

Rural Health Network Development Program Directory

2023-2027



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Introduction

The Federal Office of Rural Health Policy's (FORHP) Community-Based Division provides support to integrated health care networks who collaborate to achieve efficiencies; expand access to, coordinate, and improve the quality of basic health care services and associated health outcomes; and strengthen the rural health care system as a whole.

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

The four domains the RHND program will focus on are:

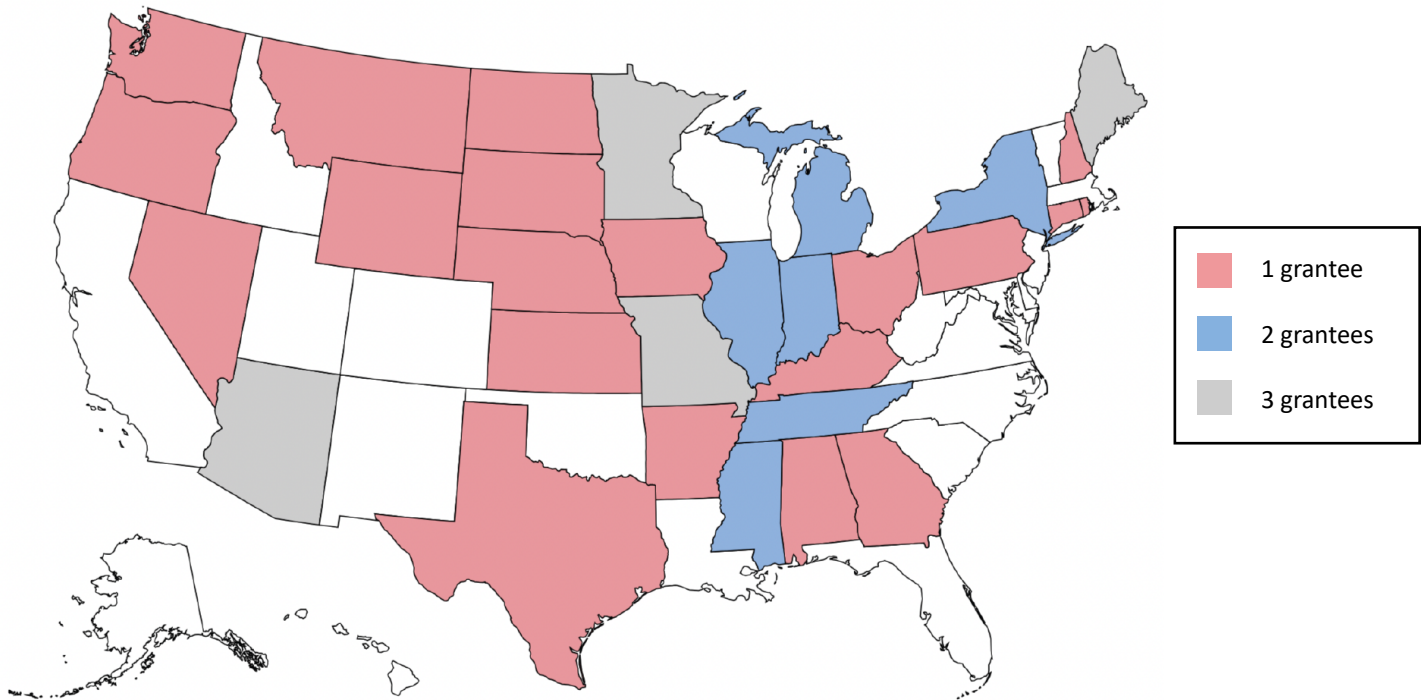
- **Improving access:** by addressing gaps in care, workforce shortages, better workflows and/or improving the quality of health care services;
- **Expanding capacity and services:** by creating effective systems through the development of knowledge, skills, structures, and leadership models;
- **Enhancing outcomes:** by improving patient and/or network development outcomes through expanding or strengthening the network's services, activities or interventions;
- **Sustainability:** by positioning the network to prepare for sustainable health programs through value-based care and population health management.

This directory provides contact information and a brief overview of the 44 initiatives funded under the RHND Program during the 2023-2027 grant period.

Cohort Snapshot

With funding provided by the fiscal year 2023 Rural Health Network Development Program, 44 grantees in 30 states and one territory are addressing these challenges by bringing together a broad range of partners to form rural health networks.

Grantee Location Map



Grantee Organization By State and Territory

Alabama
West Central Alabama Area Health Education Center
Arizona
Arizona Community Health Workers Association
Benson Hospital
Verde Valley Caregivers Coalition
Arkansas
ARcare

Connecticut
Northwest Hills Council of Governments
Georgia
Leigh-Anne White & Co
Illinois
St. Joseph's Hospital Breese of The Hospital Sisters of the Third Order of St. Francis
Wabash General Hospital District
Indiana
Indiana Rural Health Association
Indiana University Health Bedford
Iowa
North Central Iowa Mental Health Center
Kansas
Nemaha Valley Community Hospital
Kentucky
Baptist Health Foundation Corbin
Maine
MaineHealth (Diabetes Project)
MaineHealth (Neonatal Project)
Maine Primary Care Association
Marshall Islands
Ministry of Health in the Republic of the Marshall Islands
Michigan
Ferris State University
Sanilac County Community Foundation

Minnesota
Centracare Health System
Sanford Health of Northern Minnesota
Wilderness Health
Mississippi
Delta Health Alliance
Tallahatchie General Hospital Medical Foundation
Missouri
Powerhouse Community Development Corporation
Union Ambulance District
Washington County Ambulance
Montana
County of Lewis & Clark
Nebraska
Community Access To Coordinated Healthcare
Nevada
Healthy Communities Coalition of Lyon & Storey Counties
New Hampshire
Bi-State Primary Care Association
New York
Fort Drum Regional Health Planning Organization
North Country Healthy Heart Network
North Dakota
Coal Country Community Health Center
Ohio
Hopewell Health Centers

Oregon

Mid-Valley Healthcare

Pennsylvania

UPMC Kane

South Dakota

South Dakota Healthcare Research Education & Trust

Tennessee

Paris-Henry County Health Care Foundation

Rural Health Association of Tennessee

Texas

Plainview Foundation for Rural Health Advancement

Washington

Jamie's Place Adult Family Homes

Wyoming

Unaccompanied Students Initiative

Grantee Organization By Type

Grantee Organization	Ambulance District	Behavioral Health Clinic	County Government	Federally Qualified Health Center	Government Regional Planning	Hospital	Nonprofit Organization	Public Health Department	State Government	University
ARcare				•						
Arizona Community Health Workers Association							•			
Baptist Health Foundation Corbin							•			
Benson Hospital						•				
Bi-State Primary Care Association							•			
Centracare Health System							•			
Coal Country Community Health Center				•						
Community Access To Coordinated Healthcare							•			
County of Lewis & Clark								•		
Delta Health Alliance							•			
Ferris State University										•
Fort Drum Regional Health Planning Organization							•			
Healthy Communities Coalition of Lyon & Storey Counties							•			
Hopewell Health Centers				•						
Indiana Rural Health Association							•			
Indiana University Health Bedford						•				
Jamie's Place Adult Family Homes							•			
Leigh-Anne White & Co LLC		•								
MaineHealth (Diabetes)						•				
MaineHealth (Neonatal)						•				
Mid-Valley Healthcare						•				

Grantee Organization	Ambulance District	Behavioral Health Clinic	County Government	Federally Qualified Health Center	Government Regional Planning	Hospital	Nonprofit Organization	Public Health Department	State Government	University
Ministry of Health in the Republic of the Marshall Islands									•	
Nemaha Valley Community Hospital						•				
North Central Iowa Mental Health Center, Incorporated						•				
North Country Healthy Heart Network							•			
Northwest Hills Council of Governments					•					
Paris-Henry County Health Care Foundation							•			
Plainview Foundation for Rural Health Advancement							•			
Powerhouse Community Development Corporation							•			
Rural Health Association of Tennessee							•			
Sanford Health of Northern Minnesota						•				
Sanilac County Community Foundation							•			
Sdaho Healthcare Research Education & Trust							•			
St. Joseph's Hospital Breese of The Hospital Sisters of the Third Order of St. Francis							•			
Tallahatchie General Hospital Medical Foundation							•			
Unaccompanied Students Initiative							•			
Union Ambulance District	•									
UPMC Kane						•				
Verde Valley Caregivers Coalition							•			
Wabash General Hospital District						•				
Washington County Ambulance			•							
West Central Alabama Area Health Education Center							•			
Wilderness Health										

Grantee Organization By Focus Area

Grantee Organization	Access: Primary Care	Aging	Behavioral/Mental Health	Child Abuse	Chronic Disease: Cardiovascular	Chronic Disease: Diabetes	Community Health Workers/ Promotoras	Coordination of Care Services	Domestic/Intimate Partner Violence	Emergency Medical Services	Health Professions Recruitment and Retention...	Human Trafficking	Increase Access and Quality of Health Care Services	Maternal/Women's Health	Migrant/Farm Worker Health	Mobile Integrated Health Care	Social Determinants of Health	Social Drivers of Health...	Substance Abuse	Telehealth		
ARcare																					•	
Arizona Community Health Workers Association							•															
Baptist Health Foundation Corbin			•																			
Benson Hospital	•																					
Bi-State Primary Care Association																			•			
Centracare Health System														•								
Coal Country Community Health Center								•														
Community Access To Coordinated Healthcare								•														
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Ferris State University																					•	
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Indiana University Health Bedford		•																				
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Ministry of Health in the Republic of the Marshall Islands	•																					
Nemaha Valley Community Hospital														•								

Grantee Organization	Access: Primary Care	Aging	Behavioral/Mental Health	Child Abuse	Chronic Disease: Cardiovascular	Chronic Disease: Diabetes	Community Health Works/ Promotors	Coordination of Care Services	Domestic/Intimate Partner Violence	Emergency Medical Services	Health Professions Recruitment and Retention...	Human Trafficking	Increase Access and Quality of Health Care Services	Maternal/Women's Health	Migrant/Farm Worker Health	Mobile Integrated Health Care	Social Determinants of Health	Social Drivers of Health...	Substance Abuse	Telehealth
North Central Iowa Mental Health Center			•																	
North Country Healthy Heart Network						•														
Northwest Hills Council of Governments			•																	
Paris-Henry County Health Care Foundation																				•
Plainview Foundation for Rural Health Advancement											•									
Powerhouse Community Development Corporation																			•	
Rural Health Association of Tennessee																				•
Sanford Health of Northern Minnesota						•														
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UPMC Kane					•															
Verde Valley Caregivers Coalition		•																		
Wabash General Hospital District																				
Washington County Ambulance						•														
West Central Alabama Area Health Education Center								•												
Wilderness Health		•																		

ARcare

Primary focus area:
Telehealth

Worksite Wellness Network

D06RH49175

Grantee Contact Information

Grantee Contact: Colton Montgomery
Contact Title: Workplace Wellness Nurse
Organization: ARcare
Organization Type: Federally Qualified Health Center
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Project Description and Goals

This project will research, design, and implement the Hamilton Health Box model of care for rural employees, which leverages a hybrid primary care model to make health care accessible, convenient, and affordable for employers and rural populations. The network members have discussed a 24/7 health care access option for employees. The goal of this model of care for employers is to create a healthier workforce and reduce the total cost of health care through a high touch primary care model.

The overarching goal of the Worksite Wellness Network within the Arkansas Health Improvement Coalition is to position members to prepare for sustainable health programs through value-based care and population health management. The specific objectives of the proposed project are as follows:

Objective 1: Within 45 days of grant implementation, the network will develop an advisory committee.

Objective 2: Within the first four months, determine the three biggest health issues among employee participants that will be addressed over the course of the project.

Objective 3: Within 18 months, the 24/7 access to health care model implementation plan will be developed and services implemented.

Objective 4: By June 30, 2027, decrease employee absenteeism due to illness by 10 percent.

Objective 5: By June 30, 2027, reduce health care costs for two employers and 200 employees.

Objective 6: By the end of four-year project period, improve health outcomes for 200 employees.

Network Description

The members of the Worksite Wellness Network include Credence Health Care, Hamilton Health Box, and ARcare. Credence Health Care, a nursing home provider, will be responsible for development and implementation of the 24/7 access to health care model. Hamilton Health Box, a health care provider, serves as the provider of the 24/7 health care access framework. ARcare, a Federally Qualified Health Center, will serve as the lead agent for the grant-funded project, employing the network director and project director as well as taking on the responsibility and accountability for all reporting to the funder and network members in a timely manner.

Evidence-based or Promising Practice Model

While the project is not based on a single evidence-based practice/model or a promising practice, several of its aspects are promising practice tools that have been utilized in different communities. The project will include some aspects of the models, and/or evidence-based/promising practices of:

- Telehealth services
- Remote patient monitoring
- Transitional care management
- Medication therapy management
- Protocol for Responding to & Assessing Patients' Assets, Risks, and Experiences

Populations Served

- Adults
- African Americans
- Caucasians
- Older adults
- Latinos
- Pregnant people

Geographic Service Area

The geographic service area for this Rural Health Network Development grant project includes the ARcare service area within Arkansas Region B (Delta States territory). This service area covers 20 counties and approximately 365,000 residents.

Arizona Community Health Workers Association

Rural Arizona CHW Workforce
Development Network

D06RH49176

Primary focus area:
Community Health Workers /Promotores

Other focus areas:
Health Education and Promotion,
Integrated Systems of Care,
Workforce

Grantee Contact Information

Grantee Contact: Floribella Redondo-Martínez
Contact Title: Chief Executive Officer
Organization: Arizona Community Health Workers Association
Organization Type: Nonprofit organization
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Telephone Number: 928-366-3016
Email: floribella@azchow.org
Website: www.azchow.org

Project Description and Goals

As a statewide vertical network, Rural Arizona CHW Workforce Development Network (RAzCHOW) proposes to rise to the next level by adding three new network members, expanding into two new rural geographic areas, and pursuing a variety of strategies. The network embraces all community health workers (CHWs) in Arizona, most of whom have the job title of CHW, promotor(a) de salud, and community health representative.

RAzCHOW's goal of promoting a sustained, diverse CHW workforce in rural Arizona in order to improve access to health care, health outcomes, and quality of life for rural Arizonans will be fulfilled through nine strategies/objectives over the next four years. These strategies are clustered within three primary focus areas: system change, program expansion and improvement, and leadership development and recognition.

Strategy: Promote voluntary certification

Objective 1: By June 30, 2027, 90 percent of CHWs serving rural Arizona will obtain and maintain voluntary certification through the Arizona Department of Health Services.

Strategy: Maximize Medicaid and value-based reimbursement

Objective 2: By June 30, 2027, 100 percent of both clinical and community-based network partners will bill Arizona Medicaid for approved CHW services and maximize value-based reimbursement.

Strategy: Increase rural CHW training programs

Objective 3: By June 30, 2024, the number of rural health organizations approved as CHW training programs will increase by 60 percent.

Strategy: Increase the CHW workforce in northern Arizona

Objective 4: By June 30, 2027, increase the number of rural health care organizations in northern Arizona that utilize CHWs by 75 percent.

Strategy: Provide core competency and topical training for CHWs

Objective 5: By June 30, 2027, offer at least 16 training sessions to build the capacity of Arizona's rural CHWs through core competency training that is complemented by topical training in response to community and health system needs.

Strategy: Meet the needs of special populations

Objective 6: By June 30, 2027, at least five network members will help RAZCHOW tailor CHW training and technical assistance to better serve special populations with health disparities such as tribal communities, disabled, homeless, veterans, farmworkers, immigrants, migrants, and others.

Strategy: Build CHW supervisor and administrator capacity

Objective 7: By June 30, 2027, a cadre of at least six network member organizations will mentor at least 10 rural organizations regarding CHW program management and supervision to increase CHW effectiveness and retention.

Strategy: Retain the CHW workforce through appropriate compensation

Objective 8: By June 30, 2027, 75 percent of CHWs serving Arizona's rural areas will be compensated at or above a recommended minimum rate.

Strategy: Prepare CHWs For leadership roles

Objective 9: By June 30, 2027, a cadre of at least 20 CHWs from various rural areas of the state will complete CHW leadership training to prepare them for increasing leadership roles within their communities and the organizations where they work.

Together, these nine strategies align with the four Rural Health Network Development program focus areas to achieve the quadruple aim. RAZCHOW's expansion of the rural CHW workforce will improve access to care by linking more rural community members to services in more rural areas of Arizona. RAZCHOW will expand capacity and services by creating more rural CHW training programs, providing capacity, building training and technical assistance to both CHWs and their supervisors/administrators, and by promoting CHW leadership development and retention. RAZCHOW will enhance outcomes by preparing and supporting CHWs as members of care teams to educate rural residents to manage their health and live healthy lifestyles; thereby, promoting better health outcomes. Finally, RAZCHOW will promote sustainability of the CHW workforce in rural Arizona through CHW voluntary certification, Medicaid reimbursement, and value-based reimbursement.

Network Description

RAZCHOW consists of 14 member organizations (10 rural, four non-rural for 71 percent rural composition). Network members represent Federally Qualified Health Centers (4), county health departments (2), behavioral health entities (2), community-based organizations (4), an intertribal advisory group (1), and the state health department (1).

Evidence-based or Promising Practice Model

RAzCHOW will replicate and adapt four evidence-based and promising practices to fulfill the proposed scope of work for 2023-2027 program implementation. These promising practices include:

- CHW certification/licensure
- CHW core competencies
- CHW common indicators
- CHW integration into primary care teams
- CHW compensation/retention
- CHW leadership development curricula (2)

Populations Served

- Adults
- African Americans
- Caucasians
- Latinos
- Native Americans
- Older adults
- Pregnant people
- Pacific Islanders
- Uninsured

Geographic Service Area

RAzCHOW's 14 network member organizations are located in and serve five of Arizona's eight fully rural counties, and also serve 11 rural census tracts in four of Arizona's non-rural counties. The five fully rural counties to be served are Mohave in the northwest corner, Navajo in the northeast corner, Gila in the eastern-central portion of the state, Santa Cruz on the United States-Mexico border, and Graham in the southeast. Rural census tracts will also be served in four non-rural counties: Coconino, Cochise, Pima, and Pinal. Arizona only has 15 counties, so counties are exceptionally large and RAzCHOW's geographic scope covers most of the state. Some RAzCHOW partners have service sites in multiple counties, and some serve tribal members from one of Arizona's 22 tribal nations who live off-reservation or seek services in nearby communities. Driving distances within counties can be two hours or more, and it takes about six hours to traverse the state.

Baptist Health Foundation Corbin

Baptist Health Integrated Care Network

D06RH49177

Primary focus area:
Behavioral/Mental Health

Other focus areas:
Substance Abuse,
Telehealth

Grantee Contact Information

Grantee Contact: Kristi Burnett

Contact Title: Behavioral Health Special Projects Director

Organization: Baptist Health Foundation Corbin

Organization Type: Nonprofit organization

Address: 1840 Cumberland Falls Hwy, Corbin, KY 40701

Telephone Number: 606-526-4428

Email: Kristi.burnett@bhsi.com

Website: www.baptisthealth.com/corbin

Project Description and Goals

Baptist Health Integrated Care Network (BHICN) seeks to increase access to addiction care services, behavioral health services, and increase connection to community resources in the service area. The purpose of this Rural Health Network Development-funded program is to expand the network's capacity to address behavioral health, substance use, and opioid use disorders in primary care patients in three rural counties in Kentucky. The following goals were established by network members to fulfill this purpose.

Goal 1: Using a collaborative approach, BHICN will increase access to integrated primary care and behavioral health substance use disorder treatment services for residents in the service area.

Goal 2: BHICN will increase access to the Resource Connection Line by expanding the operating hours to help address social determinants of health, increase referrals to behavioral health services, and provide information to community members and patients.

Goal 3: BHICN will utilize a system of care approach to increase care coordination across the network by establishing shared referral and care coordination processes, shared data for quality improvement, and shared savings.

Goal 4: BHICN will strengthen the network’s capacity and services to be sustainable beyond the grant project period.

Network Description

The network membership includes: Baptist Health Foundation Corbin, Inc., the primary applicant; Barbourville Family Health, a rural health clinic; Grace Health, a Federally Qualified Health Center; and Baptist Health Medical Group – Dr. Gaurang Shah, a primary care practice.

Evidence-based or Promising Practice Model

Integrated care, specifically behavioral health integrated with primary care, is increasingly recognized as a best practice, and there is a multitude of evidence supporting this model of care. The ability to treat common health concerns is core to the patient-centered medical home model of care. Behavioral health concerns frequently present in primary care, and when left untreated, can lead to complications for a patient’s physical health. Integrating mental health and physical health care can lead to improved outcomes for both. The integrated care model provides a supportive environment for patients to meet most of their primary health care needs. Grace Health’s primary care sites are recognized patient-centered medical homes by the National Committee for Quality Assurance and hold a behavioral health distinction. They will be able to provide critical input into the care coordination process across the network.

Populations Served

- Adults

Geographic Service Area

The BHICN service area includes two counties in southeastern Appalachian Kentucky, Knox County and Whitley County, as well as rural Madison County, which is in the central part of the state. Lack of access to resources and employment, combined with poor physical health, leads to poor mental health in the service area.

Benson Hospital

Southern Arizona Hospital Alliance

D0649178

Primary focus area:

Access: Primary Care

Other focus areas:

Increase Health Network Efficiencies,
Promote Local Healthcare Access/Use

Grantee Contact Information

Grantee Contact: Jason Zibart

Contact Title: Community Connected Health Manager

Organization: Benson Hospital

Organization Type: Hospital

Address: 450 S. Ocotillo Ave., Benson, AZ 85602

Telephone Number: 520-586-2261

Email: Jason.zibart@bensonhospital.org

Website: Tmcaz.com/bensonhealthcare/

Project Description and Goals

The Rural Navigator Project leverages the Southern Arizona Hospital Alliance (SAHA) to address critical health care challenges in the two-county service area.

The goals of this initiative are:

1. Decrease hospital readmissions
2. Increase the number of discharged hospital patients who seek follow-up care from primary care physicians
3. Increase the number of patients who seek treatment at local rural hospitals instead of distant urban hospitals
4. Increase the reach of SAHA, thereby introducing efficiencies and improving health care throughout the region

Achieving these goals involves forming a dedicated team, creating seamless data-sharing systems among health care facilities, and launching community outreach programs. By tackling these issues, the project enhances health care efficiency and quality, reduces reliance on emergency departments for primary care, and strengthens the sustainability of health care services in the region, aligning with the four domains of the Rural Health Network Development program.

Network Description

The SAHA is a nonprofit organization made up of the small, regional health care facilities of Benson Hospital, Northern Cochise Community Hospital, Copper Queen Hospital, and Mt. Graham Regional Medical Center, plus other Federally Qualified Health Center facilities and health departments in the two-county service area. The alliance leverages existing relationships and enhances each of the members' unique strengths while promoting clinical care improvement and coordination and access to a higher level of care throughout Southern Arizona.

SAHA members include: TMC Health/Tucson Medical Center, Benson Hospital, Northern Cochise Community Hospital, Mt. Graham Regional Medical Center, Copper Queen Community Hospital, Chiricahua Community Health Centers, and Mariposa Community Health Centers.

The SAHA is a nonprofit organization made up of the small, regional health care facilities of Benson Hospital, Northern Cochise Community Hospital, Copper Queen Hospital, and Mt. Graham Regional Medical Center, plus other Federally Qualified Health Center facilities and health departments in the two-county service area. The alliance leverages existing relationships and enhances each of the members' unique strengths while promoting clinical care improvement and coordination and access to a higher level of care throughout Southern Arizona.

SAHA members include: TMC Health/Tucson Medical Center, Benson Hospital, Northern Cochise Community Hospital, Mt. Graham Regional Medical Center, Copper Queen Community Hospital, Chiricahua Community Health Centers, and Mariposa Community Health Centers.

Evidence-based or Promising Practice Model

- The care coordinator/manager model utilizes care coordinators or care managers, and community health workers 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.
- Maryland Faith Health Network
- Queen Ann's County Mobile Integrated Community Health Program

Populations Served

- Adults
- African Americans
- Caucasians
- Older adults
- Infants
- Latinos
- Native Americans
- Pacific Islanders
- Pre-school children
- Pregnant people
- School-age children (elementary)
- School-age children (teens)
- Uninsured

Geographic Service Area

The service area includes rural Cochise and Graham counties which have populations of 126,060 and 39,050 respectively, for a total of 165,110 residents. The largest city in the two counties — Sierra Vista — has fewer than 50,000 residents.

Bi-State Primary Care Association

The Vermont Food Access and Health Care Network

D06RH49179

Primary focus area:
Social Drivers of Health/Food Insecurity/
Nutrition Insecurity

Other focus areas:
Cardiovascular, Community Health
Workers/Promotoras, Diabetes,
Health Education and Promotion,
Integrated Systems of Care

Grantee Contact Information

Grantee Contact: Jamie Rainville
Contact Title: Project Director
Organization: Bi-State Primary Care Association
Organization Type: Nonprofit organization
Address: 525 Clinton Street, Bow, NH 03304
Telephone Number: 802-229-0002 x227
Email: jrainville@bistatepca.org
Website: www.bistatepca.org

Project Description and Goals

The Vermont Food Access and Health Care Network (FAHC Network) will focus on the integration of food access as part of health care, emphasizing: social driver of health data collection and standardization to advance health equity, support resource referrals, and establish high quality data for value-based care readiness; closed-loop referrals in medical and social services; training for community health workers as part of an integrated care team (and a newly recognized workforce in Vermont); evidence-based tailored food options for patients managing serious diet-related health conditions; quality improvement facilitation to optimize processes and workflows; peer-to-peer learning; learning from evidence-based models beyond Vermont; and sustainable program funding streams.

The goals of the project are:

Goal 1: Standardize and expand the comprehensiveness of Vermont's food insecurity screening and referral system infrastructure.

Goal 2: Expand evidence-based and promising programming options to increase the availability of appropriate and nutritious food for nutrition-insecure Vermonters with a focus on those with chronic health conditions impacted by diet.

Goal 3: Increase both public and provider knowledge of the resources, opportunities, and best practices to support healthy food access.

Goal 4: FAHC network partners, utilizing Health Resources and Services Administration resources and expertise, collaborate within the network structure to advance the above goals.

The expected outcomes are:

For patients: increased rate of patients screened for food insecurity, increased rate of patients offered a referral after a positive screen, decreased body mass index (although four years is a short horizon for this outcome), and increased rate of “closing the loop” for nutrition-related referrals.

For providers (especially community health workers) and food partners: increased training opportunities, optimized workflows for screenings and referrals, and investments in pilot initiatives integrating food access and health.

For the FAHC Network: effective governance with a rural focus, engagement of all network partners, and sustainability planning and the implementation of those plans.

Network Description

The FAHC Network is composed of six organizations who have been collaborating on statewide network planning activities since 2020:

- Bi-State Primary Care Association (primary care association, represents and provides quality improvement supports to all Vermont Federally Qualified Health Centers)
- Vermont Foodbank (statewide foodbank, provides nutrition education and food access, represents food shelves and community meal sites)
- Hunger Free Vermont (education and advocacy organization, provides nutrition education, policy analysis, and training on access and food safety-net services)
- Vermont Program for Quality in Health Care (quality improvement program, provides quality improvement supports to Vermont hospitals)
- Vermont Academy of Nutrition & Dietetics (association of registered dietitians and nutritionists, provides outreach to registered dietitians and nutritionists)
- Vermont Farm to Plate, a program of the Vermont Sustainable Jobs Fund (a network implementing Vermont’s Food System Plan, connects the FAHC Network to food partners/farms, convenes Vermont’s community sponsored agriculture community of practice)

Evidence-based or Promising Practice Model

The FAHC Network utilizes the “Food as Medicine Framework” developed by the National Food is Medicine Coalition. This work addresses the four foundational elements of the “Food Is Medicine Pyramid” (Supplemental Nutrition Assistance Program; Special Supplemental Nutrition Program for Women, Infants, and Children; the Healthy Incentives Pilot; Emergency Food Programs; Population-Level Healthy Food Programs; Nutritious Food Referrals; and Medically-Tailored Food Packages), and is working towards the goal of the fifth and highest level of the pyramid, Medically-Tailored Meal programs.

Populations Served

- All individuals with food/nutrition insecurity

Geographic Service Area

FAHC is a statewide network serving 13 of Vermont's 14 counties. These 13 rural counties are: Addison, Bennington, Caledonia, Essex, Franklin, Grand Isle, Lamoille, Orange, Orleans, Rutland, Washington, Windham, and Windsor County. The network does not serve Vermont's one urban county, Chittenden.

CentraCare Health System

CentraCare Perinatal Outreach and
Rural Telemedicine Project

D06RH49155

Primary focus area:
Maternal/Women's Health

Other focus areas:
Specialty Care,
Telehealth

Grantee Contact Information

Grantee Contact: Jacqueline Hoyhtya

Contact Title: Director, Maternal-Fetal Medicine, Laborist & Ob-gyn

Organization: CentraCare Health System

Organization Type: Nonprofit organization

Address: 1406 6th Avenue North, St. Cloud, MN 56303

Telephone Number: 320-251-2700

Email: jacqueline.hoyhtya@centracare.com

Website: www.centracare.com

Project Description and Goals

The project will address the immediate needs for maternal fetal medicine specialty care offered through telemedicine services in rural settings for patients who require a continuum of care and do not have access to maternal care closer to their homes.

The CentraCare Perinatal Outreach and Rural Telemedicine (PORT) Project will expand access to perinatal care services at three rural clinics in central Minnesota using proven evidence-based telemedicine services. Lack of access to early and adequate prenatal care has been cited by both the Minnesota Maternal Mortality Review Committee and Healthy People 2030 as a lead factor in maternal morbidity. PORT will expand access to perinatology experts to improve outcomes for mothers and their unborn children using telemedicine in rural communities where the nearest access to these specialty care services may be 50 miles or more away. The overarching goal is to provide extended perinatology services to locations outside of the urbanized St. Cloud, Minnesota area where these services do not currently exist.

Goal 1: Provide access to care for pregnant people who would not otherwise have access to this service using telehealth, providing level 1 and level 2 appointments on a synchronous basis.

- Establish telehealth technology at three primary care provider and obstetrics and gynecology provider sites

- Develop protocols for coordinating and scheduling level 2 synchronous appointments with a perinatologist at remote, rural sites
- Collect data on perinatology service utilization rates and improvements in health outcomes

Goal 2: Implement a team-based approach that addresses both clinical needs and social determinants of care through the use of telehealth technology at the four partner sites.

- Expand team based maternal-fetal medicine approach from existing telehealth sites to three new network sites
- Team approach includes project director, network director, and care coordinator

Goal 3: Provide genetic counseling referrals for current and future pregnancies.

- Provide patients with synchronous visits with a genetic counselor to explain pregnancy risks based on genetic testing
- Explain options for improving health outcomes for the mother and fetus

Goal 4: Create a sustainability plan to continue telehealth services beyond the project period.

- Establish a sustainability subcommittee under the advisory committee
- Identify revenue streams and grant resources that can be applied as a cost-center to sustain telehealth services.

Goal 5: Collect high quality data that can be used to assess the success of the PORT project including utilization rates and qualitative data such as surveys that contribute to the body of knowledge that demonstrates the benefit of telehealth services.

- Protocols established for collecting utilization data through electronic health records at partner sites
- Surveys will be provided to assess qualitative data for the project team, including data analyst and project director

Network Description

The PORT project is led by CentraCare (CC), which is one of the largest health care systems in Minnesota. The project includes three rural network partner sites, CC-Melrose, Mille Lacs Band of Ojibwe, and Astera Health–Wadena, and specialty perinatology services are provided at CC-St. Cloud Hospital.

Evidence-based or Promising Practice Model

- PORT follows four evidence-based studies, as well as recommendations from the American Telemedicine Association in perinatology.
- The first is a UK study, titled “Implementation of a Fetal Ultrasound Telemedicine Service: Women’s Views and Family Costs,” on the use of fetal ultrasounds through telemedicine services.
- The second is a 2020 study, “Telehealth for High-Risk Pregnancies in the Setting of the COVID-19 Pandemic” (Aziz et al., 2020), which found that telehealth for prenatal care is feasible, telehealth may reduce coronavirus exposure during prenatal care, and telehealth should be tailored for high-risk prenatal patients.
- The project also follows guidance from a 2014 American Telemedicine Association report, “State Medicaid Best Practice Telehealth for High-risk Pregnancy,” that includes state policy best practices

related to telehealth expansion for high-risk pregnancy as well as evidence-based and promising practices in the use of telemedicine for perinatology access.

- In addition, the PORT project team has considered the literature from the HRSA Rural Health Information Hub on relevant direct-to-consumer recommendations, including reviews of evidence-based toolkits for rural community health, particularly the Rural Telehealth Toolkit with telehealth models for increasing access to specialty care.

Populations Served

- Adults
- Pregnant people

Geographic Service Area

The service area consists of three rural communities that include:

1. City of Melrose with a population of 3,650
2. Mille Lacs Band of Ojibwe with 4,500 tribal members
3. City of Wadena with a population of 4,325 in Wadena County.

Of the 18 counties served by CentraCare, 17 counties are considered rural by the Health Resources and Services Administration (HRSA), and 16 sites are either health provider shortage areas or medically underserved communities as follows: Benton, Chippewa, Crow Wing, Douglas, Kandiyohi, Lyon, Meeker, Mille Lacs, Morrison, Pope, Redwood, Renville, Sherburne, Stearns, Swift, Todd, Wright, and Yellow Medicine.

Coal Country Community Health Center

Energy Capital Health Network

D06RH49156

Primary focus area:
Coordination of Care Services

Other focus areas:
Health Professions Recruitment and
Retention/Workforce,
Health Information Technology,
Integrated Systems of Care

Grantee Contact Information

Grantee Contact: Darrold Bertsch

Contact Title: Interim CEO

Organization: Coal Country Community Health Center

Organization Type: Federally Qualified Health Center

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Project Description and Goals

The Energy Capital Health Network (ECHN) will facilitate collaborative workforce activities aimed at recruitment and retention of talented, committed, and innovative staff. The network will also improve technology to enrich communication among members as well as with patients by establishing a remote patient monitoring program, a telehealth network, a unified electronic health record system, and other technologies. To improve patient outcomes, network partners will implement screening for social determinants of health and develop a robust referral network to address identified patient needs, improve obstetrical outcomes for service area patients, and develop an in-home care service delivery model for home-bound persons through integration of community health workers. Network partners will also work to identify and proactively respond to external forces that may impact care delivery through expanded partnerships, a marketing and branding campaign, and facilitation of a population health committee.

Goals

1. Develop, recruit, and retain a talented, committed, and innovative workforce for the network and its members
2. Advance technological improvements to enrich communication among the network and its members

3. Improve the care of patients served by fostering a collaborative health care environment
4. Support the local health care industry and proactively respond to external forces that impact network members

The overarching Rural Health Network Development (RHND) program outcome is to achieve the Institute for Health Care Improvement's "Quintuple Aim" for improving health outcomes: decreasing overall costs of care, improving patient satisfaction, addressing health equity, and improving care team satisfaction. This outcome is cross cutting on all four RHND domains. Other outcomes, which hoped to be achieved through the RHND project include:

- Improved employee and patient satisfaction scores
- Integration of electronic health record between all network members
- Equitable telehealth reimbursement
- Long-term sustainability of the network

Network Description

Coal Country Community Health Center and its partners in the Energy Capital Health Network (ECHN) have worked together for years to achieve efficiencies in health care service delivery, expand access to care, improve quality of care and health outcomes, and strengthen the rural health delivery system in west central North Dakota.

The network partners have realized that by collaboratively bolstering the rural health system in the region, the strength of each organization is also increased. The ECHN's overarching aim is to work together to achieve optimal community health and build healthy communities through collaboration and innovation. RHND grant funding will advance this aim by achieving project goals that support the legislative aims and align with the four RHND program domains. The network partners include:

1. Coal Country Community Health Center – Federally Qualified Health Center
2. Sakakawea Medical Center – Critical Access Hospital
3. Knife River Care Center – Skilled nursing facility
4. Western Plains Public Health – Local health department

Evidence-based or Promising Practice Model

While the project is not modeled on one specific evidence-based program or promising practice, the network partners have evaluated the Rural Health Information Hub's Evidenced-Based Tool Kits for Rural Community Health, and specifically the "Rural Health Models and Innovations" section. One project stood out as it aligns with part of the plans for the ECHN. It is the "Bridges to Care Transitions – Remote Home Monitoring and Chronic Disease Self-Management" program, which aimed to decrease hospital readmissions and emergency room visits for patients. The intervention focused on identifying at-risks patients after an emergency room (ER) visit or hospital admission and offering remote patient monitoring and disease management education and coaching. The results demonstrated decreased readmissions and ER visits paired with high patient satisfaction scores.

Populations Served

- Adults
- African Americans
- Caucasians
- Infants
- Latinos
- Native Americans
- Older adults
- Pacific Islanders
- Pre-school children
- Pregnant people
- School-age children (elementary)
- School-age children (teens)
- Uninsured

Geographic Service Area

The ECHN is an integrated health care network that serves the vast rural and frontier service area which includes all of Dunn, Mercer, and Oliver Counties, and the southeast portion of McKenzie County in west central North Dakota.

Community Access to Coordinated Healthcare

Community Access to Coordinated Healthcare Network

D06RH49157

Primary focus area:
Coordination of Care Services

Other focus areas:
Behavioral/Mental Health,
Cardiovascular,
Diabetes,
Primary Care

Grantee Contact Information

Grantee Contact: Patrick Hotovy, MD

Contact Title: Project Director

Organization: Community Access to Coordinated Healthcare

Organization Type: Nonprofit organization

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Project Description and Goals

This project will integrate behavioral health services into the Community Access to Coordinated Healthcare (CATCH) Network and address social determinants of health by screening and referring identified patients in the service area and implement strategies to sustain the integrated care coordination network.

Activities will focus on improving the capacity to deliver behavioral health services and addressing social care needs. One major activity is to identify behavioral health practitioners and develop a framework for integrating behavioral health services with primary care and public health. The plan also includes using a screening tool to identify patients with physical, mental, lifestyle risk behaviors, and social needs. Once these needs are identified, a treatment and prevention plan will be developed by the local comprehensive health care team, including public health professionals who have expertise in addressing the dimensions of lifestyle behaviors and social needs of these patients. These patients will be referred to local public health agencies who will educate them on how to prevent and control chronic diseases (e.g., weight loss), connect them to the appropriate community-based organizations to address their social determinant needs, or both.

The expected outcomes of this project are to improve individual and population health outcomes, reduce the barriers that limit access to care, decrease health care costs through a reduction in emergency department visits and avoidable hospitalizations, integrate behavioral health services with primary care clinics and local public health departments, and strengthen community programs by referring high-risk patients to preventive

programs and activities provided by community organizations. Through enhanced care coordination of patients with behavioral health and social needs, there will be a positive impact on health outcomes and the network will become more sustainable.

The goals of the project are:

Goal 1. Collaboratively integrate behavioral health care into the rural CATCH Integrated Care Coordinated Network (ICCN) program that is inclusive of both public health and primary care.

Goal 2. Assess and develop the CATCH Network's capacity to sustain the ICCN with behavioral health care services into the ICCN.

Goal 3. Develop and implement an efficient and effective screening, referral, and follow-up process, from physician clinics and behavioral health providers to local health departments for high-risk chronic care patients with hypertension, diabetes, and depression who have selected social determinant of health issues or needs.

Goal 4. Build electronic medical record capacity to collect, analyze, and share data among CATCH Network members and utilize data for quality reporting.

Network Description

The CATCH Network is composed of 30 rural counties and 26 network members, including representatives from six regional local health departments, ten rural hospital systems, eight rural clinics, one Federally Qualified Health Center, and one community action agency. For this project, the service area is a subset of the CATCH Network, composed of 21 rural counties. The types of members include four local health department districts, four rural clinics and associated rural hospitals, and one community action agency.

Evidence-based or Promising Practice Model

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

- National Diabetes Prevention Program, an evidence-based lifestyle change program established by the Centers for Disease Control and Prevention
- Freedom from Smoking® Program, developed by the American Lung Association
- Chronic Disease Self-Management Program, usually referred to as the Living Well Program in Nebraska <https://www.selfmanagementresource.com/>
- Current models for integrating behavioral health care into rural communities. These models may include hiring a social worker or a licensed mental health professional in the physician clinic or the local health department. Telehealth options will also be explored.
- Mental Health First Aid training program

Populations Served

- Adults
- African Americans
- Caucasians
- Older adults
- Infants
- Latinos
- Native Americans
- Pacific Islanders
- Pre-school children
- Pregnant people
- School-age children (elementary)
- School-age children (teens)
- Uninsured

Geographic Service Area

The Community Access to Coordinated Healthcare (CATCH) Network is composed of 30 rural counties. For purposes of this project, the service area is a subset of the CATCH Network composed of 21 rural counties with a population of 224,052 within approximately 21,435 square miles and a population density of 23.1. Four of the 21 counties are frontier counties with a population density of less than 7.0.

Delta Health Alliance

Delta Diabetes BLUES Network

D06RH49160

Primary focus area:
Chronic Disease: Diabetes

Other focus areas:
Coordination of Care Services,
Primary Care,
Specialty Care,
Telehealth

Grantee Contact Information

Grantee Contact: Lesa Wise

Contact Title: Associate Vice President of Clinical Programs

Organization: Delta Health Alliance

Organization Type: Nonprofit network organization

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Project Description and Goals

The Delta Diabetic BLUES Network seeks to achieve the following goals in a manner which supports the Rural Health Network Development (RHND) program's legislative aims by improving diabetic outcomes in a sustainable way. The BLUES Network aligns with the RHND program's four program domains in that it seeks to: 1) improve access by addressing gaps in care for patients with diabetes, improving the quality of specialized diabetes services; 2) expand rural capacity and services by implementing proven models of specialized telemedicine for rural patients; 3) enhance outcomes through the provision of patient-focused endocrinology and one-on-one case management; and 4) sustain the program through a collaborative strategy of newly billable diabetes education and population health management.

The goals of the project are:

Goal 1: Improve efficiencies in the manner in which existing health care services are provided to patients with diabetes or pre-diabetes

Goal 2: Expand access to and coordination with endocrinology services which are new to many of the rural communities

Goal 3: Strengthen the rural health care system as a whole for low-income residents of the Mississippi Delta through a new accredited diabetes self-management educational program

Network Description

The network consists of four separate, existing health care providers including: 1) the Leland Medical Clinic – a Federally Qualified Health Center lookalike and certified patient-centered medical home in Leland, Mississippi, 2) the Leflore County Health Center, a rural health clinic, member of the National Association of Free and Charitable Clinics, serving Greenwood, Mississippi, 3) Urgent & Primary Care of Clarksdale, a Delta Region Community Health Systems Development Program participating site, serving residents of Coahoma County, Mississippi, a new network member, and 4) The Endocrine Clinic – an endocrinology care provider headquartered in Southaven, Mississippi. The network is governed by a board of six local members including representatives of the four partners, plus one local business affiliate and one patient representative of the communities served.

Evidence-based or Promising Practice Model

Extension for Community Healthcare Outcomes (ECHO) Model – The Delta BLUES Network will expand use of the evidence-based ECHO Model as the approach to meet network needs for improved efficiencies, access and systems of diabetes care in the rural communities. The ECHO Model connects groups of rural community providers with specialists at centers of excellence in regular real-time collaborative sessions.

Populations Served

- Adults
- African Americans
- Caucasians
- Older adults
- Latinos
- Uninsured

Geographic Service Area

The rural counties of Bolivar, Coahoma, Leflore, Sharkey, Sunflower, Tallahatchie, and Washington in Mississippi have a combined total of 171,956 residents. 73 percent are Black, 31 percent live in poverty, only 80 percent of adults have a high school degree, 47 percent are obese, 13.9 percent have diagnosed diabetes, and mortality from diabetes is nearly double the national average.

Ferris State University

Central Michigan Recovery and Education
Network-Ferris State University

D06RH49161

Primary focus area:
Substance Abuse

Other focus areas:
Coordination of Care Services,
Integrated Care,
Transportation to Care

Grantee Contact Information

Grantee Contact: Gail Bullard, DHEd, MSA, RN
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Website: www.cmren.org for grant; www.ferris.edu for university

Project Description and Goals

This project will expand Central Michigan Recovery and Education Network–Ferris State University’s (CMREN-FSU’s) work through the HRSA Rural Communities Opioid Response Program implementation grant by amplifying substance use disorder (SUD) and opioid use disorder services and resources and expand the region served by adding a fourth county to the service area. Additionally, the consortium will be enhanced and strengthened to transform it into a broad community network — the CMREN-FSU, with a focus on developing a sustainable recovery ecosystem.

CMREN-FSU aligns with the four Rural Health Network Development (RHND) domains: I) Improve access. II) Expand capacity and services. III) Enhance outcomes. IV) Sustainability. Moving from a consortium to a network allows each partner to have a seat at the table and enhances integrated care and understanding of each entity’s role or roles, further facilitating collaborative efforts to improve patients’ health outcomes, addressing RHND program domains I-III. By bringing in new partners and leveraging the expertise of each involved entity, crucial gaps in patient care can be addressed, consistent with RHND program domains I-III. This recovery ecosystem involves system change to develop a community that provides sustainable integrated care, services, and support. This integrated care model and associated services improve quality of health and support long-term recovery by addressing numerous social determinants of health that negatively impact many individuals in this region, corresponding to all four RHND program domains. Implicit in these activities are the provision of value-based care and population health management.

The goals and expected program outcomes for this grant within the service area are:

- continue work to reduce the morbidity and mortality of SUD,
- increase the incidence of long-term recovery, and
- decrease the incidence of overdose and SUD emergency department visits through improved integrated care for individuals in need. There will be a special focus on those with SUD in four subpopulations: veterans, pregnant people, those recently released from incarceration, and adolescents and adults experiencing homelessness.

The network will plan for the integrated care and sober recovery ecosystem to be a sustainable business model beyond the grant period.

Network Description

The network is composed of 13 member organizations, all located within the four-county region. The organization types include public health, behavioral health, health care, higher education, prevention support, recovery support, and humanitarian services.

Members are:

- Ferris State University
- Corewell Health Big Rapids, Reed City, Lakeview, & Greenville - Health care system serving the listed counties
- Corewell Health Gerber-Fremont Corewell Health Opioid Integrated Care – Provider of primary and specialty care health services
- Family Health Care – Federally Qualified Health Center and provider of primary care, specialty care, behavioral health, and pharmacy services in two counties
- District Health Department #10 – provider of public health services in two counties
- Central Michigan Health Dept. – provider of public health services in one county
- Community Mental Health – Central Michigan – provider of behavioral health services in two counties
- Montcalm Care Network – provider of behavioral health services in one county
- Arbor Circle – provider of behavioral health services in one county
- Jonah Foundation – provider of faith-based support services for persons in recovery recently released from incarceration in three counties
- Families Against Narcotics – provider of recovery support services in all counties
- Angels of Action – recovery services for women in two counties

Evidence-based or Promising Practice Model

The goal is to create a seamless process within the recovery ecosystem which removes barriers to care and increases treatment compliance. This recovery-oriented system of care model for the treatment of addiction is a recommended practice model, rather than the traditional episodic acute care model.

Populations Served

- Adults
- Pregnant people
- Recent release from incarceration

Geographic Service Area

This work will take place in the current CMREN Michigan region of Mecosta, Osceola, and Newaygo counties, with the addition of Montcalm County under the new name of CMREN-FSU. The total population for the four-county region is 180,652: Mecosta (40,031), Montcalm (67,220), Newaygo (50,296), and Osceola (23,105). All counties are in Health Resources and Services Administration (HRSA)-designated health provider shortage areas.

Fort Drum Regional Health Planning Organization

Fort Drum Regional Health Planning Organization

DO6RH49162

Primary focus area:
Chronic & Transitional Care Management

Other focus areas:
Coordination of Care Service and Integrated Systems of Care, Social Determinants of Health

Grantee Contact Information

Grantee Contact: Joanna Loomis

Contact Title: Network Director

Organization: Fort Drum Regional Health Planning Organization

Organization Type: Nonprofit organization

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Project Description and Goals

This project will leverage an integrated rural health network to administer whole-person centered chronic and transitional care management (CCM and TCM, respectively) for populations within the rural service areas in Jefferson, Lewis, St. Lawrence, and Franklin counties in upstate New York. The target population includes clinically and socially complex rural community members of any insurance status who are transitioning care from a hospital or emergency department setting to an outpatient or home setting, and those who require chronic care management to better control their chronic conditions, to help prevent hospitalization and promote health equity and positive health outcomes.

The overarching goal is to improve residents' health outcomes and reduce the risk of future preventable hospitalizations and emergency department visits by improving access to TCM & CCM.

Goal 1: Improve access to value-based, person-centered transitional and chronic care management. All payor-billable TCM and CCM services will increase by at least 10 percent from baseline by the end of Project Year Four. It is estimated that the baseline completion of TCM in the service area is approximately 40 percent of eligible discharges, and for CCM, approximately 5 percent of the population with chronic conditions. By increasing these by 10 percent, this would equate to roughly 7,300 additional TCMs and 15,000 additional CCMs in the region.

Goal 2: Expand services by supporting TCM and CCM provision to the vulnerable Medicaid population. At least 12 percent of eligible Medicaid-insured individuals in the rural service area will participate in TCM, CCM, or both by the end of Project Year Four.

Goal 3: Enhance the health outcomes of individuals in the rural service area. At least 35 percent of identified open care gaps will be successfully closed for individuals engaged in TCM, CCM or both; and such individuals' 30-day potentially preventable hospital admissions and readmissions will decrease by at least 10 percent by the end of Project Year Four.

Goal 4: Promote sustainability by positioning the network to succeed in value-based care. Applicable network partners will be engaged in at least three value-based contracts by the end of Project Year Four.

Network Description

The network includes five hospitals, 25 primary care sites, nine behavioral health sites, and 13 community sites, for a total of 52 sites of which 69 percent are designated as rural by HRSA. All hospital, primary care, and behavioral health entities have been partners throughout the Delivery System Reform Incentive Payment (DSRIP) program (2015-2020), participate in the region's clinically integrated network, and are participants in the regional Accountable Care Organization and Independent Practice Association. The majority of community sites were also partners throughout New York State's DSRIP program and participate in one or more Fort Drum Regional Health Planning Organization initiatives.

Evidence-based or Promising Practice Model

The project will utilize several evidence-based practices, including the two noted below and sourced from the Rural Health Information Hub:

- Transitional care management, a strategy to “improve the coordination of care for Medicare patients between the acute care setting and community setting”
- Chronic care management, a model where “patients will receive a better coordinated team of health care professionals to help them stay healthy, a comprehensive care plan to set and track progress toward health goals, and support between regular face-to-face visits”

Populations Served

- Adults
- African Americans
- Caucasians
- Older adults
- Infants
- Latinos
- Medicaid-insured
- Medicare-insured
- Native Americans
- Pre-school children
- Pregnant people
- School-age children (elementary)
- School-age children (teens)
- Uninsured

Geographic Service Area

The service area includes Health Resources and Services Administration (HRSA)-designated rural areas of Jefferson, Lewis, St. Lawrence, and Franklin counties located in the Tug Hill Seaway region of New York State. The service area lies within the St. Lawrence River and Canadian border to the north, Lake Ontario to the west, and the Adirondack mountains to the east. It is one of the most sparsely populated in the state, with population densities ranging from 21.25 people per mile to 41.76 people per mile, compared to the state average of 411 people per mile. Additionally, the service area contains primary care and mental health HRSA-designated health professional shortage areas.

Healthy Communities Coalition of Lyon and Storey Counties

Rural Health Network Development Metabolic
Syndrome Partner Network

D06RH49163

Primary focus area:
Community Health Workers
/Promotoras

Other focus areas:
Cardiovascular,
Diabetes,
Health Education and Promotion

Grantee Contact Information

Grantee Contact: Sarah Daniel – High Sierra AHEC/Jenny Claypool

Contact Title: Project Director/Network Director

Organization: Healthy Communities Coalition of Lyon and Storey Counties

Organization Type: Nonprofit organization

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Website: www.healthycomm.org

Project Description and Goals

The purpose of the Healthy Communities Coalition is to decrease the impact of metabolic syndrome and its risk factors through education, engagement, and health care in the community, home, and primary care settings.

Goal 1: Increase access to comprehensive, coordinated, high-quality health care and supportive services through a community-based approach to individuals with or at risk of metabolic syndrome.

Goal 2: Improve health outcomes among the target population.

Goal 3: Expand the capacity of network members to integrate care and services through training, education, and systems alignment.

Goal 4: Assure financial sustainability of Healthy Communities Coalition community health worker and community paramedicine services.

Network Description

This network seeks to provide a continuum of coordinated health services, from prevention through treatment, using a health and wellness hub model to support primary and integrated care to decrease the rate of metabolic syndrome and its related drivers (hypertension, high blood sugar, obesity, and cholesterol) among individuals receiving services. This network is working to become an integral piece of the Rural Nevada Health Network as strategies for health and wellness in Lyon and Storey counties continue to evolve.

Collaborating network members:

- Healthy Communities Coalition (Dayton)
- Community Chest (Virginia City)
- Food Bank of Northern Nevada (Sparks, physically located in Storey County)
- High Sierra AHEC (Reno)
- Rural Nevada Health Network, work carried out by Turning Point, Inc., Storey County)
- Nevada Rural Hospital Partners (Reno)

Evidence-based or Promising Practice Model

The Healthy Communities Coalition plans to implement the following evidence-based models and practices:

- Community health worker models will be one of the defining factors for success in this program.
- Community paramedicine model will be developed for Lyon County with the prospect that other rural Nevada counties can adapt this model for their own needs.
- Mobile Integrated Healthcare is an evidence-based, patient-centered delivery model offering preventive services in an at-home or mobile environment.

Populations Served

- Adults
- African Americans
- Caucasians
- Older adults
- Latinos
- Native Americans
- Pacific Islanders
- Pregnant people
- Uninsured

Geographic Service Area

The Healthy Communities Coalition serves Lyon and Storey counties, located in the rural western portion of northern Nevada. Lyon County has 2,001 square miles of land area and a population of 59,235. Population density is estimated at 26 people per square mile. Lyon County is split between seven distinct communities, separated, in some cases, by an hour's drive. Lyon County is the third largest county by population in the state of Nevada, making it the largest rural county. Storey county is adjacent to Lyon County with a population of 4,104, 264 square miles, making it the smallest land size county in Nevada.

Hopewell Health Centers

Partnership to Achieve Compliance and Savings

D06RH49164

Primary focus area:
Community Health Workers
/Promotoras

Other focus areas:
Diabetes,
Coordination of Care Services,
Health Education and Promotion

Grantee Contact Information

Grantee Contact: Sherry Shamblin

Contact Title: Chief Strategy Officer

Organization: Hopewell Health Centers

Organization Type: Federally Qualified Health Center

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Website: www.healthycomm.org

Project Description and Goals

The purpose of the project is to strengthen the organizational and infrastructure capacity of the Partnership to Achieve Compliance and Savings (PACS) Consortium to implement community health worker-based models of chronic care management to demonstrate that these models improve health and reduce costs, especially for individuals who struggle to control their chronic conditions, and to achieve CHW sustainability in southeast Ohio through the development and exploration of insurance reimbursable models. The project will build on the successful implementation of the Pathways HUB Model to sustain CHWs by expanding the geographic reach, including chronic diseases eligible for CHW support beyond diabetes to include congestive heart failure, chronic obstructive pulmonary disease, falls, and patient engagement. The project will also increase PACS membership to include all state health plans and other appropriate partners. The project will lead to reimbursement by insurers for certain CHW services, creating hundreds of new jobs and a sustainable CHW workforce.

Goal 1: Demonstrate that CHWs improve health and significantly reduce health care costs.

Goal 2: Develop payment models that assist in sustaining CHWs.

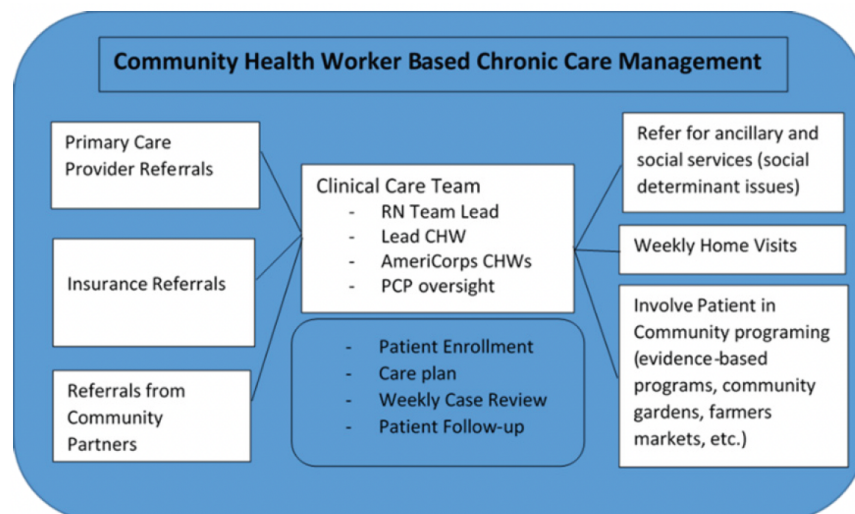
Network Description

The mission of PACS is to improve the health of the community's most at-risk residents using community health workers to quantify the savings generated by their work, and to achieve sustainable CHWs in southeastern Ohio. PACS envisions a future where people who struggle to control their chronic conditions have the assistance they need to be successful. The network is composed of local health departments, state managed care plans, community health center association, statewide coalitions, and two Pathways hubs. The Network members are listed below.

- Washington County Health Department
- Marietta/Belpre City Health Department
- Athens County Health Department
- Meigs County Health Department
- Ross County Health Department
- Vinton County Health Department
- United Healthcare
- Molina Healthcare
- CareSource
- Ohio Association of Community Health Centers
- Ohio Alliance for Innovation in Population Health/Ohio University
- The Corporation for Ohio Appalachian Development
- Access Tuscarawas
- Community Health Improvement Associates
- Oral Health Ohio

Evidence-based or Promising Practice Model

The current effort is based on work done at Marshall University. Through this work, The Health Plan of West Virginia identified high-risk members in several Central West Virginia counties and worked with a Federally Qualified Health Center to get them enrolled in a community health worker model of a chronic care management program.



Populations Served

- Adults
- Older adults

Geographic Service Area

The project service area consists of the following nine counties in southeast Ohio: Athens, Meigs, Washington, Vinton, Hocking, Ross, Perry, Gallia, and Jackson. County populations range from just over 12,000 to 62,000 residents. All counties' rates of poverty, unemployment, diabetes and heart disease above state and national averages.

Indiana Rural Health Association

Indiana Transfer of Care Network

D06RH49165

Primary focus area:
Emergency Medical Services

Other focus areas:
Health Professionals Recruitment and Retention and Workforce Development, Integrated Systems of Care, Transportation to Health Services

Grantee Contact Information

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Project Description and Goals

The purpose of Indiana Transfer of Care Network (InTOC) is to improve the quality of rural emergency medical services (EMS) and Inter-Facility Transfer (IFT) services by implementing a strategic plan to decrease the burden of ambulances responsible for emergency services, reduce delays in IFTs, and establish best IFT practices throughout central southwestern Indiana. InTOC seeks to build a network of stakeholders that will collaborate to address barriers to IFT between care settings. IFT is defined in the National Highway Traffic Safety Administration’s Guide for Interfacility Patient Transfer as “any transfer, after initial assessment and stabilization, from and to a health care facility.”

IFTs pose a unique challenge in rural communities in which neighboring hospitals are distant and the nearest hospital may not accept the transfer. Further complicating this access-to-care barrier is that IFT requires use of the community’s finite transportation vehicles — typically ambulances and helicopters utilized for EMS. An EMS agency gets paid by the number of runs they make, and often the volume in one rural community is not enough to sustain already tight EMS budgets. Additionally, the distance rural hospitals often sit from a major highway only increases difficulty getting to these locations in a timely manner.

The InTOC network seeks to leverage IRHA’s extensive partnerships throughout the target region, and likewise, utilize Indiana Rural Health Association’s professional experience serving rural communities. This program will specifically support the legislative aims by achieving three concrete goals:

1. Establish an integrated InTOC network to establish an EMS IFT network to streamline IFT routes and enhance communication between network members and facilities.
2. Develop strategies that respond to challenges of IFT, EMS, and rural health outcomes.
3. Implement the InTOC methodology and strategies for network sustainability to expand across the region and state.

Network Description

The InTOC network currently has four members, but will add members as transport providers are established. Current network members are Indiana Rural Health Association, Union Hospital Clinton, Putnam County Hospital, and Sullivan County Community Hospital.

Evidence-based or Promising Practice Model

Through this funded work, the network desires to establish the Indiana Transfer of Care model as a promising practice.

Populations Served

- Rural population

Geographic Service Area

InTOC is a collaborative network serving three Critical Access Hospitals located in the central southwest region of Indiana, identified as part of the Emergency Medical Services District Seven in Putnam, Sullivan, and Vermillion Counties. The total population of Putnam County is 36,979; Sullivan County is 20,758; and Vermillion County is 15,341. For orientation to size of InTOC's target geographic area, Putnam County is 483 square miles, Sullivan County is 454.1 square miles, and Vermillion County is 256.9 square miles. As mentioned above, all three counties host Critical Access Hospitals which are not trauma centers. If a patient requires a higher acuity of care, an interfacility transfer is absolutely necessary for a positive health outcome. Data is limited with IFTs in the service area, but one area's data showed increasing difficulty securing a transfer, with a 31.39 percent increase in unsuccessful IFT runs between 2021 and 2022.

Indiana University Health Bedford Hospital

Rural Dementia Network of
South-Central Indiana

D06RH49166

Primary focus area:
Aging

Other focus areas:
Health Education and Promotion

Grantee Contact Information

Grantee Contact: Diana Matthews

Contact Title: Project Director

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Organization Type: Hospital

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Project Description and Goals

The overall purpose of the Rural Dementia Network (RDN) is to improve population health outcomes in rural south-central Indiana for people living with dementia (PLWD) and their care partners through outreach, education, and pilot programs for the target population, trainings for the current and future workforce, and coordination of resources.

The RDN is designed to meet the many health care and social support needs of PLWD and their care partners, enabling them to remain active and independent for as long as possible. The network also collectively enables PLWD and their care partners to access professional care without feeling ashamed or embarrassed, educates the community about brain health and cognitive changes, and ensures that all people, regardless of their diagnosis, feel valued in their communities. Direct services and activities provided for PLWD and their care partners help them navigate resources within these rural communities with a sense of dignity and inclusion.

The network addresses all phases of the dementia trajectory, from diagnosis through end-of-life, both for PLWD and their care partners. The following services are provided at no cost to the target populations.

- Community education and outreach to promote awareness of brain health and combat stigmas regarding cognitive decline
- Specialized training for hospital, long-term care, and other health care staff in dementia care practices
- Training for current and upcoming certified nursing assistants and home health aides to better relate to PLWD through the Dementia Friendly Care Partner Development Program
- Coalition-building, including leading local “dementia-friendly” efforts
- Resource connections and referrals to health care and social service providers
- Individualized family consultation including home visits
- Care partner support groups and respite assistance
- Scholarships for PLWD and their care partners for training and educational opportunities related to dementia and brain health

The goals of the project are:

Goal 1: Expand the geographic scope of the RDN to two additional rural counties and expand outreach efforts in existing counties to improve access to the RDN’s services for PLWD and their care partners in a total of four counties in rural south-central Indiana.

Goal 2: Expand the RDN services by adding a comprehensive “brain health” initiative for all four counties.

Goal 3: Enhance existing RDN services for all four counties.

Goal 4: Establish sustainability for the RDN and its services beyond the grant period through collaborative strategies with public and private partners.

Network Description

In addition to IU Health Bedford Hospital, a Critical Access Hospital in rural Lawrence County, founding network members include two other rural hospitals within the IU Health network, a local area agency on aging, and a community-based resource center. The network also leverages the Alzheimer’s and Dementia Resource Service (ADRS), a unique resource center for PLWD, their care partners, and the broader community in nearby Monroe County. The RDN uniquely brings together key stakeholders to address the myriad needs of PLWD and their care partners in a way that individual entities would not be able to do on their own. For example, the hospital network members complement the work of the longstanding ADRS through dedicated health care expertise and resources. In this way, the network is able to effectively serve PLWD and their care partners throughout the continuum of the dementia trajectory, from diagnosis through end-of-life. All programs and services provided by the RDN are possible due to robust collaboration among network members as well as informal partners throughout the targeted counties.

Evidence-based or Promising Practice Model

The RDN leverages several evidence-based and promising practice models to meet the health care needs of PLWD and their care partners. These include:

- National Association of Area Agencies on Aging’s “dementia-friendly communities” model
- Positive Approach to Care training model by Teepa Snow

- Virtual dementia tour program by Second Wind Dreams
- Certified Dementia Practitioner program and its certification
- Cultural competency training curriculum, Support and Advocacy for Gay Elders, to ensure services are inclusive and effective for older adults who identify as LGBTQ+.

Populations Served

- Adults
- African Americans
- Caucasians
- Older adults
- Latinos
- Native Americans
- Pacific Islanders

Geographic Service Area

The project service area includes the four-county area of Jackson, Lawrence, Martin, and Orange counties. Populations in the counties range from as low as 10,000 to as high as 46,000 residents. The percent of the population over age 65 in the counties ranges from 17 to 20 percent.

Jamie's Place Adult Family Homes

The Methow Valley Community-Based Long-Term Care Network

D06RH49159

Primary focus area:

Health Professions Recruitment and Retention/Workforce Development

Other focus areas:

Aging, Community Health Workers/Promotoras, Integrated Systems of Care

Grantee Contact Information

Grantee Contact: Mallory Brandenburg

Contact Title: Interim Project Director

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Project Description and Goals

Develop and implement, with rurally relevant modifications as necessary, promising evidence-based practices that will provide the comprehensive services, programs, facilities, workforce and supports needed to support a sustainable, integrated community-based model of long-term care delivery in the valley. The network, led by a core set of principles and values, will work collaboratively with the community to create systems of care to address the lack of long-term care workforce, facilities, services and support in the valley.

Specific objectives of this grant project include:

- Finalize the network infrastructure, add new members, and create and staff subcommittees consistent with grant objectives.
- Develop and support a caregiving workforce through a comprehensive program of recruitment, training, and retention strategies.
- Implement and modify as necessary, innovative evidence-based and promising strategies and supports to keep seniors in their homes.
- Establish a comprehensive system of case coordination for at-risk seniors in the Valley that promotes patient safety, quality of care, and cost-effective outcomes through communication, collaboration, and coordination across community providers, agencies, and resources.

- Plan for and support the development of supported housing for seniors who cannot safely live at home.
- Assess and report on grant project progress and outcomes over the four-year grant period and modify the program as necessary.
- Participate in strategic and business planning focused on developing a sustainable business model.

The overarching expected program outcome is a sustainable integrated community-based model of long-term care delivery in the valley.

Network Description

The network established in the planning grant included three members: Jamie’s Place Adult Family Home, Family Health Centers, and Methow at Home. It also included a number of collaborating organizations which are all collaborating members in this grant as well. Through the network planning efforts (still underway), the network has determined the need to expand its official network membership to include Methow Valley School District, Liberty Bell High School, and to add multiple new collaborative organizations. The school will play a pivotal role related to workforce development. The other collaborative organizations have committed to be at the table with the network and to working side by side to implement the goals and objectives of this network development grant. They are: Methow Housing Trust, Room 1, Twisp Works, Enhabit Hospice and Home Care, Wenatchee Valley College, Aero Methow Rescue Service, All Ways Caring Home Care Agency, State Office of Community and Rural Health, and The Greenhouse Project.

Evidence-based or Promising Practice Model

- **The Stay Active & Independent for Life (SAIL):** program is an evidence-based intervention for prevention of falls.
- **Community Aging in Place-Advancing Better Living for Elders (CAPABLE):** CAPABLE is a client-directed home-based intervention to increase mobility, functionality, and capacity to age in their community for older adults.
- **The Green House Project:** The Green House Project is a nonprofit organization committed to creating radically noninstitutional eldercare environments that empower the lives of people who live and work in them.
- **Chronic Care Model (CCM):** CCM identifies the essential elements of a health care system that encourage high-quality chronic disease care including the community, the health system, self-management support, delivery system design, decision support, and clinical information systems.
- **Patient-Centered Medical Home (PCMH) Model:** The PCMH Model is an approach to delivering high-quality, cost-effective primary care, using a patient-centered, culturally appropriate, and team-based approach.
- **Community Health Worker and Care Manager Model:** As care coordinators or care managers, community health workers help individuals with complex health conditions to navigate the health care system, including a variety of health care and human services organizations.

Populations Served

- Older adults

Geographic Service Area

The Methow Valley located in remote North Central Washington State, includes the towns of Winthrop, Twisp, Mazama, Methow and Carlton. Nearly 28 percent of the valley's 6,000 residents are over the age of 65. The valley has no hospital or 24/7 emergency room. It also has no nursing home or assisted living facility, and only 12 beds of adult family home level care. There is also a critical shortage of caregivers needed to support valley residents aging in place or needing to be cared for at the local adult family homes.

Leigh-Anne White & Company, LLC

Toombs County Prevention,
Treatment and Recovery

D06RH49167

Primary focus area:
Behavioral/Mental Health

Other focus areas:
Community Health Workers/Promotoras,
Coordination of Care,
Health Professions Recruitment and Retention/
Workforce Development, Integrated Systems of Care

Grantee Contact Information

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Project Description and Goals

This project incorporates elements of health care redesign with a focus on population health management and value-based care. Funding from the Rural Health Network Development grant will provide the Toombs County Prevention, Treatment and Recovery (TC-PTR) Network the opportunity to strengthen and maintain collaborative relationships among the members that will integrate systems of care (administratively, clinically and financially) in order to (1) achieve efficiencies; (2) expand access to, coordinate and improve the quality of basic health services and associated health outcomes; and (3) strengthen the local rural health care system as a whole.

The project's overall goal is to improve access, expand capacity and services, enhance outcomes, and achieve sustainability. The objectives include:

- Continue to formalize the TC-PTR Network by developing it into a 501(c)3 organization and establishing an active board of directors. (*Sustainability*)
- Hire a full-time behavioral health clinical director who will supervise and oversee all aspects of the clinical operations of the TC-PTR Network in alignment with the network's mission and strategic plan, oversee crisis response team and co-responder police and social workers, and provide clinical oversight for all clinicians and peers providing services to individuals within the TC-PTR Network. (*Improve outcomes*)

- Develop and enhance a behavioral health disparities impact statement to support efforts to address populations in Toombs County who have historically suffered from poorer health outcomes and health inequities. The statement will describe how the network will reduce behavioral health disparities in the target rural service area and continuously monitor and measure the project’s impact on health disparities to inform process and outcome improvements. (*Improve access and outcomes*)
- Continue to coordinate substance use disorder prevention services and activities in Toombs County. (*Expand capacity and services and improve outcomes*)
- Develop and implement an effective sustainability plan that will generate \$300,000 annually for sustaining network-related services. (*Sustainability*)

Network Description

The 17 network partners include: Leigh-Anne White and Company, a local behavioral health services provider; Toombs County Family Connection Collaborative, a local grassroots community collaborative; Toombs County School System, the county public school system; Vidalia City School System, a city public school system; Mercy Medical Clinic, a free community clinic; Toombs County Health Department, public health agency; Toombs County Department of Family and Children Services, public social services; Toombs County Emergency Medical Services; Toombs County Judicial System; Toombs County Sheriff’s Office; Lyons Police Department, city law enforcement; Vidalia Police Department, city law enforcement; City of Lyons; City of Vidalia; Pineland Behavioral Health and Developmental Disabilities, public mental health organization; Safe Kids, a community-based organization; and Toombs County Recovery Community.

Evidence-based or Promising Practice Model

This project will utilize the U.S. Department of Health & Human Services’ Overdose Prevention Strategy, which expands the scope of the crisis response beyond opioids to include other substances that are often involved in overdoses, including stimulants such as methamphetamine and cocaine. This new strategy promotes groundbreaking research and evidence-informed methods to improve the health and safety of communities.

The strategy is guided by four principles:

- Equity
- Data and evidence
- Coordination, collaboration, and integration
- Reducing stigma

There are strategic priorities in the areas of primary prevention, harm reduction, evidence-based treatment, recovery support, and implementation, which depends on federal, state, and local governments working hand-in-hand with health care professionals, law enforcement, policy makers, employers, advocacy groups, and communities to remove barriers to high-quality care.

Populations Served

- Adults
- African Americans
- Caucasians
- Older adults
- Latinos
- Native Americans
- Pacific Islanders
- School-age children (elementary)
- School-age children (teens)
- Uninsured

Geographic Service Area

The service area is Toombs County, Georgia, an officially designated health provider shortage area and a medically underserved community that is home to 27,196 residents. Toombs County, Georgia has demographics like many poor, rural, and underserved areas of the country. Poverty, illiteracy, and child abuse rates are among the highest in the nation, as are several health indicators.

Lewis and Clark Public Health

Behavioral Health Systems
Leadership Team

D06RH49158

Primary focus area:
Substance Abuse

Other focus areas:
Behavioral/Mental Health, Coordination
of Care Services, Health Education and
Promotion, Integrated Systems of Care

Grantee Contact Information

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Project Description and Goals

The goal of the Behavioral Health Systems Improvement Program Expansion (BHSIPE) project is to expand the current Behavioral Health Systems Improvement Leadership Team, the network, and Local Advisory Council in Lewis and Clark County, Montana, and create a coordinated behavioral health system of care, specifically integrating substance use prevention and treatment services. This will include leadership and stakeholder expansion, addition of staffing at the lead organization focused on primary prevention and systems coordination, and a mobile unit pilot project which will integrate mental health, substance use prevention, and early intervention. This expansion will integrate substance use prevention (primary, secondary) and treatment through a collaborative structure that allows for coordination, further identification of gaps, identification of service providers that are currently doing the work (if applicable), and a way to link potential funding sources and partners to expand services in the behavioral health system of care.

Goal 1: Improve access

- Strategy 1: Increase access to substance use disorder and behavioral health prevention and treatment services in Lewis and Clark County
- Strategy 2: Improve the quality of substance use disorder and behavioral health prevention and treatment services in Lewis and Clark County

Goal 2: Expand capacity and services

- Strategy 3: Expand the capacity of the behavioral system network members to integrate substance use disorder prevention and treatment services in Lewis and Clark County

Goal 3: Enhance outcomes

- Strategy 4: Increase adoption and use of clinical systems and care practices to improve population health outcomes with mental health and substance use disorders in Lewis and Clark County

Goal 4: Sustainability

- Strategy 5: Prepare the network members to sustain the behavioral health and substance use disorder prevention and treatment services in Lewis and Clark County

Network Description

The Behavioral Health Program housed at Lewis and Clark Public Health engages with two primary groups for community efforts to identify and improve both the crisis system and continuum of care. These two groups are the behavioral health systems improvement leadership team and the behavioral health local advisory council.

The BHSI LT is a strategic alliance coalition of leaders who are key stakeholders in the community and will act as the network in this grant. The goals of the leadership team include identifying gaps in providers and services in both the behavioral health crisis systems and the full continuum of care, redesigning the crisis system utilizing best practices, and identifying and analyzing data to drive improved well-being for Lewis and Clark County. There are six current organizations on the leadership team: Lewis and Clark County Commission, Lewis and Clark County Sheriff's Office, Lewis and Clark Public Health, PureView Health Center (a Federally Qualified Health Center), St. Peter's Health (a hospital), and Shodair Children's Hospital.

In 2011, the Lewis and Clark Board of County Commissioners passed Resolution 2011-174 authorizing the creation of the Behavioral Health Local Advisory Council (LAC). The purpose of the LAC is to assist in the improvement of Lewis and Clark County behavioral health (mental illness and substance use disorders) services and to review and make recommendations about behavioral health services. The group consists of behavioral health providers, local professionals, and community consumers, who are people with lived experience (or their family members) with behavioral health disorders. The LAC utilizes the four workgroups to strategically guide the work. They will support and implement the work done by the network.

Evidence-based or Promising Practice Model

The following promising practices will guide this project:

- National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit Knowledge Informing Transformation from the Substance Abuse and Mental Health Services Administration (SAMHSA)
- Institute of Medicine's Behavioral Health Continuum of Care Framework
- U.S. Department of Health and Human Services (HHS) Overdose Prevention Strategy
- The Centers for Disease Control and Prevention Ten Evidence-Based Strategies for Preventing Opioid Overdose
- HHS Roadmap for Behavioral Health Integration

- Feasibility Study for Mobile Opioid Treatment Program Planning and Service Delivery Considerations in Montana (published 2022)
- Collective impact model
- Peer support model (SAMHSA)

Populations Served

- Adults
- Older adults
- Native Americans
- School-age children (teens)
- Unhoused Individuals

Geographic Service Area

Montana is a largely rural state with 56 counties with almost 1.1 million residents. Lewis and Clark County is the sixth most populated county in the state and is home to roughly 6.4 percent of the state's total population. The county is in west-central Montana, covering just over 3,000 square miles. The county includes two primary municipalities, Helena and East Helena, with additional small communities (with populations of less than 1,000) spread throughout the county, including the rural towns of Lincoln, Augusta, Marysville, Craig and Wolf Creek. Helena is the largest city in the county and serves as the state capitol. Only half of the residents live within Helena and over 90 percent of the county's population is within the greater Helena area (20 miles from the city center). All of Lewis and Clark County census tracts are rural.

Maine Health (Diabetes)

Food as Medicine-Oxford Network

D06RH49170

Primary focus area:
Chronic Disease: Diabetes

Other focus areas:
Health Education and Promotion,
Health Food Access,
Physical Fitness and Nutrition

Grantee Contact Information

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Project Description and Goals

This project pairs the Center for Disease Control and Prevention (CDC)'s National Diabetes Prevention Program (NDPP) and Cooking Matters, with the provision of healthy food, in an enhanced food-as-medicine model. The primary focus is on identifying and educating individuals with prediabetes. Participating in the program will be a community garden, a local hospital-based food pantry (the Maine Health Food Pantry at Stephens Memorial Hospital), Cooking Matters — which is led by Good Shepherd Food Bank and implemented through the Maine Supplemental Nutrition Assistance Program education program (SNAP Ed) — and several other organizations and programs. While both NDPP and Cooking Matters are already offered in Oxford County, this project will evaluate whether using them in conjunction with one another will lead to better outcomes for participants. The goals of the program are:

1. Improve access to prediabetic education and care by bringing enhanced education and support to rural Oxford County.
2. Expand the county's capacity to address the needs of this population by working collaboratively with health care and community partners to reach and enroll participants through direct referrals and other outreach methods.
3. Enhance measurable outcomes through a multipronged approach, by monitoring a range of health measures on a weekly basis, and by adjusting the program if needed by continuous program evaluation.

4. Assure sustainability by working both with providers to incorporate the program into their systems of care, and with community-based and network organizations to refer people to the program.

Network Description

The Food as Medicine (FAM)-Oxford Network is a subset of a Western Maine Health department, Healthy Oxford Hills (HOH). HOH is a decades-old healthy community coalition, a large, very active group of health and community-based organizations with a strong history of leading and working collaboratively with community, county and state organizations and agencies to improve the health and lives of residents across rural Oxford County. As the community health arm of Western Maine Health, HOH leads the Oxford County Wellness Collaborative, which itself leads or participates in issue-specific networks. The FAM-Oxford Network is such an issue-specific network, a group of organizations that are best positioned by their missions to operationalize and oversee this particular program. The majority have historically worked together in various iterations on a range of initiatives, both large and small. After the first year of grant implementation, and as the program grows and evolves, new member organizations may be added to increase program effectiveness should the program's ongoing evaluation indicate the need for expansion.

The roles of the network members are to assist with: development of a community outreach plan, enrollment of non-Maine Health patients in the FAM-Oxford program, and development of strategies to reduce barriers.

Current network members are the Alan Day Community Garden, Bethel Family Health Center, River Valley Healthy Communities Coalition, and Western Maine Health, including Stephens Memorial Hospital and Healthy Oxford Hills. Several community-based organizations and programs will also participate, but because they are non-rural based, they are not formal network members. These organizations and programs are: Good Shepherd Food Bank, Maine SNAP Ed program, Maine Health's Let's Go!, and Preventive Medicine Enhancement for Maine programs.

Evidence-based or Promising Practice Model

- CDC's National Diabetes Prevention Program
- Cooking Matters, part of the Maine SNAP Education program
- Franklin County Food as Medicine program

Populations Served

- Adults
- Food insecure
- People with prediabetes

Geographic Service Area

The service area for this project is Oxford County, Maine. Social determinants of health include but are not limited to: rurality, poverty, high rates of chronic illness, food insecurity, an aging population, and the effect of two concurrent epidemics (the opioid epidemic and COVID-19) on health outcomes and access to care. The rural Older adults compose a considerable percentage (22.8 percent) of the county's population.

Maine Health (Neonatal)

Maine Neonatal Telemedicine Network

D06RH49169

Primary focus area:
Telehealth

Other focus areas:
Specialty Care

Grantee Contact Information

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Project Description and Goals

The Maine Neonatal Telemedicine Network (Maine NET) network is designed to address the fact that, as the number of birthing hospitals in Maine has decreased drastically, the overall number of babies born in Maine and New Hampshire has stayed the same. Rural clinicians report feeling increasingly isolated in caring for higher-risk newborns. This likely increases the probability of transfer to a tertiary care center, and in turn creates potentially avoidable financial and other costs for rural families. Transferring newborns to tertiary care centers for low-acuity reasons is not only suboptimal for families, but also represents lost revenue for the rural hospitals and contributes to higher-than-necessary census for the tertiary care centers. The Maine NET network will address a critical need and provide support for newborn care in all hospitals (including 10 rural Critical Access Hospitals), by providing telemedicine support to rural community clinicians.

The goals of the project are:

Goal 1: Improve access to neonatal telemedicine consults to include both neurological and non-neurological diagnoses for newborns delivered in all hospitals in Maine through the use of real-time, synchronous telemedicine consults.

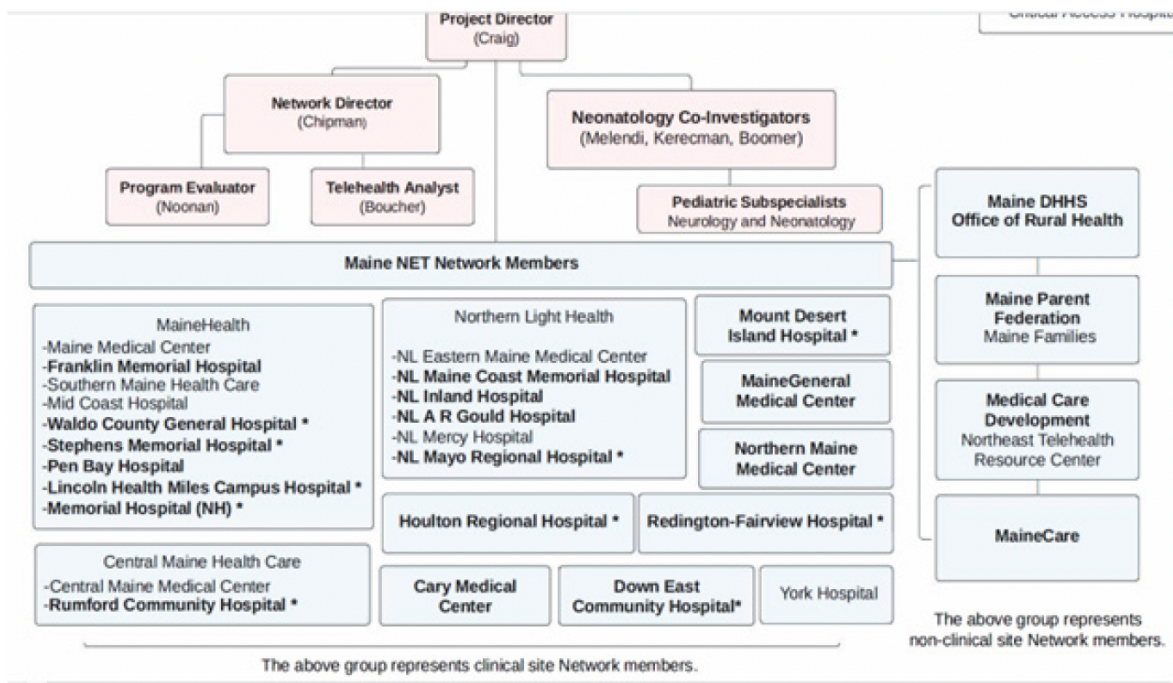
Goal 2: Provide educational outreach to clinicians in rural community hospitals to support care delivery for neonates.

Goal 3: Improve newborn outcomes by keeping families together in their community and decreasing the cost of their health care.

Goal 4: Sustain this telemedicine consultation network by analyzing the cost and staffing implications of managing transfer to tertiary care center through use of telemedicine.

Network Description

Network members include 25 hospitals of which 18 are rural community hospitals (ten critical access), and four community organizations. See the organizational chart below for members; note the correction of Mckay as network director.)



Evidence-based or Promising Practice Model

Until the advent of therapeutic hypothermia (TH), little could be done for infants with neonatal encephalopathy, of whom 15-20 percent would die and a further 25 percent would sustain permanent and severe neurological injury. Multiple pilot studies demonstrated safety of TH and multiple randomized control trials demonstrated efficacy with statistically significant reductions in death or severe neurological disability at age 12 to 18 months and in follow-up at six to seven years. TH is especially challenging since it must be started before the infant is six hours old.

At outside institutions with lower birth rates, neonatal encephalopathy is not seen as frequently and may go unrecognized. Additionally, the hypothermia intervention is relatively new, and providers in smaller or more rural locations, from which 75 percent of the infants treated at Maine Medical Center originate, may benefit from assistance in recognition of the syndrome.

Populations Served

- Infants

Geographic Service Area

The service area for Maine NET includes the entire state of Maine and all hospitals located in completely rural census tracts across Maine (and in Year Two of project, eastern New Hampshire.) The Maine counties to be served by this network are highly rural and some have poverty rates well above the national average. Ten of the 22 hospital network members are Critical Access Hospitals.

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Maine Primary Care Association Patient Safety Organization

Maine Primary Care Association Patient Safety Organization

D06RH49168

Primary focus area:
Patient Safety

Other focus areas:
Coordination of Care,
Health Information Technology,
Integrated Systems of Care,
Primary Care

Grantee Contact Information

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Project Description and Goals

Achieve efficiencies: Maine Primary Care Association Patient Safety Organization (MePCA PSO) is an integrated health care network. Eleven out of the 14 health centers engaged in this project are entirely rural and nine collaborate with an Accountable Care Organization, representing a rural integrated health care network. Working together as a network allows Federally Qualified Health Centers (FQHCs) to identify and solve common patient safety issues across a complex rural health care landscape.

Expand access: The insights made possible by the MePCA PSO into patient-related errors, “near misses,” and unsafe conditions, paired with responsive quality improvement (QI) projects, directly improve the quality and coordination of health care services. MePCA PSO “Safe Tables” learning sessions, conducted in person or through virtual meetings, are particularly important to health care services QI and expansion of access as they promote a culture of trust that encourages open dialogue by members about patient safety issues.

Strengthen the rural health care system: Identification of issues made possible through the MePCA PSO, together with a safe harbor (i.e., legal privilege and confidentiality protections) for exploring deeper connections regardless of institutional boundaries and interests, helps strengthen local and regional systems. The Patient Safety Act legislation of 2005 that provided for establishment of the MePCA PSO includes privilege and confidentiality provisions to facilitate building a culture of safety and high reliability in which all licensed health care providers are able to openly discuss in a protected manner patient safety hazards, risks, and quality

gaps. Providers can learn from analyses and share information with other providers to prevent recurrence. Similarly, insights into duplications and gaps gleaned through the MePCA PSO, and safe harbor for addressing these, could facilitate efficiencies in the system. The Patient Safety Act also states that the safe harbor the legislation affords to PSOs like the MePCA PSO “can be used to create a confidential learning system that promotes information sharing, physician education, and cost-effective patient outcomes.”

Goal 1: Improve access by addressing gaps in care, workforce shortages, better workflows and/or improving the quality of health care services

Goal 2: Expand capacity and services by creating effective systems through the development of knowledge, skills, structures, and leadership models

Goal 3: Enhance outcomes by improving patient and/or network development outcomes through expanding or strengthening the network’s services, activities, or interventions

Goal 4: Sustainability by positioning the network to prepare for sustainable health programs through value-based care and population health management

Network Description

MePCA PSO currently has 14 members, all FQHCs. Through the MePCA PSO, providers work to improve the quality of the health care provided in their healthcare settings and focus on patient and environmental safety. The MePCA PSO provides a protective collaborative framework for its members to work cooperatively to evaluate, address and share learnings regarding patient care to achieve quality and safety goals across various settings. Ultimately, the work of MePCA PSO and its providers is focused on improving clinical outcomes, saving lives, and providing the best quality, patient safety, service, and value.

Evidence-based or Promising Practice Model

Promising practices: The MePCA PSO leverages the unique characteristics of an innovative model—the Patient Safety Organization (PSO)—to create a highly efficient and reliable integrated healthcare network. In July 2005, Congress developed the federal Patient Safety and Quality Improvement Act of 2005. The Agency for Healthcare Research and Quality (AHRQ) oversees the Patient Safety Rule and certifies patient safety organizations like the MePCA PSO established by the Maine Primary Care Association. The Patient Safety Act and the Patient Safety Rule provide a structure for PSOs, while the legislation provides confidentiality and privilege protections (inability to introduce the protected information in a legal proceeding) when certain requirements are met. The program intentionally differentiates PSO work from most other regulatory and mandatory reporting programs.

PSOs support the collection, analysis, sharing and learning from incidents, near misses, and unsafe conditions through use of AHRQ Common Formats for uniform reporting of patient safety events. The information collected helps to determine what medical errors are occurring and why—with the overarching aim of preventing recurrence. Specifically, PSOs aggregate data from many providers to identify risk patterns of care and system failure. Emergency Care Research Institute allows Maine FQHCs to compare themselves to both state and national benchmarks. PSOs allow providers to work together in a confidential, protected space. Safe Table sessions further structure and facilitate this collaborative work for enhanced learning and paths to action for QI. PSOs assure protection and confidentiality to participating providers for their safety work products. PSOs are not a regulatory body and do not impose fines or other punitive measures for participating.

Populations Served

- Adults
- African Americans
- Caucasians
- Infants
- Latinos
- Native Americans
- Older adults
- Pacific Islanders
- Pre-school children
- Pregnant people
- School-age children (elementary)
- School-age children (teens)
- Uninsured

Geographic Service Area

While the target service area for participating MePCA PSO Network members covers close to the entirety of the state, the FQHCs participating in the MePCA PSO Network are primarily located in Maine's most rural counties, including (in order of rurality): Aroostook (99.9%), Washington (99.9%), Oxford (99.7%), Hancock (99.7%), Penobscot (98.7%), Knox (97.5%), Kennebec (96.3%), York (93.5%), Androscoggin (92.2%), and Cumberland (84.6%).

Mid-Valley Healthcare

Coast to the Cascades Community
Wellness Network

D06RH49171

Primary focus area:

Child Abuse,
Domestic/Intimate Partner Violence,
Human Trafficking

Grantee Contact Information

Grantee Contact: Sommer McLeish

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Organization Type: Hospital

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Project Description and Goals

The Addressing Violence in Rural Oregon Communities (AViROC) project will expand the capacity of the Coast to the Cascades Community Wellness Network (CCCWN) and its regional health coalition, Partners for Health (PFH), to improve health outcomes in the region through network development around child abuse, domestic violence, and human trafficking. The CCCWN/PFH has identified child abuse, domestic violence, and human trafficking as priority areas over the next four years. Five CCCWN/PFH members, all local organizations actively engaged in addressing these issues, will collaborate to fill gaps in outreach, education, and services in rural communities. Through AViROC, CCCWN/PFH will develop and implement a coordinated approach to address these issues; conduct outreach and education with staff, providers, and the public; and expand survivor services into rural and underserved communities. Project partners, with applicant Samaritan Lebanon Community Hospital (SLCH), include: ABC House, Acosta Services, Center Against Rape and Domestic Violence, Sarah's Place, and the Linn-Benton Anti-Trafficking Coalition.

Overarching Goal: Reduce rates of child abuse, domestic violence, and human trafficking in Lincoln and rural east Linn counties through advocacy, outreach, and education.

Goal 1: Strengthen and sustain regional Coast to the Cascades Community Wellness Network and Partners for Health to enhance capacity to provide child abuse, domestic violence, and human trafficking prevention and support services in Lincoln and east Linn counties.

Goal 2: Increase knowledge around child abuse, domestic violence, and human trafficking through outreach and education in Lincoln and east Linn counties.

Goal 3: Expand access to services that address child abuse, domestic violence, and human trafficking in Lincoln and east Linn counties.

Goal 4: Sustain activities and services of Coast to the Cascades Community Wellness Network and Partners for Health that address child abuse, domestic violence, and human trafficking through comprehensive planning for Lincoln and east Linn counties.

Network Description

Established in 2009, the CCCWN is a mature network composed of a 23- member board, seven-person steering committee, and 11 subcommittees with representation from across the tri-county region. The steering committee is responsible for managing and overseeing the actions of the network. Membership includes hospital leadership, local health department executive directors, K-12 school superintendent, dental care organization, community action agency director, medical school dean, tribal member, Office of Rural Health, Medicaid agency director, elected officials, law enforcement, nonprofit organization, and community members.

The network itself employs a nontraditional organizational structure, with the CCCWN as the hub of several local coalitions. Information, support, and leadership flow in both directions between the CCCWN and the coalitions. Under direction of the CCCWN charter and steering committee, the following coalitions are supported, led, or represented by the CCCWN: obesity prevention, mental health, oral health, pregnancy/ prenatal care, tobacco prevention, chronic care, and access to care. The steering committee develops agendas and identifies key community health initiatives based on local coalition input. The CCCWN subcommittees are responsible for locally driven activities around network priorities. The full CCCWN is responsible for ensuring that community needs are identified, gaps addressed, and services implemented to improve health in the region.

The Partners for Health is a regional coalition of the CCCWN. The CCCWN is a formal health network that includes key leaders and decision makers from health care organizations, county health departments, medical schools, school systems, government agencies, nonprofit organizations, law enforcement, and tribal

councils. They lead or are active members in local coalitions in Lincoln, Linn, and Benton counties in Oregon. They provide guidance and direction on issues that impact the health of local communities. They support multiple Health Resources and Services Administration grant programs in the tri-county region in the areas of oral health, substance/opioid use disorders (SUD/ODU), and SUD/ODU disaster preparedness.

Evidence-based or Promising Practice Model

- 1. Child Abuse- AViROC Strategies:** Collaboration, trauma counseling, community education and awareness
 - *Violence and Abuse in Rural America*. Rural Health Information Hub. Retrieved November 2022. <https://www.ruralhealthinfo.org/topics/violence-and-abuse>
 - National Center for Injury Prevention and Control, Division of Violence Prevention. (2016). *Preventing child abuse and neglect: a technical package for policy, norm, and programmatic activities*. The

Centers for Disease Control and Prevention. <https://www.cdc.gov/violenceprevention/pdf/CAN-Prevention-Technical-Package.pdf>

2. Domestic Violence / Intimate Partner Violence - AViROC strategies: Outreach, advocacy, strangulation training, crisis response

- National Center for Injury Prevention and Control, Division of Violence Prevention. (2017). *Preventing intimate partner violence across the lifespan: a technical package of programs, policies, and practices*. The Centers for Disease Control and Prevention. <https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf>
- **Strangulation training** [United States Department of Justice, Office on Violence Against Women](#)

3. Human Trafficking- AViROC strategies: Network response, training, educational summit, community education

- Wright Clayton, E, Krugman, R.D. and Simon, P, (Eds.). (2013). *Confronting commercial sexual exploitation and sex trafficking of minors in the United States*. The National Academies Press. <https://doi.org/10.17226/18358>
- Administration for Children and Families. (2020). *National advisory committee on the sex trafficking of children and youth in the U.S.: best practices and recommendations for states*. United States Department of Health and Human Services. https://www.acf.hhs.gov/sites/default/files/documents/otip/nac_report_2020.pdf
- Awerbuch, A. (2020). Raising awareness of human trafficking in key professional fields via a multidisciplinary educational approach. *International Journal of Human Rights in Healthcare*. <https://www.emerald.com/insight/publication/issn/2056-4902>

Populations Served

- Adults
- African Americans
- Caucasians
- Indigenous Guatemalans- Mam speakers
- Latinos
- LGBTQIA2S+
- Native Americans
- People of color
- School-age children (elementary)
- School-age children (teens)
- Uninsured

Geographic Service Area

The geographic service area is Lincoln County and east Linn County, Oregon. The service areas are identified as rural and medically underserved communities. Both Lincoln County and east Linn County are geographically isolated. Lincoln County is bordered on the west by the Pacific Ocean and the east by the Coast Mountains. Major services require a one-to-two-hour drive over windy mountain roads. East Linn County is bordered on the east by the Cascade Mountains and residents in its most rural areas must drive over an hour to access many services. Many of the most vulnerable populations have limited or no access to a car or time required for the trip.

Ministry of Health in the Republic of the Marshall Islands

Republic of the Marshall Islands Rural Health Network Development Project

D06RH49172

Primary focus area:

Access: Primary Care

Other focus areas:

Children's Health, Health Professions Recruitment and Retention/Workforce Development, Integrated Systems of Care, Maternal/Women's Health

Grantee Contact Information

Grantee Contact: Asdan Timothy

Contact Title: Network Director

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Organization Type: State government

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Project Description and Goals

The overall project aim is to support efforts that will, strengthen the Neighboring Island Health Centers systems, capacities, and service delivery to more effectively drive improvements in access to preventive health care services and population health outcomes. Strategies will be employed to develop partnerships, decentralize and integrate care, and make better use of data to organize care. This will change the way care is delivered to neighboring islands by enhancing skills of staff on neighboring islands to perform services often provided by visiting public health teams, allowing basic services to continuously be available on the islands, and formalizing partnerships with organizations that engage communities (women in particular) and enhance professional standards for health staff. This project supports the implementation of key priority areas of the Republic of the Marshall Islands Ministry of Health and Human Services newly drafted eight-year ministry strategic plan in alignment with the key priority areas of addressing health workforce development and foundational capabilities.

The goals of the project are:

Goal 1: Achieve efficiencies utilizing the strategy of more basic services being delivered by local staff rather than visiting Majuro-based teams. Objectives include:

- Develop and place at least one female health aide in each outer island (OI) atoll.

- Equip outer islands (OI) health staff with knowledge, skills, and tools needed to provide basic preventive and primary care services on site through provision of accredited college-level training.
- Provide regular support to OI staff to maintain the capability to deliver basic services.

Goal 2: Expand access and improve quality of basic health care services and associated health outcomes through the strategies of “up-skilling” OI staff so that a wider range of services are continuously available; female providers for maternal health & child development (MH&CD) services; institute quality and performance standards for health services. Objectives include:

- Mobilize existing OI staff to provide a full complement of preventive services.
- Place at least one female MH&CD aide or health assistant in each OI atoll.
- Institute quarterly monitoring of standards for health centers (facilities upkeep, essential medicines, supplies and equipment, inventory management, community engagement, services delivery including outreach, and record keeping and reporting).

Goal 3: Strengthen the health care system by implementing these strategies: instituting a data-driven approach to health service delivery, introducing local oversight of OI health services, monitoring quality standards, and linking to improvement mechanisms. Objectives include:

- Increase community engagement in OI health services.
- Build a data system that can track patients needing regular follow-up and prompt outreach by staff in the OIs.
- Apply explicit standards to health centers to encourage good performance.
- Provide quarterly support visits to OI staff to maintain capability to deliver basic services and prevent “capacity decay.”

Network Description

The network has three collaborating members who will drive the project forward. The Ministry of Health and Human Services, which is the national government agency responsible for health services in the neighboring islands as well as the full spectrum of prevention, primary, secondary, and tertiary care, out-of-country referrals, and disaster management for the country; the College of the Marshall Islands, which will organize accredited training programs for neighboring island primary care staff; and Women United Together of the Marshall Islands, a nonprofit organization that will organize the selection, development, and deployment of female health aides to strengthen maternal and child health care services.

Evidence-based or Promising Practice Model

- Use of Data for Decision Making program to design health information system elements in support of health service delivery reform
- Use of regular supportive supervision visits to improve the performance of community health workers in remote settings in low-income countries.

Populations Served

- Pacific Islanders
- Pre-school children
- Pregnant people
- School-age children (elementary)
- School-age children (teens)

Geographic Service Area

The Republic of the Marshall Islands is located in the north-central Pacific Ocean, roughly between Hawai'i and Guam. It comprises 29 atolls and five islands totaling 1,156 islands and islets, spanning an exclusive economic zone of 750,000 square miles of ocean but a landmass of only 70 square miles, equivalent to that of Rhode Island. Its current population is estimated at 79,906 as of the 2010 population census projections, with nearly two-thirds of the population residing in the two main urban centers of Majuro Island in Majuro Atoll and Ebeye Island in Kwajalein Atoll.

The service area for this project are the neighboring islands, located in the Pacific Ocean, covering over 1,000 inhabited islets. The communities are small, ranging from a few dozen to more than 1,300 people.

Nemaha Valley Community Hospital

Primary focus area:
Migrant/Farm Worker Health

Health Innovations Network of Kansas
Suicide Prevention Improvement Network

D06RH49173

Grantee Contact Information

Grantee Contact: Maggie Hunninghake
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Organization Type: Hospital
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Project Description and Goals

The Health Innovations Network of Kansas Suicide Prevention Improvement Network (HINK SPIN) brings together a unique collection of representatives with strong ties to both health care and agriculture. Through these deliberate and strategic connections, network partners are committed to researching and implementing approaches that have proven successful in other rural regions in reducing suicide and increasing access to needed services. They are working together to create a system of focused services to reduce suicide rates, educate the broader community, and integrate primary and mental health care with a specific focus on residents involved in agricultural production. The result will be improved mental wellness and quality of life across rural Kansas.

Proposed project activities and services will include:

Goal 1: Address the full spectrum of educational needs in the HINK region necessary to support the prevention of suicide in rural, agricultural communities of northeast and north-central Kansas

- Develop a coordinated and integrated outreach and marketing plan for community member education including outreach specifically to ag-related businesses including livestock sale barns, grain storage elevators, banks and ag lenders, etc.

- Develop HINK SPIN website to host project specific pages and evidence-based resources for target population
- Implement Man Therapy and Coffee Cup projects in the HINK SPIN region, including a targeted outreach plan to support these innovative measures
- Provide behavioral health and suicide prevention speaker sponsorships at targeted events
- Develop and implement coordinated and integrated plan for providing culturally competent training to targeted front-line medical staff
- Provide culturally relevant training to Kansas 988 staff
- Implement LandLogic continuing educational unit (CEU) training program for primary and behavioral health providers at HINK member hospitals/clinics
- Incorporate culturally relevant CEUs into annual education for HINK hospital front line staff members
- Develop and implement comprehensive plan for “Question, persuade, refer” online gatekeeper training for frontline staff (registration, billing, [physical therapy, nursing, home health and hospice staff, etc.] at each HINK member hospital

Goal 2: Develop and implement measures that will ensure long-term sustainability of the HINK SPIN

- Develop and implement member-focused communication plan
- Develop and implement external communication plan to HINK SPIN region
- Develop dues structure for HINK SPIN members to support sustainable network activities
- Apply for diversified grant funding opportunities
- Formalize HINK SPIN infrastructure (e.g., membership, voting, mechanisms for communication with HINK board, roles and responsibilities for each partner in implementing, supporting, and sustaining the HINK SPIN)

Network Description

HINK SPIN consortium is comprised of 11 hospitals (including the lead applicant, Nemaha Valley Community Hospital), one community mental health center, and six agricultural organizations and agencies.

Evidence-based or Promising Practice Model

The HINK SPIN project has identified a variety of evidence-based practices or models that will be deployed within the region to meet strategic goals. These practices/models include:

- QPR Training (www.qprinstitute.com)
- Man Therapy (www.mantherapy.org)

Populations Served

- Adults
- African Americans
- Caucasians
- Older adults
- School-age children (elementary)
- School-age children (teens)
- Latinos
- Native Americans
- School-age children (teens)
- Uninsured

Geographic Service Area

HINK SPIN covers multiple counties in northeast Kansas including Atchison, Brown, Coffey, Dickinson, Geary, Jackson, Jefferson, Morris, Nemaha, Pottawatomie, Riley, Shawnee, and Washington.

North Central Iowa Mental Health Center dba Berryhill Center

The Community Health Network

D06RH49174

Primary focus area:
Behavioral/Mental Health

Other focus areas:
Coordination of Care,
Substance Abuse

Grantee Contact Information

Grantee Contact: Melissa Klass

Contact Title: Manager Behavior Health Services

Organization: North Central Iowa Mental Health Center dba Berryhill Center

Organization Type: Hospital

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Website: www.unitypoint.org/locations/unitypoint-health---berryhill-center

Project Description and Goals

The project seeks to increase mental health and substance abuse treatment access and outcomes for patients while increasing efficiencies in delivering care. To accomplish this, the network will focus on the following goals:

Goal 1: Improve access and services to new consumers by decreasing wait times for psychiatric, therapy and substance use disorders evaluations. By using a team-based model of care, health care providers in the community health network and a care navigator will collaborate with patients and their caregivers to reduce new-patient evaluation wait times to 14 days or less. By addressing this gap in care and creating a better workflow, the result will be a 58-percent decrease in wait time and no-show rates of 15 percent or less. The effects of using a sustainable team-based health-care program will continue to increase as patients are moved more efficiently through an episode of care.

Goal 2: Expand capacity by implementing comprehensive screening activities that will increase availability of high-quality services within the community health network that are responsive to the needs of the rural community. Berryhill will hire care navigators to serve as the first point of contact for new consumers to ensure everyone is screened upon enrollment and is connected to appropriate behavioral health services. Behavioral health consultants will be utilized in the emergency department to help consumers with repeated emergency department visits to establish treatment with appropriate outpatient and community resources.

This sustainable health management system will increase the number of new consumers served to 10 percent of Webster County residents.

Goal 3: Enhance outcomes and improve patient-centered care by utilizing evidence-based practices (EBPs) aimed at stabilization and health maintenance. The care navigator, in collaboration with community health network providers, will help all new consumers establish treatment based on their needs to improve treatment outcomes. EPB enrollments will be tracked and monitored through the electronic health record. Utilizing EBPs as a sustainable health program in correlation with tracking enrollment and screening will result in a reduction in depression screening scores.

Network Description

The members of the network include:

- Berryhill Center, a state-accredited community mental health center that serves as a hub for a ten-county region and is a cornerstone of behavioral health support in the community
- Trinity Regional Medical Center (TRMC), a safety-net hospital designated by Centers for Medicare & Medicaid Services as both a sole community hospital and a rural referral center. TRMC has management agreements with five Critical Access Hospitals
- UnityPoint Clinic is composed of 50-plus physicians, mid-level providers and specialists. It covers 26 clinic locations and brings a full array of primary care services and several specialty clinics.
- Webster County Public Health, operated under county governance structure as a local board of health, offers an array of services such as maternal health, environmental health, and emergency preparedness to six counties.
- Community & Family Resources serves 14 counties across Iowa and offers a comprehensive substance use treatment provider and services for problem gambling and is an accredited mental health service provider
- Community Health Center of Fort Dodge offers comprehensive health care that includes dental, behavioral health, and general medical assistance for adults and children. They serve all residents in their target area, regardless of insurance status.

Evidence-based or Promising Practice Model

- Assertive community treatment
- Trauma-focused cognitive behavioral therapy
- Peer recovery support services
- Integrated treatment for co-occurring disorders
- Parent child interaction therapy
- Screening, brief intervention and referral to treatment
- Columbia Suicide
- Patient health questionnaire (PHQ-2, 9 & PHQ-9 for teens)
- Matrix Model (provides a framework for engaging stimulant abusers in treatment)
- Eye movement desensitization and reprocessing (a psychotherapy method proven to help people recover from trauma)

Populations Served

- Adults
- African Americans
- Caucasians
- Older adults
- Latinos
- Native Americans
- Pacific Islanders
- Pregnant people
- School-age children (elementary)
- School-age children (teens)
- Uninsured

Geographic Service Area

The target service area is ten counties located in north central Iowa: Calhoun, Franklin, Hamilton, Humboldt, Kossuth, Pocahontas, Sac, Webster, and Wright. This area covers 6,180 square miles. The overall geography is plains crossed by a network of rivers. Weather is a major factor in health care access for patients. Flooding has been a major factor affecting roads and travel in the spring and summer, and in the winter, blizzards, heavy snowfall, high winds, and extreme cold can severely limit patient ability to travel. The community health network serves individuals across ten Iowa counties in hospital, residential, outpatient and community-based settings, including schools. One hundred percent of the community health network members are in rural areas as designated by the Health Resources and Services Administration.

North Country Healthy Heart Network

Get Healthy North Country! Community Integrated Health Network

D06RH49180

Primary focus area:
Chronic Disease: Diabetes

Other focus areas:
Asthma/COPD, Cardiovascular,
Health Education and Promotion

Grantee Contact Information

Grantee Contact: Ann Morgan
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Project Description and Goals

Get Healthy North Country! aims to expand access to, coordinate, and improve the quality of chronic disease prevention in northeastern New York State by empowering a network lead entity (applicant) to operate as a community integrated health network that offers capacity to sustain ongoing, regular delivery of evidence-based chronic disease prevention services.

Goal 1 (Network Goal): To increase network capacity to sustain ongoing, regular delivery of evidence-based chronic disease prevention services.

Goal 2 (Program Goal): To reduce prevalence of diabetes in the North Country by increasing pre-diabetic and diabetic patient access to and participation in evidence-based prevention and self-management programs.

Network Description: (Include number and types of members)

Network Description

The network was formed with a shared-services model in mind, where each member has a role or contributes resources and expertise to help the network meet shared goals and objectives. In order to expand access to, coordinate, and improve the quality of chronic disease prevention in its region, the network initially required the participation of:

- organizations able to deliver chronic disease prevention and self-management (CDPSM) education programs (15 program delivery partners);
- a CDPSM training partner to train program delivery partner staff and volunteers to be program leaders and support organizations hosting the programs;
- health care provider partners interested in referring patients to these lifesaving programs;
- an organization with capacity to accept provider referrals and assist patients with program selection and enrollment (New York Connects partners);
- a way to monitor programs and program referrals to make sure they are having an impact and that the process is working (a data hub advised by a data planning team);
- a team of regional chronic disease prevention stakeholders with an interest in helping to identify opportunities for sustainability (a group that is now called the Integrated Network Development Committee);
- “emerging issues” action teams that further study and, when appropriate, develop plans for taking advantage of, opportunities for network sustainability and operational improvement. Initial network members were identified and recruited with these specific roles in mind; and
- organizations with reach to traditionally underserved populations (organizations and programs that serve older, low-income, behavioral health, disabled, and Native American communities), including area offices for the aging, two Federally Qualified Health Centers, eight hospital-run community health centers, seven behavioral health care providers, an increasing number of peer-led social support program providers, and the St. Regis Mohawk Tribe.

Evidence-based or Promising Practice Model

The network uses the Centers for Disease Control and Prevention (CDC)’s [Chronic Disease Prevention System](#) as a framework to organize and address the region’s service gaps. The CDC suggests that in order to reduce the burden of chronic disease efficiently and effectively, efforts should be coordinated in four key domain (activity) areas:

Epidemiology and surveillance: gathering data to guide, prioritize, deliver, and monitor programs/population health

Environmental approaches: designing communities and organizations so that opportunities for healthy behaviors are available for more people

Health care system interventions: improving delivery and use of quality clinical services to prevent disease, detect diseases early, and manage risk factors

- The evidence-based practice (EBP) employed in this domain is [practice facilitation](#)

Community-clinical links: ensuring that patients are connected to quality community resources that can help them to manage their conditions

Two EBPs are employed in this domain:

- [National Diabetes Prevention Program](#)
- [Chronic Disease Self-Management Program](#)

Populations Served

- Adults
- Older adults
- Individuals with chronic condition
- Latinos
- Low income
- Native Americans

Geographic Service Area

Get Healthy North Country! targets residents of Clinton, Essex, Franklin, Hamilton, and St. Lawrence counties in their entirety. It also targets residents in rural census tracts in Warren and Washington counties. These counties are located in the northeastern corner of New York State, bordered to the north by Canada and to the east by Lake Champlain. They cover 10,697 square miles, an area larger than the entire state of Massachusetts. A significant portion of the region is included in the Adirondack Park (Park), a unique six-million-acre patchwork of private and public land designated as a state park.

Northwest Hills Council of Governments

Northwest Hills Community
Health Network of Connecticut

D06RH49181

Primary focus area:
Behavioral/Mental Health

Other focus areas:
Coordination of Care Services,
Emergency Medical Services, Health
Professions Recruitment and Retention/
Workforce Development

Grantee Contact Information

Grantee Contact: Leonardo Ghio

Contact Title: Project Director

Organization: Northwest Hills Council of Governments

Organization Type: Government: Regional planning organization

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Project Description and Goals

The purpose of the Northwest Hills Community Health Network of Connecticut (NHCHN-CT) is to act as a “no- wrong-door” model for adolescents in the region, ages 13 through 18, who are either in need of services related to mental and behavioral health, or who are at risk of experiencing behavioral health concerns due to various social determinants of health and exposure to toxic stress.

Youth in the county are experiencing anxiety, depression, suicidal ideation, other disorders, or effects of toxic stress. Together, network members will achieve efficiencies, expand access to, coordinate, and improve the quality of health care services and associated health outcomes for this target population and the related system of care.

The goals of this project of the NHCHN-CT are:

- Improve and increase access to mental health services for youth in northwest Connecticut.
- Create effective systems for information sharing among health care providers in northwest Connecticut.
- Improve patient mental health outcomes by expanding and strengthening mental health activities and interventions for adolescents in northwest Connecticut.
- Ensure network sustainability through value-based care and population health management.

Network Description

This network has four partners including: Northwest Hills Council of Governments, the lead applicant employing the project director and ensuring regular communication, collaboration, and timely completion of required reporting; Greenwood Counseling & Referrals Inc., a provider organization conducting trauma and social determinants of health screenings, referrals to appropriate services, and case management; Community Health and Wellness Center of Greater Torrington, a provider organization conducting trauma and social determinants of health screenings, referrals to appropriate services, and psychiatric medication management for adolescents; and McCall Behavioral Health Network, a provider of an intensive outpatient program and psychiatric medication management for adolescents.

Evidence-based or Promising Practice Model

- Adverse childhood experiences screenings
- Social determinants of health screening
- Youth and teen mental health first aid trainings
- De-escalation training for first responders
- Continuing education trainings focused on adolescent behavioral health for school staff and social workers
- Curriculum for clinicians that addresses the root causes of substance use, mental health, and trauma

Populations Served

- School-age children (teens)

Geographic Service Area

Network services are available to the 21-town catchment area served by the Northwest Hills Council of Governments in the northwest corner of Connecticut. However, the clinical providers serve the entirety of Litchfield County. There are an estimated 12,250 youth between the ages of 13-18 years old in Litchfield County.

Paris & Henry County Healthcare Foundation

GrowWell Telehealth Network

D06RH37518

Primary focus area:
Telehealth

Other focus areas:
Behavioral/Mental Health,
Cardiovascular,
Children's Health, Diabetes, Primary
Care, School Health, Specialty Care

Grantee Contact Information

Grantee Contact: Steve Parker

Contact Title: Project Director

Organization: Network Director of Telehealth Systems

Organization Type: Nonprofit organization

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Email: sparker@hcmc-tn.org

Website: www.hcmc-tn.org and www.growwelltn.org

Project Description and Goals

Services within this program include behavioral health, obesity- and diabetic-related nutrition services, and school-based telehealth services. All services will be marketed and shared with clinics, providers, and members within the target communities. Additionally, education will be provided to explain telehealth technology and its use in increasing access to quality care close to home. Support surrounding implementation, software and hardware training, and policy and reimbursement will be provided to clinics and providers to extend these services within their practice.

- Remote Patient Monitoring (RPM) Program Pilot- Continuation of telehealth services and chronic disease management
 - RPM Pilot
 - Software and Peripherals
 - 6 months of monitoring services
- School-based telehealth cart implementation
 - Provide continued support and implementation of technology in eight new schools
 - Train staff and nurses in how to use equipment
 - Additional equipment needed for services

- Additional equipment needed for project partners
- Additional behavioral health provider for network behavior health
 - Additional capacity needed for behavior health network services
 - Implementation of behavior health services for project partners
- Ongoing support of nutrition services
 - Continuation of covered services for project partners
 - Use projected cost for dietician associates over next eight months

Network Description

The West Tennessee Delta Network is a formally established and self-governing membership organization. The network’s mission is to promote health equity and enhance the well-being of residents of rural west Tennessee through partnership development, shared resources, education, and care coordination. The network grew out of the West Tennessee Delta Consortium, a group of more than 30 health care and nonprofit agencies that have worked together since 2010. Through a Rural Health Network Planning grant, the network members established a formal organizational structure, mission, bylaws and self-governing board in 2018.

Network members are: Henry County Medical Center, Hardeman County Community Health Center, Lifespan Health, LeBonheur Community Health and Wellness, Tennessee Department of Health, and Hardeman County Schools.

Evidence-based or Promising Practice Model

- Telehealth
- Remote patient monitoring
- Digital literacy

Populations Served

- | | |
|---------------------|------------------------------------|
| • Adults | • Latinos |
| • African Americans | • School-age children (elementary) |
| • Caucasians | • School-age children (teens) |
| • Older adults | • Uninsured |

Geographic Service Area

This program service area is 13 rural counties in west Tennessee: Weakley, Henry, Gibson, Carroll, Benton, Haywood, Henderson, Decatur, Chester, Hardeman served, McNairy, Hardin, and Wayne.

Plainview Foundation for Rural Health Advancement

Total Health Network

D06RH49183

Primary focus area:

Access: Primary Care

Other focus areas:

Behavioral/Mental Health,
Coordination of Care Services,
Oral Health

Grantee Contact Information

Grantee Contact: Retta Knox

Contact Title: Executive Director

Organization: Plainview Foundation for Rural Health Advancement

Organization Type: Nonprofit organization

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Project Description and Goals

Total Health Network decided to have a network with two separate work groups within the network. This approach is driven by the needs assessment and the goals addressing the continued and expanded delivery of health care in the target area. The project's focus is to retain all current services and expand services via the coordination model. The menu of services (medical, dental, mental health, telemedicine, and education) concentrates on the whole person, while targeting improving quality of services. The work plan addresses the two groups individually. The reason for this is the needs of the three clinics involved is very different and the distance between the clinics is a challenge. The partnership expands the workforce by utilizing community health workers and creates a Federally Qualified Health Center (FQHC) to address access for the working poor. The transition to FQHC is monumental in expanding capacity and insuring future access to services.

Goal 1: Establish a lasting network to provide guidance and leadership.

This goal sets up the infrastructure to implement the care coordination model, ensuring continued services and increasing access to services.

Goal 2: Develop a working growing care coordination model.

This goal is the heart of the project and huge in its scope. Goal two could easily be divided into numerous other goals. The staff will break this goal down into segments five target areas: medical, dental, mental health, staff training, and developing resources to begin strategic planning of the project.

Goal 3: Develop a data collect and reporting system to support the project coordination. Good data is the key to continued support by existing and future partners and vital in seeking future funding.

Goal 4: Transition to an FQHC at Hart delivering coordinated comprehensive health care to improve outcomes under the management of Castro County Hospital District (CCHD). This goal is vital to the sustainability of all three clinics. The cooperative effort between PFRHA, CCHD, and Hart Independent School District will determine the future operation and growth of Hart program.

Network Description

The network partners:

- Plainview Foundation for Rural Health Advancement - a 501c3 non-profit (lead agency) currently operating three rural community clinics
- Castro County Hospital District - a tax-supported Critical Access Hospital
- Motley County Hospital District - a tax-based hospital district
- Hart ISD - a rural independent school district
- Kevin Pope, DDS - private practice dentist
- Nelson Counseling - a privately owned business
- Steve Alley, MD - independent medical practice
- Wilson Pharmacy - a community pharmacy

All are devoted to ensuring access to care and providing quality care in rural communities.

Evidence-based or Promising Practice Model

Donabedian's quality framework will be the umbrella of the approach.

Total Health Network will utilize the Rural Health Information Hub Rural Care Coordination Toolkit. Four models will be blended to address network needs. The models being used are:

1. Care Coordination Model, including development of community health worker component
2. Health Information Technology Model, adapting electronic health record and developing telehealth
3. Partnership Model, building comprehensive services through effective partnerships
4. Patient-Centered Medical Home Model

FQHC guidance and resources is not a model but will be used as a guide. The steps involved in setting up an FQHC are outlined in this guidance. The process is new to all network members so the network will be dependent on guidance and numerous consultations with agency personnel.

Populations Served

- Adults
- Older adults
- Infants
- Pre-school children
- Public funding
- School-age children (elementary)
- School-age children (teens)
- Uninsured
- Under-insured

Geographic Service Area

The service area targeted is in the High Plains Region of Texas. It consists of fourteen counties that are all farming and ranching communities. Targeted counties are: Castro, Hall, Motley, Briscoe, Swisher, Parmer, Deaf Smith, Lamb, Hale, Floyd Cottle, Crosby, and Dickens. Total population of the 14-county area is 108,464 with a loss of over 10,000 in the past 10 years. This population represents 38,716 households. This population includes 4,391 veterans. The population in the three counties (Castro, Hall, Motley) with existing Plainview Foundation for Rural Health Advancement clinics is 11,259. The network project has divided the area into two groups based on needs, location and goals for each group. Group one: Castro County and four adjacent counties minus counties with a FQHC population is 37,256, including 10,130 uninsured citizens, including counties with FQHC it increases by 51,105. Group two – CapRock Clinic’s population is nine counties totaling 20,103, including 4,877 uninsured.

Powerhouse Community Development Corporation

Health First Network

D06RH49184

Primary focus area:
Substance Abuse

Other focus areas:
Behavioral/Mental Health

Grantee Contact Information

Grantee Contact: Dona L. Stephenson

Contact Title: Project Director

Organization: Powerhouse Community Development Corporation

Organization Type: Nonprofit organization

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Project Description and Goals

Although the three Health First Network members have individually, and collectively as members of the Central Missouri Behavioral Health Network, achieved measurable strides in improving gaps in access to the essential components of integrative care, a myriad of persistent, debilitating factors continues to exist. These link to external factors which include economic and psychological impacts of the COVID-19 pandemic, severe state budget cuts for core services, challenges with accessing Medicaid-reimbursable services due to lack of provider enrollment, decrease in, and in some sectors, lack of adequate insurance coverage, and total lack of locally accessible mental health service providers and decrease in the health care and social services workforce.

A severe shortage of mental health professionals illustrates the persistent gaps in addressing behavioral health issues and significantly affects the capacity of the Health First Network's stakeholders to fully respond to prevention, treatment, and persistent, long-term recovery needs related to the problems of emotional/mental health, co-occurring disorders, opioid use disorder, substance use disorder, and social determinants of health.

Therefore, in addition to the network's ongoing responsiveness to persistent community health-related needs that affect overall health, such as have been identified through its array of ongoing needs assessments, it will launch a new initiative to expand access to specific, mental/behavioral health services, accomplished by integrating the clinically driven patient-centered medical home model, a practice of integrated care that operationalizes principles to improve access to evidence based mental health treatments for primary care

patients.

The goals of the Health First Rural Health Initiative (Health First) are:

- Goal 1: Establishment and infrastructure of the network
- Goal 2: Capacity building
- Goal 3: Data collection, integration and sharing

Network Description

Powerhouse Community Development Corporation (Powerhouse), established in 2008, as a nonprofit organization located in the rural community of Marshall in Saline County Missouri, will serve as the lead applicant for the Health First Network, implemented in partnership with a rural, diverse group of agencies rooted in behavioral health, mental health, primary health care, and social services. Network members for this project include 1) Powerhouse, 2) Katy Trail Community Health (a Federally Qualified Health Center), and 3) Recovery Lighthouse, Inc. (behavioral health organization). The Health First Network is a strategically curated initiative, informed through collaboration, assessment, and strategic planning processes of the Central Missouri Behavioral Health Network, which has been guided by the Health Resources and Services Administration's Federal Office of Rural Health Programs in developing network, planning, and implementation processes for five years.

Evidence-based or Promising Practice Model

Evidence-based/promising practices include:

- Service coordination models and training programs
- Motivational interviewing
- Solution focused therapy and structural and strategic therapy
- Matrix model
- Intensive outpatient therapy model
- Family engagement
- Fatherhood
- Patient-centered medical home
- Community-based participatory research program

Populations Served

- Adults
- African Americans
- Caucasians
- Latinos
- Native Americans
- Pacific Islanders

Geographic Service Area

The targeted service area for the project comprises four similarly situated, fully rural mid-Missouri counties of Morgan, Johnson, Pettis, and Saline which encompass approximately 2,600 square miles and are populated by an estimated combined total of 103,436 residents. The largest city in the four-county rural service area is Sedalia, located in Pettis County, with a population of 21,718 residents. Most of the catchment area consists of small towns with an average population of 39.6 residents per square mile. Rural pockets in the service area are significantly isolated, characterized by high unemployment, lack of resource agencies in close proximity, and no public transportation services. Further, this rural geographic area has remained a federally designated health provider shortage area for decades, experiencing a lack of adequate primary medical care, dental and mental health professionals.

Rural Health Association of Tennessee

Tennessee Rural Health
Clinic Network

D06RH49185

Primary focus area:

Access: Primary Care

Other focus areas:

Health Education and Promotion

Grantee Contact Information

Grantee Contact: Jacy Warrell

Contact Title: Executive Director

Organization: Rural Health Association of Tennessee

Organization Type: Nonprofit organization

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Project Description and Goals

The Tennessee Rural Health Clinic (TN-RHC) Network has formed through the Rural Health Network Development Planning grant and is working to further develop the network. The more than 250 RHCs in the state have not previously had a history of collaborating, sharing resources, or established lines of communication with state and federal agencies.

The purpose of the TN-RHC Network is to strengthen the rural health care system by integrating RHCs into the broader health care community. Services will include conducting value-based care readiness assessments, developing a “community of practice” to advance professional knowledge, and providing technical assistance to improve operational efficiencies and care coordination. These evidence-based services will support the financial viability of RHCs and improve the health of rural Tennesseans. As the network increases its value to RHCs through activities, data sharing, advocacy, and technical assistance, it is expected to grow into a fully self-sustaining organization. The development of an RHC network will expand cross-organizational collaboration, improve the quality of basic health care services, and strengthen the rural health care system in Tennessee.

TN-RHC’s overarching goal is to develop a network committed to improving the quality of health services, patient health outcomes, and strengthening the state’s overall health care system through sustainable practices.

- Objective 1: Implement a formalized governance structure to provide strategic direction and advisory support to Rural Health Association of Tennessee concerning the RHC network.
- Objective 2: Develop a single data benchmarking and reporting system to measure, track, and evaluate improvements in quality of care that supports clinics to make data driven decisions for practice sustainability.
- Objective 3: Expand the capacity and services of the RHC network by developing a “community of practice” that promotes peer-to-peer learning and other professional development and certification opportunities.
- Objective 4: Position the TN-RHC network and its individual members to successfully transition to value-based care and population health management.

Network Description

The TN-RHC network’s service delivery approach is to develop a robust network of independent and provider-based RHCs across the state that emphasizes partnership and a shared mission to improve the health and well-being of rural Tennesseans by strengthening and supporting the rural health clinics who serve them. The network will develop a broad array of services to meet the needs and interests of the clinics. This includes sharing promising practices for addressing social drivers of health through coordinated community services. The network, led by a core set of principles and values, will collaborate with the community to create or enhance equitable systems, workflows, and strategies to improve health outcomes.

The TN-RHC network is a member constituency group under the umbrella of the Regional Health Authority, with its own unique mission and governance structure. The TN-RHC Network currently has 31 members, including the five rural health clinics participating in the HRSA planning grant and an additional 20 RHCs, both independent and provider based. Also included are the East Tennessee State University Center for Rural Health Research Center, the University of Tennessee College of Pharmacy, Amerigroup (a managed care organization), and Healthcare Business Specialists (a consulting company with strong RHC relationships). The Tennessee Department of Health – Office of Rural Health participates as a non-voting, ex-officio member of the network. Network members include representatives from west, middle, and east Tennessee and will always maintain a minimum of 66-percent rural representation.

Responsibilities and engagement levels vary based on five groups within the network: Network members (inclusive of all RHC and non-RHC members), advisory board (12-15 TN-RHC governing representatives), mini-grant recipients (RHCs who apply for and receive more intensive quality improvement supports), member prospects (RHCs not yet members of the network), and partners (non-RHC network members and partners). Network members inform the development and implementation of a community of practice tailored to meet the specific needs of Tennessee’s Rural Health Clinics as they work to improve the quality of care, improve health outcomes, and transition to value-based care (VBC).

Evidence-based or Promising Practice Model

- **VBC readiness assessment** (www.ruralcenter.org/resource-library/value-based-care-assessment-tool). Developed by the University of Iowa as part of a HRSA-funded project. Network members will complete the assessment to provide a baseline understanding of the practices already implemented in RHCs. Assessment questions consider RHC governance and leadership, care coordination, clinical care, community health, patient and family engagement, performance improvement and planning, health information technology, and risk management.

- **National culturally and linguistically appropriate Services standards**
- **Community of practice.** The TN-RHC Network will serve as a single trusted source for information for regulatory updates, funding announcements, educational opportunities, and peer networking.
- **Mental Health First Aid**
- **National Healthcare Service Corps**

Populations Served

- Adults
- African Americans
- Caucasians
- Older adults
- Latinos
- Pre-school children
- Pregnant people
- Rural
- School-age children (elementary)
- School-age children (teens)

Geographic Service Area

Services will be available to all of Tennessee’s 241 eligible RHCs, located in HRSA-designated rural counties: Lake, Obion, Dyer, Weakley, Henry, Gibson, Carroll, Benton, Lauderdale, Tipton, Haywood, Hardeman, Henderson, Chester, McNairy, Hardin, Decatur, Crockett, Stewart, Houston, Dickson, Humphreys, Perry, Hickman, Lewis, Wayne, Lawrence, Giles, Marshall, Bedford, Lincoln, Franklin, Coffee, Grundy, Cannon, Warren, Van Buren, White, DeKalb, Smith, Putnam, Polk, Bledsoe, Rhea, Meigs, McMinn, Monroe, Cumberland, Scott, Campbell, Claiborne, Union, Grainger, Hancock, Johnson, Greene, and Cocke; and tracts in Blount, Hawkins, Jefferson, Madison, Robertson, Unicoi, and Wilson.

Sanford Health

Stronger Together: Community Health Worker Hub Initiative Network

D06RH49186

Primary focus area:

Community Health Workers/Promotoras

Other focus areas:

Coordination of Care Services, Health Education and Promotion, Transportation to health services

Grantee Contact Information

Grantee Contact: Erin Wichmann, BS, RN, ACM-RN

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Organization Type: Hospital

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Project Description and Goals

The purpose of the Stronger Together: Community Health Worker Hub Initiative Network is to improve health outcomes for vulnerable and underserved populations in rural northern Minnesota by establishing a community health worker hub. The Hub will centralize processes, systems, and resources to track those being serviced and tie payments for services to outcomes leading to a value-based care payment system and will be based largely on the Pathways HUB Model to create centralized processes, workflows, systems and resources to allow accountable tracking of those being served and a method to tie payment to outcomes. The network will draw upon the expertise and experience of community health worker solutions to support the design and implementation of the HUB.

Goals:

1. Identify and engage a cohort of organizations to launch a community health worker hub for the Bemidji region.
2. Develop a community health worker hub that keeps health equity at the forefront, improving health outcomes for American Indian, vulnerable, and underserved populations in the region.
3. Create a system of care that eliminates duplication of services by establishing workflows and strategies aimed at improving health outcomes.
4. Maintaining network and stakeholder commitment to achieve sustainability of the project.

The implementation of the community health worker hub will positively impact health outcomes for vulnerable populations in this region by address social determinants of health. Social and structural factors play a critical role in driving disparate health outcomes. This program intends to financially impact the community through measurement of reduced emergency visits through the implementation of wraparound services and mobile health in the community.

Network Description

Stronger Together: Community Health Worker Hub Initiative Network was established as a network of care focused on identifying and addressing risk factors for individuals and families in the region. The five network members have a history of working together and include: Sanford Health of Northern Minnesota, rural hospital; Leech Lake Indian Health Service, Beltrami County Health and Human Services, public health; PrimeWest Health (state Medicaid agency), and Northwest Technical College.

Evidence-based or Promising Practice Model

- **Evidence-Based/Promising Practice Model #1:**
Pathways Community HUB Model: The information in the Pathways Community HUB Manual is intended to assist service providers and community organizations in creating a HUB to coordinate delivery of health care and social services. The content was developed by the Pathways Community HUB Certification Program.
- **Evidence-Based/Promising Practice Model #2:**
Connecting Those at Risk to Care: The Quick Start Guide to Developing Community Care Coordination Pathways: a quick start guide and reference resource for public and private stakeholders engaged in improving the community care coordination system for identifying high-risk individuals; documenting their specific health, social, and behavioral health risk factors; and addressing those risks in a pay-for-performance approach. The HUB focuses on individuals and populations and it provides coordination, measurement, and impact data that can help guide local and regional policies and reimbursement strategies. The target audience includes all those involved in the design, implementation, and financing of care coordination services, especially within the community setting. This guide includes an overview of the process, as well as tools and resources needed to develop a HUB.

Populations Served

- Adults
- Caucasians
- Older adults
- Infants
- Native Americans
- Pre-school children
- Pregnant people
- School-age children (elementary)
- School-age children (teens)
- Uninsured

Geographic Service Area

Service area counties include Beltrami, Cass, Clearwater, and Hubbard Counties in Minnesota. All counties were confirmed as rural through the Rural Health Grants Eligibility Analyzer. The intention to focus on the American Indian population within that region is important. This region has a larger Native American population, with three reservations in the area. Residents in these communities face multiple barriers to maintaining their health, including transportation, childcare, and financial impacts.

Sanilac County Community Foundation

Thumb Community Health Partnership

D06RH49187

Primary focus area:
Social Determinants of Health

Other focus areas:
Community Health Workers/Promotoras,
Coordination of Care Services,
Integrated Systems of Care

Grantee Contact Information

Grantee Contact: Kay Balcer

Contact Title: Network Director

Organization: Sanilac County Community Foundation

Organization Type: Nonprofit organization

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Project Description and Goals

The purpose of the Care Connect Project is to improve community and population health through cross-sector solutions that address health related social determinants of health (SDOH). Over the last three years, the Thumb Community Health Partnership has aligned needs assessment activities, prioritized health issues, conducted consistent messaging campaigns, created collaborative plans to address health and human service workforce issues, and piloted two community outreach projects. In spring 2022, partners identified SDOH needs as a major barrier to achieving community and population health goals.

The project will create efficiencies by aligning systems of SDOH supports. It is difficult for individuals to improve a chronic health condition or manage a behavioral health diagnosis when they are worried about basic needs such as housing, transportation, and food. This project will strengthen the health care system as a whole by creating a “No Wrong Door” system where SDOH are comprehensively and systematically addressed in all settings.

The framework for the Care Connect Project is the Community-Clinical Linkage model developed by the Centers for Disease Control and Prevention. The model includes seven strategies that have demonstrated effectiveness for improving population health. 1) Learn about community and clinical sectors. 2) Identify and engage key stakeholders from community and clinical sectors. 3) Negotiate and agree on goals and objectives of the linkage. 4) Know which operational structure to implement. 5) Aim to coordinate and manage the

linkage. 6) Manage the linkage. 7) Grow the linkage. Project activities include resource mapping; workforce assessments and solutions; gaps and needs analysis; SDOH projects; coordinating a resident empowerment task force, SDOH Workgroup, and Bridges out of Poverty Community Team; policy and system change; enhancing the 2-1-1 information and referral system; provider training, Bridges out of Poverty programs; Getting Ahead classes for the target population; outreach campaign; and creation of strategic, business, and sustainability plans.

These activities and strategies will help achieve the goals of this project.

Goal 1: Improve access and expand capacity and services related to SDOH supports.

Goal 2: Demonstrate the impact of SDOH services on enhancing network and community health outcomes.

Goal 3: Position the Thumb Community Health Partnership for sustainability beyond the grant-funded period.

Network Description

The Thumb Community Health Partnership as a cross-sector network has the relationships, qualified staff, and experience to address complex, integrated health issues like social determinants of health. Membership includes every hospital, every community mental health agency, and every local public health department as partners. Partners also include a community action agency, a behavioral health provider, and a Federally Qualified Health Center. In order to effectively address social determinants of health, nine partners were added to the partnership: four social service departments, three Great Start Collaboratives, the 2-1-1 call center for the region, and a community foundation.

A strong component of membership is the Community and Residents Empowered Connect Taskforce, through which grassroots organizations and people with lived experience are actively involved in planning and implementation of SDOH strategies. The membership is at 37 and growing.

Evidence-based or Promising Practice Model

- Michigan Department of Health and Human Services. (2022). *Michigan's Roadmap To Healthy Communities*. <https://www.michigan.gov/mdhhs/inside-mdhhs/legislationpolicy/2022-2024-social-determinants-of-health-strategy>
- Sustainable Network Model, CRL Consulting, Federal Office of Rural Health Policy technical assistance provider for Rural Healthcare Network Planning Grant, <http://www.crlconsulting.com/grantee-portal>
- Centers for Disease Control and Prevention. (2016). *Community-Clinical Linkages for Prevention and Control of Chronic Diseases: A Practitioner's Guide*. U.S. Dept of Health and Human Services.
- Agency for Healthcare Research and Quality. (2016). *Pathways Community HUB Manual: A Guide to Identify and Address Risk Factors, Reduce Costs, and Improve Outcomes*. The information in the Pathways Community HUB Manual is intended to assist service providers and community organizations in creating a HUB to coordinate delivery of health care and social services.
- Berner, L. (2020). *Community Information Exchange: Using Data to Coordinate Care for People Experiencing Homelessness: Addressing COVID-19 and Beyond*. National Health Care for the Homeless Council. www.nhchc.org/CIE

- Callaghan, T. H et al. (2019). *Community Health Worker Roles and Responsibilities in Rural and Urban America*. Southwest Rural Health Research Center. <https://srhrc.tamhsc.edu/>
- Bridges out of Poverty will open your eyes to the challenges of poverty around you and equip you with the resources to cultivate sustainable success in your school or community. <https://www.ahaprocess.com/our-model/>
- Getting Ahead in a Just-Gettin'-By World is a book and a 45-hour workshop that helps individuals in poverty build their resources. <https://www.ahaprocess.com/our-services/>

Populations Served

- Adults
- Caucasians
- Older adults
- Infants
- Latinos
- Low income
- Pre-school children
- Pregnant people
- School-age children (elementary)
- School-age children (teens)
- Uninsured
- Vulnerable populations

Geographic Service Area

Thumb Community Health Partnership serves 152,000 rural residents in Huron, Lapeer, Sanilac and Tuscola Counties — the area of Michigan commonly referred to as the thumb. 92 percent of the population in the region is non-Hispanic white and 4 percent Hispanic. The area has a higher percentage of residents over age 65, with Huron County having the highest at 25.4 percent. The region has 12,878 veterans and 35,044 people with disabilities. Median income is consistently lower for the region, \$56,275 compared to a median income of \$63,400 for the state. Poverty rates vary greatly by county — lowest in Lapeer (9.9 percent) and highest in Sanilac (14.9 percent). The percent of households below the cost of living is 42 percent for three counties and 34 percent in Lapeer. Children are more likely live below 200 percent of the federal poverty level. Residents with bachelor's degrees is about half the Michigan rate and there is less access to computers and the internet. Residents in the region are more likely to be uninsured (7 percent), and health insurance often has high deductibles, copays, and limited coverage. Evidence of health disparities include higher rates of years of potential life lost for eight of the top 10 leading causes of death as compared to the state rates. Risk factors related to obesity, physical activity, and behavioral health are also elevated.

South Dakota Association of Healthcare Organizations Healthcare Research Education and Trust

South Dakota Rural Workforce Network

D06RH49187

Primary focus area:
Health Professions Recruitment and
Retention/Workforce Development

Grantee Contact Information

Grantee Contact: Becky Heisinger

Contact Title: Director of Quality Integration

Organization: South Dakota Association of Healthcare Organizations
Healthcare Research Education and Trust

Organization Type: Nonprofit organization

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Project Description and Goals

The project will create a network of health care organizations and community partners called the South Dakota Rural Workforce Network. The network will include a variety health care and non-health care organizations that have a commitment to seeing rural South Dakota communities thrive. The project goal is to improve access to health care services in rural South Dakota by developing an all-inclusive pipeline of health care essential workers. Essential health care workers are defined as a group of entry level jobs that provide support to health care professionals to improve the quality and delivery of health care services. Examples of these jobs include but are not limited to nursing assistants, phlebotomists, home health aides, housekeepers, food preparers, and medical assistants. The network will focus on developing a pipeline of health care essential support staff by targeting 1) rural ethnic and racial minorities and refugees 2) second-career adults, and 3) high school students.

Network Description

The network consists of eight members. The network is led by South Dakota Association of Healthcare Organizations Healthcare Research Education and Trust, a nonprofit organization. The remaining network members include three Critical Access Hospitals, a nursing home, a technology school, a post-secondary university, and a nonprofit social services organization. The health care organizations were identified based on geographic spread across the state, need and experience with working with the targeted populations.

Evidence-based or Promising Practice Model

- Plan-Do-Study-Act
- Project management tools
- Brainstorming techniques

Populations Served

- Adults
- African Americans
- Caucasians
- Older adults
- Latinos
- Native Americans
- Pacific Islanders
- Pregnant people
- School-age children (teens)

Geographic Service Area

The geographic area to be served by this grant includes the communities and surrounding areas in South Dakota: Hot Springs (Fall River County), Huron (Beadle County), Irene (Clay County) and Mobridge (Walworth County).

St. Joseph's Hospital Breese

Illinois Telehealth Network

D06RH49189

Primary focus area:
Telehealth

Other focus areas:
Behavioral/Mental Health,
School Health,
Specialty Care

Grantee Contact Information

Grantee Contact: Alison Rhodes
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Project Description and Goals

This project is The Illinois Telehealth Network (ITN): New Sustainable Pilots, New Members and Expanded Service Areas to Increase Multi-Specialty Health Care Access for Rural and Underserved Populations. Because a “go-it-alone” rural telehealth approach is often cost-prohibitive, inefficient, and full of barriers, this project’s purpose is to build the capacity and sustainability of telemedicine and telehealth projects of mutual member concern in the ITN by implementing the following goals:

Goal 1: Expand current services by expanding the geographic availability, utilization, financial sustainability, and collection of quality measures of current network member rural telemedicine services through:

1. Improved access: Project identifies and addresses rural gaps in care, workforce shortages, and deploys telehealth pilots for better workflows, improved quality of health care services, or both
2. Expanded capacity and services: Project creates effective systems through the collaborative development of knowledge and leadership models with shared services and economies of scale
3. Enhanced outcomes: Project improves patient outcomes through network services expansion
4. Sustainability: Project positions network for value-based population health management

Goal 2: Develop two new telemedicine pilots for:

1. Tele-skilled nursing facility consults
2. Inpatient and outpatient tele-behavioral health

Goal 3: Support program sustainability by:

1. Supporting facility and provider reimbursements
2. Public policy advocacy and education that supports reimbursement
3. Process for monitoring and sharing patient-provider encounter volumes and quality metrics for quality improvement and measure pilot success

Network Description

The ITN is a 501c3 30-member network with extensive experience in serving rural and federally designated health provider shortage area populations. More than 75 percent of network members were founding ITN members in 2014. Members include the following types of organizations:

- Accountable care organization
- Behavioral/mental health organization
- Critical Access Hospitals
- Federally Qualified Health Center
- Hospitals
- Long-term care facility
- Pharmacy
- Private practice primary care
- Private practice specialty care
- School district

Evidence-based or Promising Practice Model

- University of Vermont Medical Center's nursing home telepsychiatry service
- New Horizons Geriatric Counseling Program (Texas)

Populations Served

- Adults
- African Americans
- Caucasians
- Older adults
- Infants
- Latinos
- Native Americans
- Pacific Islanders
- Pre-school children
- Pregnant people
- School-age children (elementary)
- School-age children (teens)
- Uninsured

Geographic Service Area

The ITN has 22 rural and eight urban members across 21 central and southern Illinois counties, with 73 percent of the network in rural counties. Rural counties served include Adams, Christian, Clay, DeWitt, Effingham, Greene, Marion, Mason, Montgomery, Pike, Schuyler, and Shelby. Rural census tracts in partially “rural” counties served include: Bond, Clinton, Jersey, Macoupin, Madison, and Piatt. Non-rural counties served are Macon, Sangamon, and St. Clair.

Tallahatchie General Hospital Medical Foundation

Mississippi Diabetes Network

D06RH49190

Primary focus area:
Chronic Disease: Diabetes

Other focus areas:
Health Education and Promotion,
Physical Fitness and Nutrition,
Telehealth

Grantee Contact Information

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Organization Type: Nonprofit organization

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Project Description and Goals

The Mississippi Diabetes Network aims to address the massive burden diabetes places in the state, the health care system, and residents (and their families) living and suffering with diabetes and its related comorbidities. The network will utilize a systems-of-care approach that utilizes community and health care partnerships to create a coordinated array of broad yet flexible services. The network's members will work together with communities, health care facilities, and worksites to create and improve upon equitable systems, workflows, and strategies to improve health outcomes and build a stronger, more resilient network of health care providers and nontraditional health care partners focused on alleviating the massive burden diabetes places on the service area. The network's overarching aim is to improve access to and quality of diabetes care through sustainable health care programs and services created as a result of the network's collaboration. Associated aims are to demonstrate improved health outcomes and community impact, promote the sustainability of the network through the creation of diverse products and services, and utilize evidence-based and promising practice models in the delivery of health care services.

Goals:

1. Improve access to diabetes care (including diagnosis, treatment, and management).
2. Improve quality of diabetes care (diagnosis, treatment, and management).
3. Improve diabetes prevention and management at the patient level.

4. Improve diabetes diagnosis, prevention, and management at the provider level.
5. Reduce unnecessary health care costs, hospital admissions/readmissions, and use of emergency department through increased provider training, screening for diabetes/prediabetes, increasing access to care, and patient supports.
6. Improve diabetes-related health outcomes in patients with diabetes and prediabetes.
7. Improve emotional health and wellbeing by increasing access to behavioral health care services.
8. Improve diabetes diagnostics to identify individuals with undiagnosed prediabetes and diabetes.
9. Operate and grow a sustainable vertically integrated network of health care providers and stakeholders to address and reduce the burden and cost of diabetes in the service area.
10. Demonstrate improved health outcomes and community impact.

Network Description

There are six founding members of this network: Tallahatchie General Hospital Medical Foundation, Tallahatchie General Hospital, University of Mississippi's Community First Research Center for Wellbeing and Creative Achievement, William Carey University College of Osteopathic Medicine, The National Diabetes and Obesity Research Institute, and Baptist Memorial Hospital – North Mississippi.

Evidence-based or Promising Practice Model

- Chronic Care Management
- Diabetes Self-Management Education, Support, and Training
- Association of Diabetes Care and Education Specialists Diabetes Care and Education Curriculum
- Diabetes Prevention Program
- Diabetes Solutions (promising practice)

Populations Served

- Adults
- African Americans
- Caucasians
- Older adults
- People with diabetes
- Pre-school children
- Pregnant people
- School-age children (teens)
- Uninsured

Geographic Service Area

The service area for this project includes 20 rural counties in northwest Mississippi: Attala, Bolivar, Calhoun, Carroll, Coahoma, Grenada, Holmes, Humphreys, Lafayette, Leflore, Marshall, Montgomery, Panola, Quitman, Sunflower, Tallahatchie, Tate, Tunica, Washington, and Yalobusha.

Unaccompanied Students Initiative

Unaccompanied Students Initiative
Network

D06RH49190

Primary focus area:
Coordination of Care Services

Other focus areas:
Behavioral/Mental Health, Children's
Health, Health Education and Promotion,
Transportation to Health Services

Grantee Contact Information

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Project Description and Goals

The goal of the program is to continue improving the overall health outcomes of rural homeless youth in Albany County, Wyoming, and in surrounding rural areas by uniting key stakeholders and organizational partners towards this common goal. This is carried out by disseminating knowledge, encouraging case-based learning, peer-to-peer education models, increasing the reach of health care providers by combatting geographical barriers and workforce scarcity, and encouraging the integration of strong monitoring and evaluation practices to track progress. Strategies include the following:

- Strategy 1: Continue promoting, designing, and implementing interventions grounded in the social determinants of health in alignment with national Healthy People 2030 goals to improve health outcomes among rural youth.
- Strategy 2: Lead the development and implementation of Project ECHO (Extension for Community Healthcare Outcomes), an all-teach, all-learn telecommunication case-based learning program uniting the key stakeholders across rural areas for the provision of targeted care to homeless youth and unique sub-populations.
- Strategy 3: Raise awareness and education among the general population about homeless youth and increase knowledge about the services and organizations that can provide them assistance.

Network Description

Unaccompanied Students Initiative Network provides support for the program as well as networking opportunities for its members. While growing, the network currently includes 13 members that include universities, diversified non-clinic service providers, local law enforcement, local health systems, and local businesses. Collaboration through the Rural Health Network Development program allows for partners to cross-refer unaccompanied youth they encounter, which helps keep them from falling through the cracks and remaining overlooked.

Evidence-based or Promising Practice Model

- The socio-ecological model and framework
- Social determinants of health
- Wrap-around services to provide person-centered care
- Neuroimaging
- Project ECHO
- Peer-to-peer messaging
- Advisory board

Populations Served

- Adults
- African Americans
- Caucasians
- Latinos
- Native Americans
- Pacific Islanders
- School-age children (teens)
- Students experiencing homelessness
- Uninsured

Geographic Service Area

Unaccompanied Students Initiative provides physiologic support to students in Laramie County, Natrona County, and Albany County in Wyoming. The state of Wyoming is largely rural with limited resources for services needed.

Union Ambulance District

Eastern Missouri Mobile
Integrated Health Network

D06RH49192

Primary focus area:
Mobile Integrated Healthcare

Other focus areas:
Behavioral Health,
Health Education and Promotion,
Telehealth

Grantee Contact Information

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Project Description and Goals

The Eastern Missouri Mobile Integrated Healthcare Network is a local systems of care approach focused on whole person care. The MIHN is a network of partners that utilize evidence-based practices and protocols to provide comprehensive care in a mobile setting, generally a person's home. The service delivery model in eastern Missouri capitalizes on the local partnership of the ambulance districts including Union, Meramec, St. Clair, and Lincoln County, along with health care providers including Compass Health Network, Mercy-Lincoln, and Mercy-Washington.

The network's primary focus is reaching unserved or underserved patients who inappropriately utilize emergency care to meet their health care needs or to address conditions that result in preventable readmissions or issues related to behavioral health, through a mobile integrated health care (MIH) model. MIH is a patient-centered, innovative delivery model offering on-demand, needs-based care and preventive services, delivered in the patient's home or mobile environment. For this project, the network will collectively identify a cohort of individuals who have had multiple preventable hospitalizations, and individuals who have high emergency services utilization for behavioral health, particularly patients requiring crisis stabilization.

Goal 1: Replicate, test and refine the evidenced-based Washington County MIHN model for behavioral health and preventable hospital readmissions in Franklin and Lincoln Counties within the high need/high utilizer population.

Goal 2: Increase workforce education, training and capacity that supports MIHN service delivery to improve population health and lower overall costs to the health care system.

Goal 3: Develop strong relationships and partnerships between health care providers and key local, regional, and state stakeholders to further support replication, expansion, and sustainability of the MIHN model in Missouri.

Network Description

The network has seven members: four ambulance districts, two hospitals, and a Federally Qualified Health Center. This collaborative relationship/partnership is new and is supported by other local partners to include, but is not limited to, local public health agencies, Franklin and Lincoln sheriff's offices and county jails, food pantries, and others, to create a coordinated array of broad and flexible services. Each of the participating partners provides distinctive expertise which will help the network better address gaps in care, assist their organizations in acclimating to the evolving health care environment and improve social determinants of health by addressing relevant health care needs identified by the Eastern Missouri MIH Network. While the Eastern Missouri MIH Network members have never formally collaborated on a project, services often intersect as the network members all serve as a safety net for the underserved populations in the region. Each member has extensive experience serving rural underserved populations in Missouri.

Evidence-based or Promising Practice Model

- Mobile integrated health care
- Patient-centered medical home
- Chronic care model
- Screening, brief intervention, and referral to treatment

Populations Served

- Adults
- Uninsured

Geographic Service Area

The targeted geographic service area is Franklin County and Lincoln County, Missouri. The primary disparity in Franklin and Lincoln counties is related to socioeconomic status, with individuals having lower paying jobs, less education and lower health literacy. A total of 161,219 people live in the combined 1,519.22 square mile service area, according to the United States Census Bureau American Community Survey 2016-2020 five-year estimates. The population density for this area is estimated at 104 persons per square mile. Of the total population of 161,219, 76.2 percent are age 18 or older and 49.9 percent are male.

UPMC Kane

Reducing the Rural Healthcare
Desert Project

D06RH49193

Primary focus area:
Chronic Disease: Cardiovascular

Other focus areas:
Aging, Asthma/COPD, Diabetes, Health
Information Technology, Primary Care,
Substance Abuse

Grantee Contact Information

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Project Description and Goals

The network is working to integrate multi-disciplinary models of health care in a cross-agency collaborative to improve the health of individuals with chronic disease management needs such as chronic obstructive pulmonary disease or heart disease, as well as substance abuse and other health management needs. The network will apply multi-disciplinary models in support of a vertical collaboration as well as a horizontal service network of agencies to assist in care coordination, nontraditional health care access points, and services for socioeconomic determinants of health. In response to ongoing Covid-19 and the multitude of safety steps required to care for those at higher risk for illness, the plan will incorporate technology such as telehealth and telemedicine services. The UPMC Kane Reducing the Rural Healthcare “Desert” Network (RHDN) project goals are to improve delivery of cost-effective, coordinated, culturally and linguistically appropriate, equitable health care services, redesigned care coordination, enhanced chronic disease management, wellness, and primary care access expansion.

Network project activities and services that align with the four RHDN program domains:

1. Improve access: Address “health care desert” gaps in care, workforce shortages, better workflows and improving the quality of health care services in primary care. Telemedicine will be used to reduce the hospital bypass via direct access using mid-level providers.
2. Expand capacity and services: Network providers will expand prevention and disease management programs through telemedicine and linked knowledge, skills, structures, and leadership via the network.

3. Enhance outcomes: Improve patient and network development outcomes and reduce potentially avoidable utilizations through expanded network services and interventions.
4. Sustainability: The network will engage sustainable health programs (evidence-based) across providers and nontraditional access points to use value-based care and population health management strategies along with disease-prevention programs.

Expected Outcomes: Improved health of individuals with chronic illnesses, reduced hospital readmissions, increased patient focused prevention, increased utilization of community-based self-directed prevention programs, and greater access to pain management and reduced substance abuse in target population. The Extension for Community Healthcare Outcomes (Project ECHO) evidence-based model will be used for managing the target population with activities that include prevention, patient self-directed education, and disease management.

Network Description

Project partners are:

1. UPMC Kane (applicant), Kane, PA - rural hospital
2. UPMC Home Health Care, Kane, PA - home health agency
3. Lutheran Home of Kane, Kane, PA - senior long-term care facility
4. Area Agency on Aging (Kane Senior Citizen Center) - preventive care, screenings.
5. Alcohol & Drug Abuse Services, Inc. – Single county authority for substance abuse/opioid abuse services.
6. Kane Area Community Center - community services for wellness and social services.

Evidence-based or Promising Practice Model

The model used will be an adaptation of Project ECHO, where social services agencies and providers will be trained on disease management services to help patients and clients better manage their disease. The project will also promote prevention education to project partners so they can expand their outreach to create additional access points for chronic disease management care.

These models will be adapted for the quality initiative:

- [Project ECHO® – Extension for Community Healthcare Outcomes](#)
- [Chronic Disease Self-Management Program](#)

Populations Served

- Adults
- Older adults
- Caucasians
- Uninsured

Geographic Service Area

The service area includes a total population of approximately 110,009 individuals in outlying rural areas of McKean, Elk, and Warren Counties that have no access to walk-in care, prevention, and non-emergent and disease management services to prevent hospitalization. UPMC Kane is the only hospital in the area. Secondary roads make travel to the next closest hospital difficult. The next closest hospital is approximately two hours away.

Verde Valley Caregivers Coalition

Verde Valley Rural Health Network

D06RH49193

Primary focus area:
Aging

Other focus areas:
Behavioral/Mental Health, Coordination
of Care Services, Transportation to
Health Services

Grantee Contact Information

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Project Description and Goals

This initiative establishes a rural health collaboration to improve access to health care and supportive services for adults in need: older adults aging in place, adults with disabilities wishing to live independently, and families caring for their loved ones.

The goals of the project are:

1. Launch a comprehensive telehealth support network that engages multiple health care and behavioral health providers.
2. Develop and operate a referral network of health and social services providers with patient/client follow-up surveys and accountability for actual care and services provided.
3. Develop a care coordination team supported by a group of volunteer retired nurses that is not constricted in its delivery of skilled attention by the limits dictated by payers or organizational mandates.

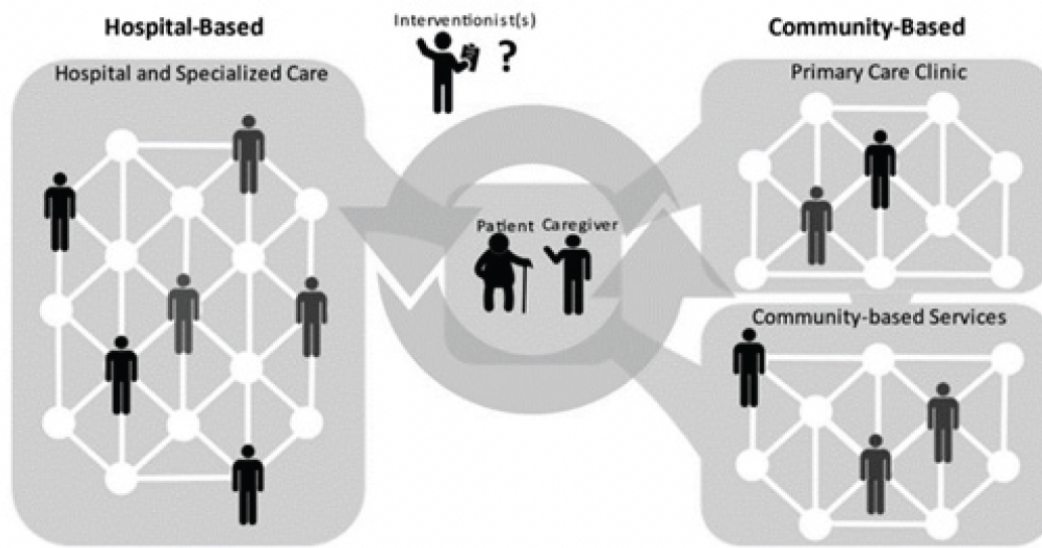
Network Description

The Verde Valley Rural Health Network is a collaboration between Verde Valley Caregivers Coalition, a community-based nonprofit serving older adults and adults with disabilities; the area's leading health care institutions; behavioral health providers; and social/human services organizations. Together, they seek to

improve access to health care and supportive services. Network members include: Verde Valley Caregivers Coalition; Northern Arizona Healthcare; Spectrum Healthcare and Behavioral Health; Polara Health, behavioral health; Manzanita Outreach, a regional food provider; Community Health Center of Yavapai County; and Yavapai Free Library Districts.

Evidence-based or Promising Practice Model

As the interventionists noted in this diagram, members of the network will provide person-centered care management through a referral and client/patient tracking platform to ensure the social determinants of health are assessed and achieved.



Populations Served

- Older adults

Geographic Service Area

The service area of the Verde Valley Caregivers Coalition is approximately 800 square miles in north central Arizona, known as the Verde Valley with a population of approximately 74,000 residents. The area consists of: two rural cities, Cottonwood and Sedona; three rural towns, Camp Verde, Clarkdale, and Jerome; and a large expanse of unincorporated rural communities, including unincorporated areas of Cornville, Lake Montezuma, McGuireville, Rimrock, and Village of Oak Creek. Access to health care and shopping centers is an ongoing challenge for older adults and individuals with disabilities.

Wabash General Hospital District

Comprehensive Rural Health Care Network
of Southern Illinois

DO6RH49195

Primary focus area:
Increase Access and Quality of
Health Care Services

Other focus areas:
Coordination of Care Services,
Chronic Disease,
Oral Health

Grantee Contact Information

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Project Description and Goals

The Comprehensive Rural Health Care Network of Southern Illinois (CRHCNSI) is driven by its members' collective identification of gaps in care and the target population's selection of top community health priorities. The network will address a critical need through the Addressing Gaps in Comprehensive Care (AGCC) project, which is a lack of access to comprehensive chronic care management for adults, which includes oral health care and primary/preventative care. This gap in care currently results in high and costly utilization of the emergency department for nonemergent needs, high hospital readmission rates for chronic conditions, and poor health outcomes for individuals across the life span.

AGCC's key goals include:

1. Expanding care coordination to serve individuals in their homes by establishing a community paramedicine (CP) program (the Wabash CP program)
2. Increasing access to dental care for adults through a new oral health referral network
3. Improving the preventative health care available to adults through new referral patterns for vaccinations and screening lab panels at no or low cost

Network Description

CRHCNSI is composed of Wabash General Hospital District, including its five rural health clinics; Wabash General Emergency Medical Services; Wabash Community Health Center, which is a Federally Qualified Health Center lookalike; Wabash County Health Department; and Comprehensive Dental Care of Mt. Carmel.

Evidence-based or Promising Practice Model

- Community paramedicine model
- Interprofessional oral health referral network model

Populations Served

- Adults

Geographic Service Area

The service area includes Edwards, Lawrence, Wabash, and White Counties in rural southern Illinois. The population in this area is highly medically underserved and experiences well-documented disparities in health outcomes, disease burden, and social determinants of health.

Washington County Ambulance District

Missouri Highlands Rural Health Network

D06RH49196

Primary focus area:

Chronic Disease: Cardiovascular

Chronic Disease: Diabetes

Chronic Disease: Asthma/COPD

Other focus areas:

Aging, Behavioral/Mental Health,

Community Health Workers/Promotoras,

Primary Care, Specialty Care,

Grantee Contact Information

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Organization Type: County government

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Project Description and Goals

Missouri Highlands Mobile Integrated Healthcare Network (MIHN) is an integrated health network focusing on integration of health care services, improvement of health care delivery systems, increased access to coordinated and quality essential health care services, and improvement of population health in Reynolds County, Missouri. The network is implementing a mobile integrated health care model to address health priorities in Reynolds County, and to identify and reduce gaps between social determinants of health and other systemic issues that contribute to achieving health equity.

Goal 1: Replicate, test, and refine the evidenced-based Washington County MIHN model for behavioral health in Reynolds County within the target population.

Goal 2: Increase workforce education, training and capacity that supports MIHN service delivery to improve population health and lower overall costs to the health care system.

Goal 3: Develop strong relationships and partnerships between health care providers and key local, regional, and state stakeholders to further support replication, expansion, and sustainability, of the MIHN model in Missouri.

Network Description

The MHIN serves all residents of Reynolds County, with a focus on individuals who may be unserved or underserved, be high risk for chronic conditions, have co-morbidities, or utilize emergency services inappropriately. This network is made up of three members. These members are: Washington County Ambulance District, Reynolds County Health Center, and Missouri Highlands Healthcare.

Evidence-based or Promising Practice Model

Evidence-based models, including but not limited to:

- Washington County Mobile Integrated Healthcare Network model of care®
- Mobile integrated health care
- Patient centered medical home
- Telehealth
- Chronic care management

Populations Served

- Adults
- Caucasians
- Older adults
- Pregnant people
- Uninsured

Geographic Service Area

This project will serve the residents of Reynolds County, located in central Missouri. The largest cities in the county include Centerville and Ellington. The Missouri Highlands Health Care Center is in the City of Ellington and the Washington County Ambulance District is in the City of Mineral Point. A total of 6,274 people live in the 808.5 square miles defined according to the United States Census Bureau American Community Survey 2016-20 five-year estimates. The population density for this area, estimated at eight persons per square mile, is less than the national average population density of 92 persons per square mile.

West Central Alabama Area Health Education Center

Southwest Alabama
Healthcare Collaborative

D06RH49197

Primary focus area:
Coordination of Care Services

Other focus areas:
Diabetes,
Health Education & Promotion,
Primary Care

Grantee Contact Information

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Project Description and Goals

The Southwest Alabama Healthcare Collaborative (SAHC) will implement the Goldenrod Outreach (GO) Initiative, a coordinated community-based approach involving multisectoral interventions to increase services for prevention, treatment, and long-term management among those at risk for diabetes and heart disease in rural Alabama.

This project will allow the SAHC to build necessary infrastructure to become a recognized entity, create committees to address chronic disease in the region, and create support programs for both individuals and health care providers to prevent, treat and support recovery for those at risk of diabetes, heart disease, or both in targeted service area in rural southwest Alabama.

Goals of the GO Initiative are:

1. Expand the capacity and sustainability of the SAHC to address barriers to care for individuals at risk or diagnosed with diabetes, heart disease, or both by formalizing network structure by August 2024;
2. Identify and address gaps in community-based prevention and treatments for diabetes and heart disease by increasing membership of the SAHC by 50 percent by August 2025;

3. Increase the quality and quantity of chronic disease treatments available to community members in southwest Alabama by identifying and implementing at least two evidence-based protocols for individual and group care for diabetes, heart disease or both in conjunction with population health management by July 2027;
4. Facilitate a minimum of six continuing education offerings for health professionals and staff, increasing knowledge of chronic diseases, value-based care and the impact of social determinants of health on treatments, patient outcomes, and billing opportunities by 10 percent by July 2027;
5. Improve provider and community capacity for care and reduce social, economic and environmental barriers to better health for individuals at risk and diagnosed with diabetes, heart disease, or both by implementing a community health worker program in two community facilities by July 2027; and
6. Enhance the community's ability to prevent and support ongoing efforts to reduce the impact of comorbidities by implementing some combination of at least four community-based education and physical activity programs each year, reaching at least 500 individuals by July 2027

Network Description

The SAHC, a multimember network of health care providers, community leaders, and civic organizations, was founded in 2020 through a Health Resources and Services Administration grant to execute a multisectoral approach aimed at increasing community capacity for prevention, treatment, and recovery support for those at-risk and diagnosed with substance use disorder. All network members who will participate in the GO Initiative are located in fully rural, medically underserved counties and have extensive experience implementing community-based initiatives aimed to improve primary care services and access to care for rural, underserved, and historically marginalized populations. The four core partners are: West Central Alabama Area Health Education Center (nonprofit health education organization), Southern Alabama Area Health Education Center (nonprofit health education organization), Whitfield Regional Hospital (health care provider), and Health and Wellness Education Center (nonprofit health education organization).

Evidence-based or Promising Practice Model

In implementing the GO Initiative, the SAHC will use the chronic care model, utilizing care coordination services to build capacity within the target population who will, in turn, serve vulnerable, rural, and underserved populations.

Populations Served

- Adults
- African Americans
- Caucasians
- Older adults
- Uninsured

Geographic Service Area

This project will target the following fully rural counties in Alabama: Choctaw, Clarke, Escambia, Marengo, Monroe, and Sumter.

Wilderness Health

Wilderness Health

D06RH49198

Primary focus area:
Behavioral/Mental Health

Other focus areas:
Coordination of Care Services,
Health Professions Recruitment and
Retention/Workforce Development,
Integrated Systems of Care

Grantee Contact Information

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Project Description and Goals

Providers in the service area struggle to keep up with patient volume and demand and have identified struggles in supporting patients with complex mental health concerns. The complex, multi-layered mental health care system is challenging and cumbersome to navigate, especially for those in distress, to get the help they need. This causes patients to wait extended periods of time before receiving comprehensive care.

Through a previous Health Resources and Services Administration Rural Health Network Development (RHND) grant, the network identified a need to offer more avenues to mental health care. By developing a complex care navigation program, this project will develop pathways to triage and navigate the health care system, offering more access to resources that go beyond the basic level of care. It will include evidence-based practices to ensure mental health needs are identified and addressed while reducing co-morbidities. The care navigation program will work across the network to help patients in the rural area. It will modify systems to proactively identify patient care needs and simplify the referral process. Navigators will connect patients to physicians, medication, resources for substance use disorder, housing programs, and so much more. In addition to program development, new staff positions will include hiring a clinical social worker as well as a registered nurse as a care navigator for the navigation team. The team will include training and act as a resource for the existing network of care coordinators. This program will support all the legislative aims and align with all of the RHND program domains by integrating internal and external resources to create more efficient care pathways in the region.

Goals of the project are:

1. Increase treatment pathways for complex mental health patients and decrease their length of time for care referrals.
2. Leverage technology to facilitate facility communication and patient care management.
3. Reduce the number of patients who are no-shows or don't complete the intake process for referred services.
4. Implement this service to add additional capacity with integrated mental health resources within primary care (either in-person or via telehealth), including through consultation and educational opportunities with the care navigation team.
5. Continue annual survey of network members to assess gaps in mental health resources and educational needs.
6. Continue working with members to increase consistent screening processes for depression and anxiety.
7. Continue development work with other community-based organizations and referral providers to inform all of local community needs, reduce duplication of efforts, and partner to coordinate efforts, including outreach on mental health stigma and how to access care in the community.
8. Increase the percentage of patients closing the referral loop for social determinants of health.
9. Provide training to network members on change management and care coordination.

Network Description

Wilderness Health was formed as a non-profit, tax-exempt corporation in Minnesota in 2013 with the desire for independent health systems to work together on various initiatives, including improving patient health outcomes, finding cost savings opportunities for members, and working with payers on alternative payment models. There are nine health systems in northeastern Minnesota that are members of WH, six of which are Critical Access Hospitals. Many of these health systems are located in the most remote parts of the state with large distances between facilities. Many of the hospitals own primary care clinics located throughout the region, including two in northwestern Wisconsin.

Evidence-based or Promising Practice Model

The Collaborative Chronic Care Model for Mental Health Conditions

- <https://doi.org/10.1097/MLR.0000000000001145>

Effectiveness of Implementing a Collaborative Chronic Care Model for Clinician Teams on Patient Outcomes and Health Status in Mental Health: A Randomized Clinical Trial

- <https://pubmed.ncbi.nlm.nih.gov/30821830/>

Populations Served

- African Americans
- Native Americans
- Patients with chronic conditions
- Patients with mental health needs

Geographic Service Area

The area served by Wilderness Health spans eight counties across northeastern Minnesota (Carlton, Cook, Itasca, Lake, and St. Louis counties) and northwestern Wisconsin (Ashland, Bayfield, and Douglas counties). All communities in the region are in a federally designated health provider shortage area for several services, including mental health.

