
- improving coordination between Network members and non-traditional healthcare entities to address social determinants of health,
- and launching a new medical transportation service to offer on-demand rides to medical appointments and provide a new source of income for community members.

Project Officer:

Marcia Colburn
301-443-3261
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FLORIDA

Lake Okeechobee Community-Integrated Rural Health Network

Lake Okeechobee Rural Health Network Inc.

Palm Beach Garden, FL

www.lorhn.org

Network Director:

Andrea Stephenson-Royster

561-844-4220 x 2500

astephenson@hcsef.org

Focus Area(s) of the Development Project:

- Chronic Disease Management
- Health Care Access
- Other: Health Literacy and Patient Empowerment, Care Coordination, Resources and Referrals
- Population Health

Grant Activities:

1. Integrate the community health worker (CHW) model into rural communities that have significant health disparities.
2. Utilize the CHW to deliver programs and services throughout 4-county area.
3. Promote self-management for patients with chronic conditions using evidence-based programming.
4. Assist residents with enrollment in health insurance and prescription assistance programs.
5. Increase the health literacy of the priority populations through workshops that provide information, resources, and practical tools.
6. Work closely with patients that are considered high ER utilizers, those without a medical home, and those admitted with ambulatory sensitive conditions, to help them access care in more appropriate and less costly settings. Link these patients with other health and human services and supports.
7. Coordinate provider "network" meetings to increase inter-agency service referrals.

Project Officer:

Jayne Berube

301-443-4281

jberube@hrsa.gov

GEORGIA (2)

South Georgia Regional Prevention Coalition Rural Health Network Development Initiative

Bleckley County Board of Education, Inc.
Cochran,GA

Director:

Regina Smith
478-934-4300 x 3
regina_smith@bleckley.k12.ga.us

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Community Based Care Coordination
- Health Care Access
- Health Promotion and Disease Prevention
- Oral Health
- Quality Improvement (QI)
- Recruitment and/or Retention
- School Based Care Coordination

Grant Activities:

1. Integrate behavioral health in school-based primary care settings.
2. Integrate oral health in school-based primary care settings.
3. Create and implement the same clinical protocols that will assist in the improvement of the delivery of healthcare services for primary care and mental/behavioral health services.
4. Provide consumer assistance in enrolling for the local SBHC services and other community support services that will result in access to health care services.
5. Use telehealth services for specialty and primary care consultation and chronic disease care.
6. Develop and implement an effective sustainability plan for sustaining network related SBHC services.

Project Officer:

Jayne Berube
301-443-4281
jberube@hrsa.gov

Southeast Georgia Rural Community Network; Meadows Regional Medical Center Care Coordination and Telemedicine Program

Meadows Regional Medical Center, Inc.

Vidalia, GA

<http://www.meadowsregional.org>

Grant Program Director:

Susan McLendon

912-535-5555

smclendon@meadowsregional.org

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Clinical Based Care Coordination
- Health Care Access
- Health Promotion and Disease Prevention
- Integration of Patient Health Information
- Population Health

Grant Activities:

1. Strengthen local infrastructure within three health care organizations to implement coordinated care for patients in poor control of chronic diseases with a special focus on diabetes, hypertension, and CHF within the target region of Toombs, Tattnall, Montgomery, and Treutlen Counties of southeast Georgia.
2. Increase chronic disease care management through patient and health care provider education.
3. Decrease disease morbidity and improve general health status of patients enrolled in the care coordination program.

Focused activities to achieve the program goals will include, expanding a telemedicine program for access to endocrinology and other specialty consults, expansion of a specialty care network to help patients obtain dental, eye and foot care, as well as behavior health counseling, expansion of diabetes education and community programs, and one professional health conference offered through telehealth technology.

Project Officer:

Jayne Berube

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IOWA

Healthy Henry County Communities

Henry County Soldiers and Sailors Memorial Hospital

Mount Pleasant, IA

www.hchc.org

www.healthyhenrycounty.org

Network Director:

Kelly Carr

319-385-6523

carrk@hchc.org

Focus Area(s) of the Development Project:

- Chronic Disease Management
- Community Based Care Coordination
- Health Promotion and Disease Prevention

Grant Activities:

Develop a system to share information between network partners to better address social issues. Begin looking at service gaps in the mental health, dental, and transportation areas and identify innovative solutions. Ensure awareness of resources and services available to residents. Implement proven prevention strategies in four high-opportunity areas of CDC's 6/18 Initiative: reduce tobacco use, control high blood pressure, control asthma and control and prevent diabetes. Develop a community health worker program to help people manage chronic disease risk factors, expand access to tobacco cessation treatments, implement home-based asthma self-management education and self-measured blood pressure monitoring for home-use.

Project Officer:

Michele Gibson

301-443-7320

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ILLINOIS (2)

Illinois Telehealth Network

St. Francis Hospital Thrd Ord

Litchfield, IL

www.stfrancis-litchfield.org

Director:

David Mortimer

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David.mortimer@hshs.org

Focus Area(s) of the Development Project:

- Alternative Payment Models
- Behavioral/Mental Health
- Chronic Disease Management
- Clinical Care Integration
- Health Care Access
- Quality Improvement (QI)
- Transitions of Care

Grant Activities:

three telehealth Activities: to (1) expand current services; (2) develop new services; (3) support program sustainability

Project Officer:

Michele Gibson

301-443-7320

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Right Care, Right Place, Right Time

Katherine Shaw Bethea Hospital

Dixon, IL

www.ksbhospital.com

Project Director:

Drew Fenner

815-285-5450

dfenner@ksbhospital.com

Focus Area(s) of the Development Project:

- Clinical Based Care Coordination
- Other: Pediatric Medical Home

Grant Activities:

- 1.) Establish a certified Patient Centered Medical Home (PCMH) model within the pediatric practice of KSB and include the hiring of a Pediatric Care Coordinator;
- 2.) Develop an Electronic Health Record for use by KSB pediatricians and the team of care providers;
- 3.) Co-locate pediatricians with the team of care providers including behavioral and developmental practices. An identified outcome of this project during year 3 is the creation of a Health Information Exchange that will enhance the self-management of chronic conditions being exhibited by children.

Project Officer:

Michele Gibson

301-443-7320

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INDIANA

ASPIN Health Improvement Program 2.0

Affiliated Service Providers of Indiana Inc.

Indianapolis, IN

<http://www.aspin.org>

Project Director:

Kathy Cook

317-471-1890

kcook@aspin.org

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Chronic Disease Management
- Clinical Care Integration

Grant Activities:

Goal #1: Integrate primary care into behavioral health care by training CHWs on chronic disease management.

Goal #2: To ensure that persons in rural communities served by ASPIN providers have health insurance coverage by providing ongoing navigator certification and CEUs.

Goal #3: Implement a diabetes self-management skills program and support groups in the networks behavioral health centers.

Project Officer:

Jayne Berube

301-443-4281

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KENTUCKY (4)

Appalachian Kentucky Health Care Access Network Community Health Worker

Montgomery County Health Department
Mount Sterling, KY

Project Director:

Gina Brien
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ginaL.brien@ky.gov

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Chronic Disease management
- Health Care Access
- Health Promotion and Disease Prevention
- Population Health

Grant Activities:

AKHCAN, with RHNDP funding, will expand its work to include all areas of rural Kentucky, most of which are health professional shortage areas, and/or designated as medically underserved community/population. It will support a statewide association of CHWs and will utilize data and evaluation, alongside targeted marketing strategies, to promote effective utilization of CHWs in a wide variety of settings, including, FQHCs; health departments, hospitals, emergency departments; social service agencies and more. Finally, AKHCAN will develop a CHW technical assistance center for CHWs, those who employ CHWs including the provision of a formalized CHW training program.

Project Officer:

Marcia Colburn
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Integrated Primary Care/Behavioral Health Telehealth Project
Mercy Health Partners of Southwest Ohio
Irvine, KY
www.marcumandwallace.org

Network Director:

John Isfort
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Focus Area(s) of the Development Project:

- Alternative Payment Models
- Behavioral/Mental Health
- Clinical Based Care Coordination
- Clinical Care Integration
- Health Care Access
- Population Health
- Quality Improvement (QI)
- Transitions of Care

Grant Activities:

The Project HOME Network will be able to implement a patient-centered, integrated approach across local health settings that facilitates community access to quality and affordable behavioral health services. With the principal aim of supporting access to mental health services as a routine part of primary care, the Project HOME Network will integrate behavioral health care within medical settings through the co-location of mental health services, which are to be provided by locally-based behavioral health consultants either in person or via telehealth. Funding will support the initial integration of behavioral health consultants within interdisciplinary care teams and the establishment of a local telehealth infrastructure that will support increased efficiencies in the use of area mental health resources and support an expansion in the workforce capacity of the region.

Project Officer:

Megan Lincoln
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Northeast Kentucky Regional Health Information Organization (NeKy RHIO)

Northeast Kentucky Regional Health Information Organization

West Liberty, KY

www.nekyrhio.org

Executive Director:

Andrew Bledsoe

606-824-0484

a.bledsoe@nekyrhio.org

Focus Area(s) of the Development Project:

- Quality Improvement (QI)
- Quality Reporting

Grant Activities:

NeKY RHIO is applying for the Rural Health Network Development program in order to provide training and technical assistance to Rural Health Clinics (RHCs) across the state of Kentucky to prepare them for payment reform. For this program we will partner with the Kentucky Primary Care Association and Kentucky Office of Rural Health. Our interventions will be targeted to an RHC's level of need and will be focused on preparing RHCs for value-based payment models.

~ Improving performance on quality measures for clinicians as through the Physician Quality Reporting System or the Medicare Quality Payment Program, as well as for hospitals, skilled nursing facilities, home health agencies and/or ambulatory surgical facilities.

~ Implementing Health IT and Meaningful Use (MU) activities that may include e-prescribing and incorporating lab results into a Health Information Exchange (HIE), electronic transmission of patient care summaries, patient access to self-management tools, and patient-centered HIE.

~ Leveraging competitive negotiations and contract with Qualified Health Plans through Essential Community Provider collaboration

Project Officer:

Jayne Berube

301-443-4281

jberube@hrsa.gov

Purchase Area Health Connections
Purchase District Health Department, Inc.
Paducah, KY
<http://www.purchasehealth.org>

Network Director:

Larrissa Roach
270-444-9625 x 112
larrissad.roach@ky.gov

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Chronic Disease Management
- Clinical Care Integration
- Community Based Care Coordination
- Health Care Access
- Health Promotion and Disease Prevention
- Integration of Patient Health Information
- Population Health
- Quality Improvement (QI)
- Quality Reporting
- Transitions of Care

Grant Activities:

PAHC will train Community Health Workers (CHWs) to collaborate with member hospitals to meet with patients about to be discharged to home. Following best practices and evidence-based models, the CHWs will engage the patients in a series of follow up in-home visits and phone calls 30-90 days following discharge. These visits and calls will assist and empower recently discharged patients to better understand and take ownership of their health once they return home. Network members will design the program, test it with a pilot group, refine it accordingly, and then test it with all three PAHC member hospitals. PAHC will collect data on the program's success at reducing readmissions, especially among those patients at the highest risk of readmission. This approach will improve Network member collaboration while strategically addressing some of the social determinants of health faced by area residents.

Project Officer:

Jayne Berube
301-443-4281
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MARYLAND

Mountain Health Alliance

Western Maryland Area Health Education Center
Cumberland, MD

Project Director:

Susan Stewart

301-777-9150

susan.stewart@ahecwest.org

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Chronic Disease Management
- Oral Health
- Other: practice transformation utilizing non-clinical extenders
- Population Health

Grant Activities:

1. By June, 2017, begin disseminating knowledge of the established and evolving evidence for new models of healthcare that lead to better population health outcomes, to culminate in a regional practice transformation and needs-assessment summit conducted by the end of year one.
2. By August, 2017, begin training or coordinate training of nonclinical extenders identified by current MHA members: Community Health Workers, Peer Recovery Specialists (addictions and behavioral health), Healthcare Insurance Enrollment Assistants, and Community Dental Health Coordinators.
3. By May, 2018, facilitate transformation of healthcare delivery into a patient-centered, community inclusive medical model through meaningful integration of non-clinical extenders as part of the healthcare team as identified in the summit, to continue throughout the grant period.
4. By August, 2018, begin analyzing data of cost savings and health outcomes as it relates to non-clinical extenders, and continuing throughout the project, with a summative report detailing project findings to be included in the project evaluation.

Project Officer:

Jayne Berube

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MAINE (2)

Aroostook County Health Network

Pines Health Services

Caribou, ME

www.pineshealth.org

Network Director:

Amy Kane

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Focus Area(s) of the Development Project:

- Clinical Based Care Coordination
- Community Based Care Coordination
- Health Care Access
- Integration of Patient Health Information
- Transitions of Care

Grant Activities:

- a) Establishment of a county-wide platform for a streamlined system of care coordination;
- b) continuity of care for residents discharged from hospitals;
- c) reduced ambulatory care sensitive condition and hospital readmission rates;
- d) implementation of County-wide social health determinants scale;
- e) increased enrollment in health insurance and social service programs; and
- f) improve care coordination for children and families participating in Let's Go, a nationally recognized program focused on early childhood weight and health.

Project Officer:

Megan Lincoln

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Northern New England ECHO-CARES HUB
Maine Quality Counts
Manchester,ME

Network Director:

Lisat Tuttle
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Focus Area(s) of the Development Project:

- Alternative Payment Models
- Behavioral/Mental Health
- Chronic Disease Management
- Clinical Based Care Coordination
- Clinical Care Integration
- Community Based Care Coordination
- Health Care Access
- Health Promotion and Disease Prevention

Grant Activities:

Project ECHO (Extension for Community Healthcare Outcomes) is an evidence-based method developed by researchers at the University of New Mexico that virtually links specialist teams with primary care practices to help primary care providers improve their ability to manage complex conditions. The Project ECHO Northern New England Network Hub will offer one or more ECHO sessions per year for rural primary care practice teams throughout the tri-state region to help improve patient care and outcomes for complex conditions that present particular challenges to patients and providers in the region. Project ECHO Northern New England ECHO Network will also expand the traditional ECHO model to engage community partners working with primary care teams to address social determinants of health and reach 'beyond the clinic walls' to further enhance primary care capacity in our rural clinics.

(1) offer ECHO sessions for a range of complex conditions to rural primary care practice teams across the region, (2) and offer technical assistance and support to other organizations across the region that would like to offer their own ECHO sessions to rural providers. The goals of the project are to improve the quality of care for complex conditions for practices and patients in HRSA-designated rural areas of the tri-state region by offering specialty support to primary care clinicians and practice teams through the ECHO model.

Project Officer:

Megan Lincoln
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milcoln@hrsa.gov

MINNESOTA (3)

Ely Behavioral Health Network

Well Being Development

Ely, MN

www.wellbeingdevelopment.org

Network Director:

Jennifer Uhrich Swanson

218-576-5756

jennyu@elynlc.org

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Community Based Care Coordination
- Health Care Access
- Transitions of Care

Grant Activities:

- 1) to enable the region to embrace mental health as an integral part of health and wellness;
 - 2) to implement a cross-agency system for screening, referral, interventions, and follow-up for behavioral health issues;
 - 3) to increase access to behavioral health services by building organizational capacity; and
 - 4) to sustain an actively involved and engaged network to plan collaborative behavioral health services for the region.
- Strategies employed include: the behavioral health network, stigma reduction campaign, and care coordination using the hub and spoke model, development of evidence based strategies such as tele-mental health, a pain education group, and recovery programs.

Project Officer:

Marcia Colburn

301-443-3261

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Lac qui Parle Behavioral Health Network Lac qui Parle Health Network Hospital Services Cooperative

Madison, MN

<http://www.lqphnmn.org>

Network Director:

Bernice Robinson

320-698-7199 x 7100

brobinson@lqphnmn.org

Focus Area(s) of the Development Project:

- Alternative Payment Models
- Behavioral/Mental Health
- Clinical Based Care Coordination
- Clinical Care Integration
- Health Care Access
- Health Promotion and Disease Prevention
- Population Health
- Other:
 - Develop system efficiencies that lead to integrated behavioral health and primary care and shared cost savings in the Lac qui Parle Health Network (LqPHN) region.
 - To reduce the stigma associated with seeking behavioral health wellness, prevention and treatment services and increase community awareness and understanding of behavioral health issues and resources available in the community

Grant Activities:

- Develop consistent and streamlined system for screening for behavioral health issues in the primary care setting.
- Develop shared clinical flow chart and action plan for care team to ensure consistent integration of behavioral health and primary care.
- Develop a steering committee to lead the project and allow input from all collaborative care team members.
- Develop infrastructure for health information exchange between providers including shared release of information.
- Provide regularly occurring continuing education for providers that support the integration of evidence based practices and intervention methods in the primary care setting.
- Utilization of electronic health information at point of care.

Project Officer:

Cassandra Phillips

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cphillips1@hrsa.gov

Sanford One Connect Behavioral Health
Sanford Health of Northern Minnesota
Bemidji, MN
<http://www.sanfordhealth.org/bemidji>

Network Director:

Susan Berry
605-312-4162
susan.berry@sanfordhealth.org

Focus Area(s) of the Development Project:

- Behavioral/Mental Health

Grant Activities:

In the first year, the project will focus on the emergent needs for behavioral health services in rural Minnesota, South Dakota and North Dakota communities. Also, in Phase One the project team will begin to expand tele-behavioral health services from the emergency department to the final disposition or placement of the patient. After the first year of the grant period and the successful implementation of tele-behavioral health in 15 sites emergency departments, the project team will begin expansion into the remaining sites. In year three, the project team will continue evaluation of tele-behavioral health services from emergent need to final disposition. The team will begin to address other behavioral health needs, such as placement services and referrals.

Project Officer:

Cassandra Phillips
301-945-3940
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MISSOURI (3)

Bootheel Health Alliance

Missouri Bootheel Regional Consortium, Inc.

Sikeston, MO

www.mbrcinc.org

Network Director:

Tiffany Pulley

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tpulley@mbrcinc.org

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Chronic Disease Management
- Community Based Care Coordination
- Health Promotion and Disease Prevention
- Integration of Patient Health Information

Grant Activities:

Activities will include the use the health education community health workers, the Power to Prevent® curriculum and case management. The Power to Prevent ® principles will be implanted in both one-on-one settings as well as in group setting in the community. Health education will be provided by CHW in clinical setting to increase medical compliance, overcome social determinants of health and improve quality of care. In addition, we will provide depression screen and follow-up services.

Project Officer:

Megan Lincoln

301-443-2702

milncoln@hrsa.gov

Missouri Ozarks Rural Health Network
Douglas County Public Health Services Group Inc.
Ava, MO

Network/Project Director:

Becky Gann
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regann@mo-ozarks.org

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Chronic Disease Management
- Clinical Based Care Coordination
- Clinical Care Integration
- Health Care Access
- Health Promotion and Disease Prevention
- HIT Infrastructure
- Integration of Patient Health Information
- Oral Health
- Population Health
- Quality Improvement (QI)
- Quality reporting
- School Based Care Coordination

Grant Activities:

Our project, which is known as Great EXPECTations, is a pregnancy medical health model, built on the foundational elements of the Our Healthy Start program, with components of OB Nest incorporated. Through the Network, we will provide a full spectrum of services for women. Women’s health physicians/practitioners will provide quality care in a patient-centered environment. Services include targeted outreach, care management, integrated primary care, oral health and behavioral health services, linkage to social services, home visits and connection to post-natal (and pediatric) care before delivery. Great EXPECTations (pregnancy medical home model) will provide early access to prenatal services, improve birth outcomes and lower overall medical costs. The scope includes all prenatal patients touched by our health center in any one of our five clinic locations.

Project Officer:

Jayne Berube
301-443-4281
jberube@hrsa.gov

Rural Mental Health Network
Randolph County Caring Community Inc.
Moberly, MO
<http://rccaringcomm.org>

Network Director:

Brian Williams
660-263-7173
caringcomm@rcccpmo.org

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Community Based Care Coordination
- Health Care Access
- Health Promotion and Disease Prevention
- HIT Infrastructure
- Population Health
- Quality Improvement (QI)

Grant Activities:

The focus of the Solutions project is to expand the membership base of the existing Rural Mental Health Network, which consists of partners that represent mental health, behavioral health, primary care, and social services, in order to provide increased availability and access to coordinated and integrated healthcare. The Solutions project will implement a Care Coordination model supported by a strong network of providers and a cadre of Community Health Workers working within the targeted rural communities. A technology platform provided through the Community Connections MO (Missouri) web-based health information system will be utilized to collect and track data for the Solutions project. Expected and measurable objectives will focus on increased availability and accessibility of coordinated and implemented services.

Based upon these identified gaps and needs, a Mental Health Transformation Plan, was developed, which will have informed the implementation strategy for the a Care Coordination model, supported by strong network infrastructure, providers, resources, expanded role of the RMHN within the targeted rural communities, and a cadre of trained Community Health Workers who will assist clients with navigation of the complex aspects of co-occurring disorders and chronic disease management.

Project Officer:

Jayne Berube
301-443-4281
jberube@hrsa.gov

MISSISSIPPI

Deer Creek Behavioral Health Network

Delta Health Alliance, Inc.

Stoneville, MS

<http://www.deltahealthalliance.org>

Network Director:

Anthony Wood

662-686-7004

awood@deltahealthalliance.org

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Chronic Disease Management
- Clinical Based Care Coordination
- Health Care Access
- Population Health

Grant Activities:

The Deer Creek Behavioral Health Network seeks to utilize and build upon a pre-existing evidence-based Patient Centered Medical Home model in order to address depression and mental illness on rates of diabetes in a rural population that is overwhelmingly African American and living in poverty in the Mississippi Delta. This collaborative endeavor has two specific aims: 1) To establish a system to help patients and clinicians make better informed health decisions about how to treat and manage chronically ill patients with comorbid mental health conditions, and 2) To improve chronic illness outcomes by engaging patients in selecting specific behavioral health services with regular primary care.

Assessments at baseline and 3, 6, 12, 18, 24 and 30 months of care will examine the program's impact on depression measures, patient perceptions regarding wellness levels, glycemic control, blood pressure, and hospitalizations, designed to assess each patient's improvements as they relate to treatment options for their behavioral health and chronic diseases.

Project Officer:

Jayne Berube

301-443-4281

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MONTANA (3)

Montana GME Network

Montana State University Inc.

Bozeman, MT

<http://healthinfo.montana.edu>

Network Director:

Cindra Stahl

406-994-6499

Cindra.stahl@montana.edu

Focus Area(s) of the Development Project:

- Health Care Access
- Recruitment and/or Retention

Grant Activities:

~ Provide training to rural hospitals and clinics on the strategies and procedures for participating in rural primary care education and developing a culture of learning in their facilities.

~ The Network will engage community members from 6 communities per year in understanding and supporting medical residents, medical students and health professions students.

~ The Network will facilitate the process to develop community capacity for medical education with four rural and frontier communities per year that have high potential for affiliating with one of the MT GME Network residencies.

~ Develop financial and operational models that support growth and efficiency in the graduate medical education system in Montana.

~ Provide technical assistance to cohort facilities and communities to determine the financial models that would support participation in rural rotations and GME.

~ Provide technical assistance to cohort communities and facilities to develop operational models that include coordination and efficiencies.

~ Utilize primary care workforce analysis to assess and plan for meeting the primary care provider needs in Montana.

Project Officer:

Cassandra Phillips

301-945-3940

cphillips1@hrsa.gov

Montana Health Network
Rural Health Development, Inc.
Miles City, MT
www.montanahealthnetwork.com

VP Strategy and Development

Christopher Hopkins
406-234-1420
chopkins@montanthealthnetwork.com

Focus Area(s) of the Development Project:

- Chronic Disease Management
- Health Promotion and Disease Prevention

Grant Activities:

1. Improving performance on quality measures for clinicians such as through Physician Quality Reporting System (PQRS) or the Medicare Quality Payment Program (MQPP), for hospitals, skilled nursing facilities, rural health clinics and home health.
2. Improving the quality and safety of health care by improving care transitions from the hospital to other settings.
3. Improving the coordination of services
4. Implementing telehealth services that will include home monitoring and the use of tele-video for the delivery of patient and provider education and administrative support.
5. Implementing Health IT and Meaningful Use (MU) activities that include the electronic transmission of patient care summaries and patient access to self management tools.
6. Implementing innovative alternative payment and delivery models.
7. Implementing programs to increase primary care work force in rural areas.
8. EM3C will establish a care coordination model to deliver improved outcomes to deeply frontier patients with chronic health conditions. The program will initially apply documented and accepted clinical protocols to diabetes patients recently diagnosed and those struggling with self-management. The project will also include diabetes patients identified to have one or more co-morbidities like cardiovascular disease and COPD. A remote patient monitoring (RPM) model will be developed to support those eligible patients at higher risk for Emergency Department visits and hospitalization.

Project Officer:

Jayne Berube
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Northcentral Montana Hospital (NMHA) Enhancing Behavioral
Healthcare Access through Technology
Central Montana Medical Facilities Inc.
Lewistown, MT

Grant Administrator

Doris Barta
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Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Clinical Based Care Coordination
- Clinical Care Integration
- Health Care Access
- Population Health

Grant Activities:

Through collaboration among NMHA Network members, we will develop a strategy for Integrating Behavioral Healthcare Services in the Primary Care setting in rural Montana, using a Collaborative Care Model of integrated care that includes incorporating telehealth technology as a means to increase timely behavioral health access to underserved communities. The model we have chosen is the University of Washington's Best Practices Model of Integrated Care: Leveraging psychiatric consultation to provide more access to effective mental health care. Additionally the needs identified in planning meetings among Network members for this grant application included educating primary care physicians on how to assess behavioral health needs in patients presenting with physical health needs, how to train professionals in their home environments who can identify, assess and recommend treatment options, developing a crisis line 24/7 to help those in the field dealing with an urgent/emergent situation and developing a community based Mental Health First Aid Training Program that will help identify people in the community who need help and refer them to primary care before they present in the Emergency Room (ER).

Project Officer:

Jayne Berube
301-443-4281
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NEBRASKA (2)

Mercy Health Network-Siouxland's Tele-behavioral Health Program

Oakland Mercy Hospital Foundation

Oakland, NE

www.oaklandhospital.org

Network Director:

Rob Stowe

712-279-2137

rob.stowe@mercyhealth.com

Focus Area(s) of the Development Project:

- Behavioral/Mental Health

Grant Activities:

To bring behavioral health services to our primary care clinics via telehealth. The network will work together to: develop standardized protocols and processes across hospitals and clinics; define the role of local staff members in behavioral health service provision; coordinate vendor contracting for installation of required equipment and service provision; and community outreach to identify additional service gaps which the service could potentially fill. In addition, we will collaborate on data collection and analysis, project evaluation, and sustainability planning, to monitor and ensure success of this grant-funded initiative.

Project Officer:

Michele Gibson

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Partnering for Behavioral Health in Rural Northeast and North-Central Nebraska

Northern Nebraska Area Health Education Center, Inc.
Norfolk, NE

Network Director:

Jon Bailey
402-844-7928
jonmbailey1@gmail.com

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Recruitment and/or Retention

Grant Activities:

1. Create and implement an online Centralized Placement System (CPS) for behavioral health/mental health professionals in the region.
2. Collaborate with 4-5 communities in the region on community supports for behavioral health/mental health professionals.
3. Collaborate with 4-5 communities in the region on housing projects.
4. Create a financial aid program in the region for behavioral health/mental health professionals.
5. Cultivate connections between NeNEBHN and its stakeholders.
6. Establish and implement a community and stakeholder outreach project.
7. Establish and implement a communications project.
8. Assess and evaluate NeNEBHN and its activities to inform planning and document results and actions to adapt NeNEBHN to ensure its ongoing effectiveness.

Project Officer:

Marcia Colburn
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NEW HAMPSHIRE (2)

Controlled Substance Management Network (CSMN)

Cheshire Medical Center

Keene, NH

www.cheshire-med.com

CSMN Director:

Polly Morris

603-354-5454 ext. 2118

pmorris@cheshire-med.com

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Chronic Disease Management
- Clinical Care Integration
- Community Based Care Coordination
- Health Care Access
- Integration of Patient Health Information
- Population Health

Grant Activities:

The activity we will focus on is the integration of behavioral health into a primary care setting through a focus on optimal CS prescribing and management including the implementation of a shared care coordination software solution to link Network Partners and Regional Collaborators.

Project Officer:

Marcia Colburn

301-443-3261

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Ways2Wellness Connect
North Country Health Consortium
Littleton, NH
www.nchcnh.org

Network Leader:

Nancy Frank
603-259-3700 x 223
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Focus Area(s) of the Development Project:

- Chronic Disease Management
- Clinical Based Care Coordination
- Community Based Care Coordination
- Health Care Access
- Health Promotion and Disease Prevention
- HIT Infrastructure
- Population Health
- Quality Improvement (QI)
- Recruitment and/or Retention

Grant Activities:

The Ways2Wellness CONNECT model will train Community Health Workers to serve as intermediaries between traditional health care providers and those in the target population who will benefit from a coordinated care management plan. In addition, the Ways2Wellness CONNECT model will be integrated into the third-year community clinical program for University of New England College of Osteopathic Medicine. This component of the model will introduce students to the concept of patient engagement and chronic disease management.

Project Officer:

Jayne Berube
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jberube@hrsa.gov

NEVADA (2)

Humboldt General Hospital District

Humboldt General Hospital District

Winnemucca, NV

www.humboldthospital.org

Project Director:

Elissa Palmer MD

702-992-6888

elissa.palmer@unlv.edu

Focus Area(s) of the Development Project:

- Health promotion and Disease Prevention
- Other: Our evidence based activities to be expanded to new population service areas include Basic Life Support Obstetrics Course (BLSO®), Advanced Life Support Obstetrics Course (ALSO®), and Project ECHO (Extension for Community Healthcare Outcomes). New innovations involve modification of the Screening, Brief Intervention and Referral to Treatment Course (SBIRT) to address opioid dependence and development of new courses: (1) Basic Sports Safety Training Course (SSTC©), (2) Medical Flight Curriculum, and (3) Clinical Health Assessment and Promotion Program (CHaPP) for individuals with intellectual disabilities. To expand oversight of rural resident physicians in training and develop physician faculty at the rural sites, we will pilot virtual precepting of teaching encounters by primary care and specialty physicians. To investigate potential expansion of residency sites, we will engage in formalized assessment of critical access hospitals for educational and financial viability.

Grant Activities:

Topics/Activities to be expanded to new population service areas in this project include: the Basic Life Support Obstetrics Course (BLSO®), the Advanced Life Support Obstetrics Course (ALSO®), and Project ECHO (Extension for Community Healthcare Outcomes).

A) Implementation of Evidence Based National Courses

1. TeamSteps® Primary Care Curriculum Training
2. SBIRT (Screening, Brief Intervention and Referral to Treatment) Course

B) Development and Implementation of Innovative New Curricula

1. Basic Sports Safety Training Course (SSTC©)
2. Medical Flight Curriculum
3. Clinical Health Assessment and Promotion Program (CHaPP)

C) Enhancement of Rural Track Residency Education and Access to Care for Patients

1. Virtual Precepting
2. Assessment of Critical Access Hospitals as Potential Residency Sites

Project Officer:

Marcia Colburn

301-443-3261

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NRHP Population Health Management Program

White Pine County Hospital District

Ely, NV

www.nrhp.org

Network Director:

Matt Walker

775-289-3001 x 222

mwalker@wbrhely.org

Focus Area(s) of the Development Project:

- Population Health

Grant Activities:

This proposal plans to integrate Emergency Medical Services within the hospital outpatient settings of primary care, post-acute care, and chronic care management by (1) implementing a community paramedicine program with a shared population health management platform; (2) promoting wellness and population health within the communities; and (3) conducting a statistical and financial analysis of population health management within a value-based payment reform model.

Project Officer:

Marcia Colburn

301-443-3261

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NEW YORK

NORTHERN COUNTY VALUE BASED PAYMENT READINESS PROJECT

Northern New York Rural Behavioral Health Institute

Saraanac Lake, NY

<http://www.behavioralhealthnet.org>

Network Contact:

Barry Brogan

518-891-9460

barry@behavioralhealthnet.org

Focus Area(s) of the Development Project:

- Alternative Payment Models
- Behavioral/Mental Health
- Clinical Care Integration
- HIT Infrastructure
- Quality Improvement (QI)
- Quality Reporting
- Transitions of Care

Grant Activities:

- 1) Improving the quality and safety of health care by improving care transitions from the hospital to other settings and reducing hospital readmissions
- 2) Improving coordination of services
- 3) Leveraging competitive negotiations and contracts with Qualified Health Plans (QHPs) through Essential Community Provider (ECP) collaboration
- 4) Implementing innovative alternative payment and delivery models

Project network name revised in February 2018 from Northern County Shared Services Development Project Phase 2.0. The goal of this project is to move 12 or more rural behavioral health providers toward Medicaid managed care value based payment readiness. The primary focus is to develop enhanced data capacity among these agencies including development of common quality metrics to track population health trends and clinical best practices, to support the coordinated and integrated delivery of mental health, substance abuse treatment and prevention services. Access to data warehouse services and high value quality and operational analytics will be developed. The NNYRBHI will also seek to develop a number of shared administrative services among network members to include a potential Independent Provider Association, (IPA) marketing, IT support services, HR, and managed care negotiation technical support. Our project will partner with other available health system reform funding available through New York State.

Project Officer:

Jayne Berube

301-443-4281

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OKLAHOMA (2)

Tele-Behavioral Health Integration

Rural Health Network of Oklahoma Inc.

Hugo, OK

<http://www.rhnofoklahoma.org>

Network Director:

Stacie Pace

580-372-0966

stacie@rhnofoklahoma.org

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Clinical Based Care Coordination

Grant Activities:

The project will continue to build the network and promote member sustainability through the addition of clinical behavioral health services integrated into primary care. This goal and its objectives will be achieved by: expanding services to include the Health Access Network through Oklahoma State University; increasing access to behavioral health services via telehealth provided by a licensed psychiatrist; utilization of robust health analytics provided by a Health Information Exchange; improving patient health status through integrated health care services in the primary care setting; and deployment of a community health worker to help patients access community resources.

Project Officer:

Marcia Colburn

301-443-3261

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Tri-County Health Improvement Organization (Tri-CHIO)
Rural Health Project Inc.
Enid, OK

Project Director:

Allison Seigars
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agseigars@nwsu.edu

Focus Area(s) of the Development Project:

- Chronic Disease Management
- Community Based Care Coordination
- Health Care Access
- Health Promotion and Disease Prevention
- Population Health
- Quality Improvement (QI)

Grant Activities:

1. Establish an evidence-based chronic disease management program available to persons across the target area;
2. Communicate program details to primary care providers and provide academic detailing and practice facilitation to them in order to provide a system for clinical referrals to the chronic disease management programming;
3. Assist rural-based providers with educational needs regarding current clinical best practice guidelines for patients with chronic diseases or at risk of developing chronic diseases through academic detailing, performance evaluation and feedback through practice facilitation, and email connections to chronic disease experts to answer specific questions that arise;
4. Develop chronic disease resources for clinicians and patients in the three county target area;
5. Establish a feedback loop with primary care providers to evaluate program outcomes and conduct ongoing program evaluation, and
6. Prepare for sustainability of the Chronic Disease Management Outreach Program by disseminating program information and securing ongoing funding.

Project Officer:

Marcia Colburn
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mbolburn@hrsa.gov

OREGON (2)

Coast to the Cascades Culinary Health Education and Fitness (CHEF) Project

Mid-Valley Healthcare Inc.
Lebanon, OR

Network Director:

JoAnn Miller
541-768-7330
jomiller@samhealth.org

Focus Area(s) of the Development Project:

- Chronic Disease Management
- Other: obesity

Grant Activities:

Through a two-prong approach, the CHEF Project will: 1) provide 77 nutrition-focused culinary education courses and 2) expand the evidence-based Coordinated Approach to Child Health (CATCH) program to 11 new schools. The six-week culinary education courses, with individual curricula designed specifically for elementary school children, middle school children, and families, will provide experiential nutrition-focused culinary education to over 1,500 children and families. The CATCH program is a comprehensive physical activity and nutrition education program that teaches children the importance of healthy eating and physical activity to improve overall health.

Project Officer:

Marcia Colburn
301-443-3261
mbolburn@hrsa.gov

Northeast Oregon Network (NEON)

Northeast Oregon Network

La Grande, OR

www.neonoregon.org

Network Director:

Eric Griffith

541-910-4986

egriffith@neonoregon.org

Focus Area(s) of the Development Project:

- Alternative Payment Models
- Chronic Disease Management
- Clinical Based Care Coordination
- Community Based Care Coordination
- Health Care Access
- Health Promotion and Disease Prevention
- Other: Service area geographic expansion and sustainable funding
- Quality Reporting

Grant Activities:

- ~ Increase the geographic areas and target populations served by Network Activities by adding two new counties and serving Migrant/Seasonal Farmworker and Native American Tribal Populations as well as low income populations;
- ~ Increase access to and impact of Care Coordination Services through the use of a standardized evidence based care coordination best practice that also includes addressing social determinant of health needs;
- ~ Realign financial incentives for care coordination towards a payment for outcome model;
- ~ Improve patient and population health outcomes for cardiac and diabetic indicators; and
- ~ Achieve ongoing non-grant sustainability of the Pathways Community Hub Program.

NEON currently operates a Hub in the Union, Baker and Wallowa Counties, but finds that in order to become large enough to be fully sustainable with insurers, will need to expand to additional neighboring counties and populations in need.

Project Officer:

Jayne Berube

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SOUTH CAROLINA (2)

South Carolina Behavioral Health Telehealth Network

Palmetto Care Connections

Bamberg, SC

www.palmettocareconnections.org

Network Director:

Kathy Schwarting

803-245-2672

kathys@palmettocareconnections.org

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Other: build telehealth network among behavioral health clinics

Grant Activities:

This project will expand an existing telehealth network through: 1) linking substance abuse and behavioral health providers in 23 South Carolina counties with primary care providers; 2) creating universal policies, procedures, and workflows for integrating behavioral health and primary care services via telehealth; 3) creating a centralized scheduling system for network members; 4) providing training to providers on best practices on telehealth and tele presenting; 5) connecting members and participating sites to a health information exchange; and 6) supporting network members in their current efforts to improve school based health centers through the previous activities.

Project Officer:

Jayne Berube

301-443-4281

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Upper Midlands Rural Health Network
Mid-Carolina Area Health Education Consortium, Inc.
Lancaster, SC

Network Director:

Karen Nichols
803-377-8026
knichols@umrhn.org

Focus Area(s) of the Development Project:

- Chronic Disease Management
- Transitions of Care

Grant Activities:

The Care Transition Intervention® (CTI®) program is an evidence based model developed by Dr. Eric A. Coleman, MD, MPH and was introduced at Springs Memorial Hospital in June 2016 by UMRHN. The current project will expand the program by 1) teaching the Transition Coach® how to engage the caregivers through the Advanced CTI® training, 2) involving the providers and future medical professionals with the CTI® components, 3) expanding the program to the Emergency Department, 4) connecting the patients to existing social service agencies in the community, and 5) ensuring the program meets the CMS requirements for Transitional Care or Chronic Care Management for future sustainability.

Project Officer:

Marcia Colburn
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VIRGINIA

Amherst-Nelson Behavioral Health Network

Blue Ridge Medical Center Inc.

Arrington, VA

Network Director:

Stephanie Martin

431-841-3966

smartin@brmedical.com

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Clinical Care Integration
- Integration of Patient Health Information

Grant Activities:

a) improve integration of behavioral health and primary care services through co-location and care management; b) improve performance on and tracking of quality measures through automated health information exchange, case management and peer counseling, and participation in Virginia's Practice Transformation Network; c) engage patients in their care through case management and education; d) use case management to overcome access barriers by providing transportation, referrals, and program eligibility assistance; d) educate network partners about the levels of integrated care and the preparation necessary to qualify for value based payments from Medicaid; e) fully implement its strategic plan for development and sustainability of the network; and to f) use its newly created "Speakers Collective" for education on behavioral health issues and integrated care to other clinical and human service providers.

Project Officer:

Marcia Colburn

301-443-3261

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VERMONT

Vermont Care Network Rural Health Network Development

Behavioral Health Network of Vermont Inc.

Montpelier, VT

www.vermontcarepartners.org

Network Leader:

Simone Rueschemeyer

802-262-6124

simone@vermontcarepartners.org

Focus Area(s) of the Development Project:

- Alternative Payment Models
- Behavioral/Mental Health
- Clinical Care Integration
- Community Based Care Coordination
- HIT infrastructure
- Integration of Patient Health Information
- Population Health
- Quality Improvement (QI)
- Quality Reporting

Grant Activities:

This project's activities focus on system-level improvements including a plan for inclusion in the All Payer Model, the development of a successful value-based payment model, standardization of robust population health metrics statewide, development of formal bidirectional integrated care partnerships, implementation of health information technology that meets the needs of a transformed delivery system, and wide dissemination of best practices related to the social model of care.

Project Officer:

Jayne Berube

301-443-4281

jberube@hrsa.gov

WISCONSIN

Rural Wisconsin Health Cooperative (RHWC) Primary Care Outcomes Improvement Network

Rural Wisconsin Health Cooperative (RWHC)

Sauk City, WI

<http://www.rwhc.com>

Project Director:

Louis Wenzlow

608-644-3237

lwenzlow@rwhc.com

Focus Area(s) of the Development Project:

- Chronic Disease Management
- Health Promotion and Disease Prevention
- Other: primary focus is MIPS compliance and quality improvement associated with diabetes and hypertension on care
- Population Health
- Quality Improvement (QI)
- Quality Reporting

Grant Activities:

1. PQRS is transitioning to its recently-finalized replacement program, the Merit-Based Incentive System (MIPS). Network participants will work together to achieve early-phase MIPS compliance on MIPS measures relating to the project's clinical focus areas, which are to improve HbA1C and Blood Pressure control for diabetic and hypertensive patients by implementing Wisconsin Collaborative for Healthcare Quality (WCHQ) Toolkits for Improving Diabetes and Hypertension Care and Outcomes.

2. Project participants all have ONC certified meaningful use EHRs. Participants will utilize their certified EHR data in conjunction with outside data analytics services to achieve MIPS compliance and better identify and implement targeted strategies for cost and quality improvement in the project target areas of diabetes and hypertension.

Project Officer:

Jayne Berube

301-443-4281

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WEST VIRGINIA
STRENGTH IN PEERS
Future Generations
Franklin, WV
www.strengthenpeers.org
www.future.org

Network Director:

Nicky Fadley
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nfadley@future.org

Focus Area(s) of the Development Project:

- Behavioral/Mental Health
- Other: trauma-informed care awareness and policy development
- School Based Care Coordination

Grant Activities:

Project network name revised in February 2018 from Future Generations. The Network will partner with Shenandoah County Public Schools with a goal to improve resiliency, whole-health, and academic outcomes among school-aged children in southern Shenandoah County. It includes a two-pronged approach. The first strategy is to establish and pilot a program of integrated, school-based behavioral, primary, and dental services. The project will repurpose a classroom to serve as clinic site, develop the capacity to bill Medicaid, and assist parents with enrolling in health insurance. The second strategy is to develop the capacity of health, school, and other community agencies to serve children with adverse childhood experience, histories of trauma and/or exhibiting behavioral health issues. The project will provide Network members and school staff training and technical assistance with implementing trauma-informed policies and practices. It also will train master trainers who would educate the larger community in trauma and resilience.

Project Officer:

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