Rural Northern Border Region Outreach Program

2024 Grantee Directory

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

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Introduction

Title 42 USC 254c(e) (§330A(e) of the Public Health Service Act) authorizes the Rural Northern Border Region (RNBR) Outreach Program to promote the delivery of health care services to rural underserved populations in the Northern Border Regional Commission (NBRC) region of Maine, New Hampshire, New York, and Vermont. The 60 counties located in the NBRC region represent some of the most distressed counties in the four northeastern border states, with many of these areas facing significant provider shortages and poor health outcomes when compared with the national average. The Federal Office of Rural Health Policy (FORHP) in partnership with the NBRC, a federal-state partnership for economic and community development, funded organizations in this four-state region to address unmet health and social needs through a focus on collaboration, engagement with local communities, and innovative, evidence-based or -informed programs tailored to the unique needs of this region's rural communities.

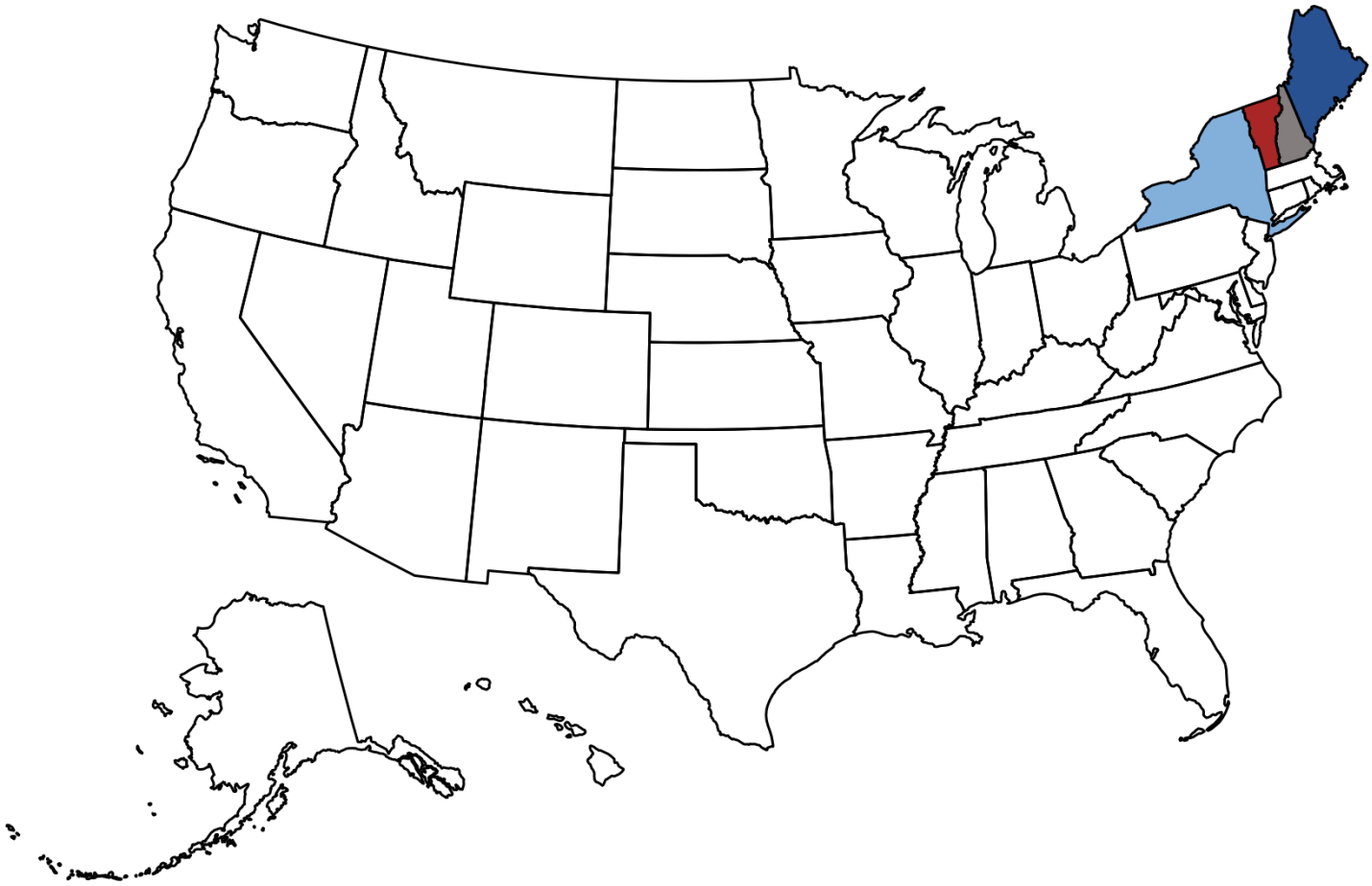
The overarching goals of the RNBR Outreach Program are to:

- Expand delivery of health care services to include new and enhanced services in Northern Border rural communities;
- Deliver health care services through a strong, collaborative consortium;
- Utilize community engagement and evidence-based or -informed, innovative approaches to addressing local needs;
- Improve health and demonstrate outcomes; and
- Increase financial sustainability.

This directory provides an overview of the RNBR Outreach Program cohort, including profiles for each of the 13 initiatives funded for this 2024-2027 project period. Awardee profiles include information on project focus areas, partners, populations served, evidence-based and promising practice models, project strategies, and expected project outcomes.

Cohort Snapshot

Grantee Location Map



Grantee By State

Maine
Eastern Maine Healthcare Systems
Healthy Acadia
MaineHealth
Medical Care Development Inc.
Rangeley Region Health and Wellness Partnership
The Harry E. Davis Partnership for Children's Oral Health
University of Rochester Medical Center
New Hampshire
Ammonoosuc Community Health Services
Littleton Hospital Association
Partnership for Public Health Inc.
New York
Carthage Area Hospital Inc.
Fort Drum Regional Health Planning Organization Inc.
Vermont
Vermont Program for Quality in Health Care Inc.

Grantee Organization Type

Grantee Organization	Critical Access Hospital	Federally Qualified Health Center	Health System	Hospital	Nonprofit	Public/Community Health Nonprofit
Ammonoosuc Community Health Services		•				
Carthage Area Hospital Inc.	•					
Eastern Maine Healthcare Systems			•			
Fort Drum Regional Health Planning Organization Inc.					•	
Healthy Acadia						•
Littleton Hospital Association	•					
MaineHealth			•			
Medical Care Development Inc.						•
Partnership for Public Health Inc.					•	
Rangeley Region Health and Wellness Partnership						•
The Harry E. Davis Partnership for Children's Oral Health					•	
University of Rochester Medical Center				•		
Vermont Program for Quality in Health Care Inc.					•	

Grantee by Primary Focus Area

Grantee Organization	Access: Primary Care	Access: Specialty Care	Behavioral/Mental Health	Care Coordination	Community Health Workers	Chronic Disease Management	Diabetes	Health Education, Promotion, and Prevention	Health Information Technology	Maternal/Child Health	Mobile Integrated Health/ Community Paramedicine	Oral Health	Other*	Social Determinants of Health	Telehealth/Telemedicine	Transportation	Workforce Development
Ammonoosuc Community Health Services								•					•			•	
Carthage Area Hospital Inc.	•					•							•				
Eastern Maine Healthcare Systems													•				•
Fort Drum Regional Health Planning Organization Inc.	•				•												
Healthy Acadia			•		•												•
Littleton Hospital Association	•			•							•						
MaineHealth										•			•				•
Medical Care Development Inc.						•								•	•		
Partnership for Public Health Inc.					•	•					•						
Rangeley Region Health and Wellness Partnership					•								•				
The Harry E. Davis Partnership for Children's Oral Health		•										•			•		
University of Rochester Medical Center	•			•					•								
Vermont Program for Quality in Health Care Inc.													•				

* Other includes analytics, respiratory therapy, Food as Medicine, rural health access, health disparities, and sexual assault/violence.

New Hampshire

Ammonoosuc Community Health Services

Federally Qualified Health Center

G59RH53699

Primary focus area:
Health Education; Other: Food as Medicine, Promotion and Prevention, Transportation

Grantee Contact Information

Address: 25 Mount Eustis Road, Littleton, NH, 03561

Website: https://www.ammonoosuc.org/

Target Population

Primary population is the 31,000 residents in 26 towns of New Hampshire's Northern Grafton and Coös counties Ammonoosuc Community Health Services (ACHS) service areas. The secondary population is the 31,270 residents of Coös county.

Project Goals

1. Food as Medicine Portable Teaching Kitchen. Sharing meals you feel good about. Through an experiential multisensory experience, participants will learn how to cook healthy, cost-effective foods from pan to plate in fewer than 30 minutes.
2. TRIP Marketplace. Friends, families, and neighbors solving the transportation challenge one ride at a time. Leveraging one to two degrees of separation among hyperlocal communities of trust integrated into an intuitive logistics platform. The empty seats in vehicles moving from one destination to another can be filled with friends, families, and neighbors.

Evidence-Based or Promising Practice Model Being Used or Adapted

Food as Medicine Portable Teaching Kitchen. *Sharing meals you feel good about.*

- The initial demonstration was performed with a HRSA supplemental funding grant.
- This is consistent with —
  - The national Equitable Long-Term Recovery and Resilience | odphp.health.gov
  - The national Food is Medicine: A Project to Unify and Advance Collective Action | odphp.health.gov

    - The New Hampshire State Health Improvement Plan Our Background | New Hampshire State Health Assessment
- Predicated upon Howard Gardner's understanding of the multiple forms of intelligence, Edward Deci, et.al., adult motivational theory, and the Dunn and Dunn model of learning styles.

TRIP Marketplace. *Friends, families, and neighbors solving the transportation challenge one ride at a time.*

- Predicated on the degrees-of-separation framework; in this instance one to two degrees of separation.
- Research on hyperlocal frameworks of trust.
- Logistical framework of other web-based search and find portals that bring those with a request and those with an offer together.

Project Description

Food as Medicine Portable Teaching Kitchen. *Sharing meals you feel good about.*

- Establishing a sustainable network of AHCS — Food as Medicine Portable Teaching Kitchens (five in total) across Northern Grafton and Coös counties as a cocreative and collaborative process.

TRIP Marketplace. *Friends, families, and neighbors solving the transportation challenge one ride at a time.*

- Resolve the transportation challenges of Northern Grafton and Coös counties through a cocreative collaborative community effort among high-trust communities and high-fidelity logistics software. Doing so in a manner that is sustainable and replicable to link high-trust communities with few (one to two) degrees of separation.

Expected Outcomes

Food as Medicine Portable Teaching Kitchen. *Sharing meals you feel good about.*

- A sustainable community-based program that may require one full-time employee in project coordination of human resources (volunteer cooks) and tangible resources (teaching kitchen calendar of events and collaborating food providers) as a facet of the broader solution set of food security within the context of the ACHS — Resilient American Communities (RAC) Initiative.
- Within the ACHS–RAC website, a curated collection of food videos and high-visual-content recipes that are accessible within and beyond the target population of this effort.
    - Home. | Resilient American Communities
    - ACHS RAC North Country NH | Resilient American Communities
- Over time, an intergenerational culture shift toward securing, preparing, and sharing "real" foods with a shift away from "manufactured" foodlike stuff.

TRIP Marketplace. *Friends, families, and neighbors solving the transportation challenge one ride at a time.*

- *A legacy logistics transportation system that is right-protected yet open-access for replication and a process of community engagement vis-à-vis trust development and demonstration.*

Consortium Partners

Organization	County	State	Organization Type
North Country Health Consortium	Northern Grafton and Coös counties	NH	Nonprofit
White Mountain Community College	Vermont and northern Grafton and Coös counties in New Hampshire	NH	Higher education
Northern Vermont University	New Hampshire and Vermont	VT	Higher education
Southern New Hampshire University	National	NH	Higher education
AmeriHealth Caritas New Hampshire	New Hampshire	NH	Insurance company
New Hampshire Hunger Solutions	New Hampshire	NH	Nonprofit
Bi-State Primary Care Association	New Hampshire and Vermont	NH	Nonprofit
National Association of Community Health Centers	National	DC	Nonprofit
Littleton Food Coop	Northern Grafton and Coös counties	NH	Nonprofit
Rochester Institute of Technology	National	NY	Higher Education
Health Initiatives Foundation Inc. (HIFI)	National/ International	DC	Nonprofit
New Hampshire Department of Health and Human Services	New Hampshire	NH	Government
New Hampshire Governor's Council on the New Hampshire State Health Assessment/State Health Improvement Plan, of which the ACHS CEO is an appointee/co-chair.	New Hampshire	NH	Government

Carthage Area Hospital Inc.

Critical Access Hospital

Primary focus area:
Access: Primary Care, Chronic Disease Management, Other: Analytics/Dashboard information sharing

G59RH53700

Grantee Contact Information

Address: 251001 West Street, Carthage, NY, 13619
Website: https://www.carthagehospital.com/

Target Population

The rural, low-income, and under- and uninsured populations of Jefferson, Lewis, and St. Lawrence counties.

Project Goals

The North Star Health Alliance (NSHA) Operations Center will enhance hospital efficiency and patient care through real-time resource allocation, improved communication, and advanced data analysis, using dashboards to monitor bed availability, staffing, and patient flow. It will also provide ongoing staff training and support, maintain rigorous quality and safety monitoring, and engage stakeholders through regular updates.

1. Reduce emergency department waiting, boarding, and diversion.
2. Improve patient access to care and enhance regional health care coordination within a year of implementing the operations center by reducing the number of instances where Carthage and Claxton-Hepburn Medical Center are unable to accept patient transfers.
3. Enhance patient retention and improve health care outcomes within a year of project start date by reducing outpatient leakage.
4. Enhance patient satisfaction and loyalty by improving the “would recommend the facility” score for all consortium members within 1.5 years of implementing the operations center.
5. Establish and maintain an average patient length of stay of less than 96 hours.
6. Foster collaboration, transparency, and communication within the consortium.
7. Improve access to care for rural clinics.
8. Enhance chronic disease management for outpatients through Operations Center workflow.

Evidence-Based or Promising Practice Model Being Used or Adapted

The NSHA Operations Center is based on the operational command center model. The operational command center model is revolutionizing the way hospitals manage patient flow across the entire care continuum. Reducing time for patient access is a complex problem to be solved as populations grow and age. Spending on health care has become a matter of national attention with fast-rising costs and variable quality outcomes. Operational command centers play a crucial role in minimizing waste by facilitating visibility, alignment, and resource coordination across health systems.

Project Description

The current operations center, established in April 2024, is modeled after a military tactical operations center or command post. It provides leadership with vital information for resource allocation, communication, and monitoring using computer systems (dashboards) to track operations. Its primary functions include receiving, distributing, and analyzing information; making recommendations to departments and leadership; integrating resources; and synchronizing efforts. Current measures are tracked daily and manually entered into a spreadsheet, with the exception of bed management, which has been successfully integrated into a real-time dashboard. Funds provided will include the purchase of a similar analytical software used by Johns Hopkins to reduce manual data entry and apply predictive analytics to tracked measures. Data is tracked for both facilities and all rural clinics at both hospital operations center locations.

Expected Outcomes

Improved access to care, particularly for geographically isolated and underserved populations, enhanced care coordination and real-time communication among health care providers, reduced wait times, improved patient satisfaction, and equitable health care access for low-income families and elderly residents. The anticipated economic impacts include job creation and sustaining local health care facilities by retaining patients within the health system.

Consortium Partners

Organization	County	State	Organization Type
Carthage Area Hospital Inc.	St. Lawrence, Lewis, and Jefferson counties	NY	Critical Access Hospital
Claxton-Hepburn Medical Center	St. Lawrence, Lewis, and Jefferson counties	NY	Hospital
Canton Health Center	St. Lawrence, Lewis, and Jefferson counties	NY	Rural Health Clinic
Madrid Health Center	St. Lawrence, Lewis, and Jefferson counties	NY	Rural Health Clinic
Hammond Health Center	St. Lawrence, Lewis, and Jefferson counties	NY	Rural Health Clinic
Waddington Health Center	St. Lawrence, Lewis, and Jefferson counties	NY	Rural Health Clinic

Eastern Maine Healthcare Systems

Health System

G59RH53701

Primary focus area:
Other: Respiratory Therapy, Workforce Development

Grantee Contact Information

Address: The Cianchette Building, 43 Whiting Hill Road, Brewer, ME, 04412-1005
Website: https://northernlighthealth.org/

Target Population

The target population to be served by the Rural Northern Maine Respiratory Therapy Program (RNMRTP) is individuals with respiratory health care needs living in the rural communities of nine predominantly rural Maine counties: Aroostook, Hancock, Kennebec, Knox, Penobscot, Piscataquis, Somerset, Waldo, and Washington. All of these counties are within the Northern Border Regional Commission (NBRC) region. RNMRTP will recruit and train young adults and adults from within the target service area interested in securing training and employment in respiratory therapy..

Project Goals

The overarching goal of the RNMRTP is to support and strengthen matriculation, retention, graduation, and successful employment of participants from a recently expanded Commission on Accreditation for Respiratory Care (CoARC) respiratory therapy program serving the rural northern regions of Maine. The specific RNMRTP goals are:

1. To make respiratory therapy training more accessible to individuals in Maine's northern rural communities by formalizing and stewarding the RNMRTP to ensure a strong, multisector consortium committed to building and sustaining the project from September 30, 2024, through September 29, 2027, and beyond.
2. To support Kennebec Valley Community College's recently expanded CoARC rural respiratory therapy training program to increase availability to individuals in rural Maine via a hybrid remote and in-person modality with a focus on student support and retention and program sustainability from September 30, 2024, through September 29, 2027, and beyond.
3. To implement and continually enhance a coordinated outreach and recruitment program for the purpose of educating diverse and underserved populations of individuals about the respiratory therapy profession

and the available RNMRTP from September 30, 2024, and beyond.

4. To hire and onboard registered respiratory therapists in rural health care settings with a focus on employee retention and professional growth between June 30, 2025-July 31, 2027.

Evidence-Based or Promising Practice Model Being Used or Adapted

The evidence-based model that this project will use is the CoARC-accredited respiratory therapist training program. This accreditation provides confirmation that a program meets the highest standard of educational quality and that resources, educational processes, and outcomes are continually reassessed to ensure the program's integrity. CoARC is the sole nationally recognized authority for the accreditation of first professional degree programs in respiratory care. CoARC's mission is to ensure that high-quality educational programs prepare graduates to be competent respiratory therapists with proficiency in practice, education, research, and service. For these reasons, the CoARC model is the appropriate one to use for the RNMRTP.

CoARC accredits entry into professional practice programs in respiratory care at the associate, baccalaureate, and master's degree levels; degree advancement programs in respiratory care at the undergraduate and graduate levels; and advanced practice respiratory therapy programs at the graduate level. CoARC also accredits polysomnography programs offered by these programs. CoARC accreditation activities are limited to programs in the United States and its territories.

CoARC and its collaborating organizations cooperate to establish, maintain, and promote high-quality educational standards for programs that prepare individuals for respiratory care practice and to provide recognition for degree-granting, postsecondary education programs that meet the requirements outlined in the CoARC standards. The accreditation process is voluntary and is initiated only at the request of an institution that meets the criteria for program sponsorship, as identified in the CoARC standards. The CoARC standards were initially adopted in 1962 and have been revised 11 times subsequently. The standards are approved by the CoARC board. CoARC collects outcomes data of CoARC-accredited programs annually and presents the data for use and analysis by members..

Project Description

The purpose of RNMRTP is to support and strengthen matriculation, retention, graduation, and successful employment of participants from a recently expanded CoARC respiratory therapy program serving the rural northern regions of Maine. The focus area is the improvement of access to respiratory therapy training and education in a target service area of five fully rural Maine counties located in the rural NBRC region: Aroostook, Hancock, Kennebec, Piscataquis, and Somerset. The area that will be positively impacted by this project spans nine Maine counties in NBRC region: Aroostook, Hancock, Kennebec, Knox, Penobscot, Piscataquis, Somerset, Waldo, and Washington. The proposed RNMRTP project is very much needed in the target service area due to the high need for respiratory services in the underserved communities, severe current and forecasted shortages of registered respiratory therapists in the service area, and challenges in training and retaining registered respiratory therapists.

Expected Outcomes

The expected outcomes achieved by the end of the period of performance are the following:

- To increase the number of respiratory training programs available to rural communities in Northern Maine;
- To increase the number of students from rural communities in the target service area enrolled in the respiratory therapy program with a target of eight new students enrolled;
- To increase the number of registered respiratory therapists graduating from the respiratory therapy program with a target of six students graduating;
- To increase the number of newly graduated RNMRTP registered respiratory therapists employed and providing services in rural northern Maine with a target of six employed and providing services;
- To increase reported annual income for RNMRTP participants after they complete the program;
- To decrease the number of open positions for respiratory therapists in network rural northern Maine hospitals;
- To decrease rural hospital reliance on costly contingency staffing;
- To increase the number of rural hospitals that are able to use “earn to learn” programs in respiratory therapy as a strategy for supporting movement in rural health care career ladders;
- To increase access to respiratory therapy services in rural northern Maine;
- To increase coordination and communication between hospital care management staff and community-based in-home respiratory care providers, who are critical components of case management for patients with chronic illness or long-COVID; and
- To increase rural community knowledge and understanding of the respiratory therapy profession.

Consortium Partners

Organization	County	State	Organization Type
Eastern Maine Healthcare Systems d/b/a Northern Light Health	Aroostook, Hancock, Kennebec, Knox, Penobscot, Piscataquis, Somerset, Waldo, and Washington counties	ME	Health Care System
Kennebec Valley Community College	Aroostook, Hancock, Kennebec, Knox, Penobscot, Piscataquis, Somerset, Waldo, and Washington counties	ME	Community College
Northern Maine Community College	Aroostook County	ME	Community College
Eastern Maine Medical Center d/b/a Northern Light Eastern Maine Medical Center	Aroostook, Hancock, Kennebec, Knox, Penobscot, Piscataquis, Somerset, Waldo, and Washington counties	ME	Health Care/Education
The Aroostook Medical Center d/b/a Northern Light A.R. Gould Hospital	Aroostook County	ME	Hospital
Blue Hill Memorial Hospital Inc. d/b/a Northern Light Blue Hill Hospital	Hancock County	ME	Hospital
Charles A. Dean Memorial Hospital d/b/a Northern Light C.A. Dean Hospital	Piscataquis County	ME	Hospital
Inland Hospital d/b/a Northern Light Inland Hospital	Kennebec County	ME	Hospital
Maine Coast Regional Health Facilities d/b/a Northern Light Maine Coast	Hancock and Washington counties	ME	Hospital
Sebasticook Valley Health d/b/a Northern Light Sebasticook Valley Hospital	Somerset County	ME	Hospital

Fort Drum Regional Health Planning Organization Inc.

Primary focus area:
Access: Primary Care, Community Health Workers

Nonprofit

G59RH53702

Grantee Contact Information

Address: 120 Washington Street, Suite 230, Watertown, NY, 13601
Website: https://www.fdrhpo.org/

Target Population

Individuals who reside in rural service areas of Jefferson, St. Lawrence, and Lewis counties. Individuals who are elderly, disabled, or low-income. Individuals who have been identified as appropriate for community health worker (CHW) engagement by consortium members. Individuals who have not been engaged in primary care; are due for preventive treatment services such as immunizations, well visits, or cancer screenings; are candidates for transitional or chronic care management (e.g., have multiple chronic conditions or inpatient or emergency department utilization); or have one or more health-related social need.

Project Goals

1. Provide CHW interventions to target population members. CHWs will engage at least 30% of the targeted population members by the end of Project Year 3.
2. Enhance health outcomes of target individuals in the rural service area. By the end of Project Year 3, target individuals who have engaged with CHWs will have at least 10% fewer potentially preventable inpatient admissions and emergency visits, closure of at least 35% of identified open care gaps, and closure of at least 50% of identified health-related social needs referrals.
3. Promote sustainability. Consortium members will have at least one identified avenue to continue collaboration post-award, and primary care consortium members will participate in at least two value-based contracts and maximize their reimbursement for project-related services.

Evidence-Based or Promising Practice Model Being Used or Adapted

To promote better health outcomes, this project will utilize CHWs, which is an evidence-based model recognized by a growing body of research. From 2014 to 2016, CHW interventions were studied 574 times

with favorable results (Association of State and Territorial Health Officials, 2022). Randomized control trials have shown that CHW interventions led to "increased likelihood of obtaining primary care, increased mental health improvements, and reduce[d] likelihood of multiple 30-day readmissions from 40% to 15.2% as well as increased support for disease self-management and lower hospitalization cost." The Centers for Disease Control and Prevention considers CHWs to be a best practice "based on effectiveness and impact," with CHW interventions determined to be "supported or well supported" across six evaluative domains: effect, internal validity, implementation guidance, independent replication, research design, and external and ecological validity.

Project Description

This program model will leverage CHWs in rural primary care sites to reach out to and engage populations in health services. These services will include preventive screenings, care management, health education, and reengaging populations who have not had regular primary care services. Social barriers to care, such as transportation barriers, housing instability, food insecurity, and difficulties with financial aspects of health care cost and needs will be addressed. CHWs will use their vast range of knowledge of community resources to address social barriers to care. CHWs will work as liaisons with primary care sites to bridge gaps in care. CHWs will also be available on-site to assist with health literacy barriers.

Expected Outcomes

- Thirty percent of the identified target population will reengage in primary care or engage in primary care for the first time. Once the population members are engaged in primary care, it is anticipated that they will utilize it for a variety of preventive and acute needs.
- CHWs are trusted community members and reflect the populations they serve; it is anticipated that they will foster increased trust in primary care. Annual surveys will be conducted with a sample of the targeted population and analyzed to assess their levels of satisfaction with CHW interventions.
- CHWs will screen and address health-related social needs, which can lead to improved nutrition, improved housing conditions, improved access to transportation, services for domestic violence victims, and other positive outcomes.
- This project is expected to result in a 10% decrease in potentially preventable hospital admissions and emergency department visits.
- A 35% closure rate of identified care gaps and a 50% closure rate of initiated health-related social needs among target populations are expected.
- Further, the project is expected to generate organizational-, consortium-, and system-level impacts from the use of integrated CHW model. At an organizational level it is anticipated that the use of CHWs will alleviate practices' workforce-related issues, as CHWs will be placed in practice sites at no cost and will assist care teams in the meaningful yet time-consuming work of patient outreach and engagement. It's anticipated there will be a revenue increase in reimbursable services from CHW-supported services. It is expected that consortium members will foster deep collaboration and trust among one another as a result of the project, including regular consortium meetings. The final return on investment report is expected to showcase the project outcomes and will be disseminated to stakeholders. This project and its outcomes may contribute to the larger statewide and national conversation about CHW integration.

Consortium Partners

Organization	County	State	Organization Type
Northern Regional Independent Living Center	Jefferson, Lewis, St. Lawrence	NY	Nonprofit
Carthage Area Hospital	Jefferson, Lewis, St. Lawrence	NY	Hospital-based primary care
Clifton-Fine Hospital	St. Lawrence	NY	Hospital-based primary care
River Hospital	Jefferson	NY	Hospital-based primary care
Samaritan Medical Center (Clayton clinic)	Jefferson	NY	Hospital-based primary care
Claxton-Hepburn Medical Center	Jefferson, Lewis, St. Lawrence	NY	Hospital-based primary care

HealthyAcadia

Public/Community Health Nonprofit

G59RH53703

Primary focus area:
Behavioral/Mental Health, Community Health Workers, Workforce Development

Grantee Contact Information

Address: 77 Beechland Road, Ellsworth, ME, 04605
Website: Healthyacadia.org

Target Population

The overall target population is individuals affected by substance use disorder or mental health disorders and who are living in Hancock or Washington counties; this population experiences significant unmet health needs across a broad range of health indicators. Our target population includes racial and ethnic minority subpopulations and communities who have historically suffered from poorer health outcomes, health disparities, and other inequities. It includes two tribal populations; a growing Latine population; and Black, Indigenous, and people-of-color communities.

Project Goals

1. Expand and sustain the existing two-county, multisector, rural Downeast Substance Treatment Network, ensuring a strong, multisector network committed to successfully implementing the project from September 30, 2024, through September 29, 2027.
2. Create new, robust behavioral health workforce development programming to expand workforce capacity to address behavioral health needs and to help improve health outcomes for individuals facing substance use disorder or mental health disorders across the two-county region, from September 30, 2024, through September 29, 2027.
3. Expand and enhance Healthy Acadia's community health navigation programming to further support individuals and families facing substance use disorder or mental health disorders across the two-county region, with an emphasis on those who are underserved or face significant disparities, from September 30, 2024, through September 29, 2027.
4. Implement new trainings to clinical and community providers, and provide education and trainings to families and community members to improve health outcomes for community members impacted by

substance use or mental health disorders, including reducing discrimination, racism, and bias in clinical and community settings and increasing health literacy across the population, from September 30, 2024, through September 29, 2027.

Evidence-Based or Promising Practice Model Being Used or Adapted

The model for the Health Equity and Resource Team (HEART) Project is derived from three evidence-based or informed approaches that are effective in addressing gaps and needs in community settings: (1) workforce development, (2) care navigation, and (3) education and training.

Project Description

The HEART Project's focus area is to expand and enhance the delivery of behavioral health services and improve health outcomes in two rural, northeastern counties of Maine: Washington and Hancock counties, also known as Downeast Maine.

Expected Outcomes

Our expected outcomes include a robust and sustained network of partners committed to addressing regional behavioral health needs long into the future; increased numbers of community members entering the behavioral health workforce, enabling partners to better meet their hiring needs, along with increased capacity to address behavioral health needs across front-line community workers; expanded and enhanced community health navigation services across the region, leading to improved health and other outcomes for vulnerable community members experiencing behavioral health challenges; increased understanding and skills around behavioral health, health equity, cultural competency, and related issues among clinicians and community members, leading to improved outcomes for communities members; and the sustaining of this important work through Healthy Acadia's planning and sustainability efforts.

Consortium Partners

Organization	County	State	Organization Type
Eastport Healthcare Inc.	Washington County	ME	Federally Qualified Health Center
Aroostook Mental Health Services Inc.	Hancock and Washington counties	ME	Private, nonprofit community health and social service organization
Mount Desert Island Hospital	Hancock County	ME	Hospital

Littleton Hospital Association

Critical Access Hospital

G59RH53704

Primary focus area:
Access: Primary Care, Care Coordination, Mobile Integrated Health/Community Paramedicine

Grantee Contact Information

Address: 600 St. Johnsbury Road, Littleton, NH, 03561
Website: https://littletonhealthcare.org/

Target Population

The proposed Littleton Regional Healthcare Mobile Integrated Health (LRH-MIH) program aims to support patients who are high utilizers of emergency medical services (EMSs) and emergency department (ED) visits or are at risk for hospital admission or readmission. In Grafton and Cöos Counties, these patients typically fall into three subpopulations: low-income individuals, individuals requiring additional health care support, and older adults.

Project Goals

The goals of the LRH-MIH program are as follows:

1. Improve access to health care systems;
2. Decrease unnecessary utilization of hospital services (admission and readmission); and
3. Decrease unnecessary utilization of emergency services (EMS and ED visits).

Evidence-Based or Promising Practice Model Being Used or Adapted

The LRH-MIH program was designed using MIH-Community Paramedicine (MIH-CP), a health care delivery approach that utilizes EMS personnel and systems workings directly with other health care professionals to meet health needs of patients in their homes.

Project Description

The LRH-MIH program seeks to ensure patients have access to primary care and preventive services while decreasing their utilization of hospital and emergency services.

To achieve this, program activities include developing referral processes within Littleton Regional Healthcare to streamline patient enrollment, establishing and strengthening partnerships with local organizations, and disseminating program success stores in newsletters and local media. Additionally, mobile integrated health home visits will be conducted to provide comprehensive patient assessments that will facilitate the identification of social determinants of health and allow for the development of individualized care plans to address an array of needs and ensure continuity and coordination of patient care.

Expected Outcomes

In alignment with the project goals, the expected outcomes of the LRH-MIH program are as follows:.

- This project expects to enroll at least 500 patients in the LRH-MIH program within three years, ensure that 90% of enrolled patients have a regular source of primary care within three months of enrollment, and ensure that 100% of enrolled patients identified as needing additional support are referred to appropriate services within three years.
- This project expects to reduce hospital admission and readmission rates by 20% within three years.
- This project expects to reduce the number of EMS and ED high utilizers by 25% within three years.

Consortium Partners

Organization	County	State	Organization Type
Littleton Regional Healthcare	Grafton and Cöos counties	NH	Critical Access Hospital and Hospital EMS
Lisbon EMS	Grafton County	NH	Community EMS (Volunteer)
Linwood Ambulance	Grafton County	NH	Community EMS (Private)
Littleton Fire & Rescue	Grafton County	NH	Community EMS (Fire Department)

MaineHealth

Health System

G59RH53705

Primary focus area:
Maternal/Child Health, Other: Rural Health Access, Workforce Development

Grantee Contact Information

Address: 22 Bramhall Street, Portland, ME, 04102
Website: www.mainehealth.org

Target Population

The target population for this proposal is women and birthing persons who are struggling to access maternal or obstetric health care in their rural communities. This project will also support OB-GYN and family medicine residents who are seeking additional maternal care training in rural settings to help them better prepare for postgraduate practice. Training and recruiting more family medicine and OB-GYN graduates to provide rural maternal care will support existing maternal care providers whose work burden may be unacceptably high due to vacant positions and understaffing of care models for the number of patients seeking maternal care.

Project Goals

1. Create a new rural obstetrics education consortium of engaged stakeholders across rural Maine and Eastern New Hampshire to create a novel educational intervention. Convene a rural obstetrics patient advisory committee as a rural obstetrics education consortium subcommittee.
2. Craft an innovative rural obstetrics training intensive to provide an immersive obstetrics training experience for family medicine and OB-GYN residents.
3. Develop an infrastructure of rural clinical training sites for OB-GYN and family medicine residents to provide additional, rural-based maternal care training for residents.
4. Develop a new rural obstetrics curriculum to complement the clinical training, including education on health care disparities, social determinants and drivers of health, and other inequities affecting health outcomes.
5. Support rural family medicine and OB-GYN faculty who are teaching residents in rural settings with directed faculty development, including mentorship resources.
6. Develop and implement a marketing and recruitment strategy.

7. Develop a procedure by which other rural training intensives may be developed for additional high-priority health care needs, such as geriatrics training, behavioral health, and others. The procedure and results thereof will be broadly shared such that other health care systems and graduate medical education (GME) institutions may replicate the strategy in a broad range of rural settings and across a diverse array of health care topics.

Evidence-Based or Promising Practice Model Being Used or Adapted

Recruitment of physicians to practice in rural communities is a challenge for many states, including Maine — a state that, notably, has the second-highest proportion in the nation of its population (61%) living in rural areas.[1] One key strategy to improve rural physician recruitment is to strengthen the pipeline for rural practice. Physicians in GME training programs — residents — have demonstrated greater likelihood to practice in the geographic areas in which they have trained; specifically, the location of residency training appears to be the most significant factor, with 54.2% of residents practicing in the state where they received training.[2] A body of research supports the effectiveness of preparing future physicians for practice in rural settings by engaging them in thoughtful and targeted training in rural locations during residency.[3] These national findings are similar to those seen in the four Maine-based Sponsoring Institutions (SIs) accredited by the Accreditation Council for Graduate Medical Education (ACGME): Eastern Maine Medical Center-Northern Light (EMMC), Central Maine Medical Center (CMMC), MaineHealth–Maine Medical Center (MH-MMC), and the Maine–Dartmouth Family Medicine Residency (MD-FMR) program, for whom between 49% and 55% of graduates remain to practice in the state of Maine (local data, 2022).

Studies investigating the barriers to rural practice after residency have identified multiple contributing factors, including high workload due to recruitment struggles, reimbursement concerns, lack of opportunities for partners and children, and concern about lack of specialty care to support rural OB-GYN practice.[4] Compounding the problem is that most residency training in the United States occurs in urban areas, with 99% of Medicare spending for GME programs going to programs located in urban settings.[5] This limits the exposure that residents have to rural practice during their training. Yet, one of the strongest predictors for eventual rural practice is experiencing rural training during residency, indicating that those who do receive training in such settings have, or develop, a greater appreciation for its benefits.[6] A scoping review indicated that rural rotations during training had a positive association with residency graduates choosing to practice in rural settings after training.[7] Training in a rural residency program or hybrid urban-rural track program were also positively associated with post-graduation rural retention.[8] Again, this finding is consistent with the experience of the four ACGME-accredited SIs in Maine; the three urban-based programs retained 21%-25% of graduates into rural communities, and the only fully rural program, MD-FMR in Augusta, Maine, had 35% of graduates stay in practice in rural Maine communities (local data, 2022).

In 2022, the four SIs in the state of Maine partnered to create the Maine Rural GME Education (MERGE) Collaborative — the first-ever GME collaborative in our state. The MERGE Collaborative SIs worked cooperatively with new partners across rural Maine to create 33 new GME elective training sites across rural communities in 13 different specialties. Early outcome data from the MERGE Collaborative indicates that this promising practice model is positive. Of the eight residents who completed a MERGE elective rotation from July 2023 to May 2024 and graduated in June 2024 into practice, six have chosen to practice in a rural community. The other two will serve a rural catchment population in Lewiston. The opportunity to train in a rural setting was cited in resident feedback, influencing their choice to practice in a rural setting after graduation.

MaineHealth believes that this successful model of developing short, elective rotations in any specialty can be intentionally expanded to develop longer, curated clinical training intensives — supported by a rural

curriculum, faculty development, and mentorship — curated to a high-priority need in the target service area. MaineHealth has chosen access to maternal health care access in rural communities as the first health care priority based on the alarming data previously reviewed on the availability and accessibility of health care services. MaineHealth believes that creating new rural obstetrics training intensives for both family medicine and OB-GYN residents in Maine and Eastern New Hampshire (to start) will increase the number of resident graduates who choose to provide maternal care in these catchment areas, thereby positively impacting the maternal health care access crisis in these rural areas.

Project Description

The overall aim of this project is to address maternal care access in rural communities by leveraging GME to increase the number of OB-GYN and family medicine residents who provide maternal care in rural communities after residency training by providing high-quality training in rural settings during residency to improve both competence and confidence for rural practice

Expected Outcomes

The long-term expected outcome for this project is improved access to maternal care in rural communities, by strengthening the GME pipeline for rural practice and improving obstetrics education in rural settings. Shorter-term expected outcomes include:

- Creation of a novel educational intervention, the rural obstetrics training intensive, to provide clinical, didactic, experiential, and simulation-based education to better prepare OB-GYN and family medicine residents who are considering providing maternal care in rural communities after graduation. MaineHealth believes that the rural obstetrics training intensive experience will not only better prepare residents to provide maternal care after practice, but also, by introducing clinical training and mentorship in the rural setting, allay fears the trainees may have about rural practice. Both the development of this workforce pipeline and provision of mentorship in training align with key recommendations put forth by researchers and clinicians of the HRSA-funded Rural Maternity and Obstetrics Management Strategies (RMOMS) Program, as outlined in its 2023 report.
- The development, and refinement, of an educational strategy to develop rural training intensives may then be applied to other high-priority health care needs for rural communities, such as better education on addiction medicine, behavioral health, and geriatrics, to name a few. This educational strategy may also be applied to other states and different clinical settings and for an interprofessional health care workforce.

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Consortium Partners

Organization	County	State	Organization Type
Mount Desert Island Hospital	Hadcock, Washington	ME	Hospital
Northern Light Mayo Hospital	Piscataquis, Somerset	ME	Hospital
Maine Dartmouth Family Medicine Residency	Kennebec	ME	Family Medicine Residency Program
Stephens Memorial Hospital	Oxford	ME	Hospital
Franklin Memorial Hospital	Franklin, Oxford, Somerset	ME	Hospital
Memorial Hospital	Carroll	NH	Hospital

Medical Care Development Inc.

Public/Community Health Nonprofit

G59RH53706

Primary focus area:
Chronic Disease Management, Social Determinants of Health, Telehealth/Telemedicine

Grantee Contact Information

Address: 105 Second Street, Suite 2A, Hallowell, ME, 04347
Website: www.MCD.org and www.SeacoastMission.org

Target Population

The Seacoast Care Collaborative's Downeast Maine service area consists of more than 9,500 square miles of Washington, Hancock, and Knox counties, with a primary focus serving the unbridged islands of Great Cranberry, Litte Cranberry, Frenchboro, Matinicus, Swans, Isle au Haut, Isleboro, North Haven, and Vinalhaven. This region and these year-round island communities are isolated and economically disadvantaged, lagging the state and nation in wealth, food security, and most measures of socioeconomic well-being. Compared to state and national averages, island household sizes are smaller, the median age higher, the percentage of people in poverty is greater, and the number fishing for a living is more sizable. Workers in this region are dependent on seasonal, agricultural, fishing, and other low-paying jobs. These factors make it difficult for residents, especially the elderly, disabled, self-employed, and financially disadvantaged, to afford trips to the mainland for health care. The elderly find it difficult to age in place on islands with limited resources. They cope with the significant challenges of social isolation that come with small household size, small communities, long distances to the mainland, and a strong tendency toward privacy and individualism. The Maine Seacoast Mission, the cofacilitator for the Seacoast Care Collaborative, provides community and social services to these island communities through a boat called the Sunbeam. More than 90% of year-round island residents depend on one or more of the Maine Seacoast Mission's community programs. In 2023, the Sunbeam provided 249 vaccinations, 1,684 in-person client interactions, 48 home medical visits, and 4,717 virtual health connections, and 1,078 visitors boarded our ship for services.

Project Goals

The Seacoast Care Collaborative aims to improve access to health care for residents of Maine's unbridged island communities through a statewide telehealth network, facilitated by the Sunbeam crew. This project will:

1. Facilitate access to and provide health care services through a strong collaborative network in which every network member organization is actively involved and engaged in the planning and implementation of activities.
    - Lead and manage the network with shared staffing and collaboration tools, including program oversight, project management, and reporting.
    - mplement and maintain operating agreements, business associate agreements, and a network charter between partners.
    - Support partner participation in project planning, resource development, and shared dissemination of best practices in real time
2. Expand the delivery of new or enhanced health care services, including through telehealth, to serve Maine's unbridged island communities and improve access to care across the region.
    - Manage and integrate an island health plan that guides strategies and processes to regularly engage island residents to support their medical and behavioral health needs, including patient navigation strategies for accessing telehealth.
    - Manage a Seacoast Care Collaborative operations plan to guide a shared understanding of program approaches and needs across network members and use the plan to manage ongoing program implementation.
    - Develop untapped resources to support administrators, providers, and community anchor institutions to better support the health care needs of island communities.
3. Utilize community engagement and evidence-based or innovative, evidence-informed telehealth models in the delivery of health care services.
    - Provide support to network members to implement and optimize telehealth programs.
    - Maintain a communication strategy to disseminate information, resources, and surveys to islanders.
    - Provide health care navigation and raise awareness of resources for islanders and island community organizations established through the Maine Health Care Bridge Collaborative during in-person island visits by the Sunbeam.
    - Identify regional and national best practices to improve health outcomes for isolated, rural communities.

Evidence-Based or Promising Practice Model Being Used or Adapted

The Seacoast Care Collaborative aims to implement and integrate collaborative telehealth technologies to enable the Collaborative Care Model, the value-based care model, and integration of community health workers and similar promising practices.

Project Description

The Seacoast Care Collaborative will focus on improving chronic and acute care needs of island residents through telehealth. Through strong partnerships between community-based organizations and mainland health care providers, the project will enable care coordination, support patient engagement, and improve overall access to care through telehealth. It will leverage the collaborative's co-leads' expertise in telehealth program optimization, experience in quality improvement, and knowledge of island culture and social determinants of health to enable collaborative members to develop and sustain accessible telehealth programs.

Telehealth utilization is growing significantly across and beyond the United States due to advances in technology; changing patient needs, demands, and demographics; and discernible benefits toward achieving health care reform. While health systems and organizations throughout Maine are also implementing telehealth programs, adoption has been slow to expand and be sustained due to fragmented approaches among internal and external partners, in addition to a complex reimbursement landscape, significantly limiting the systemic potential. There is a clear need for a collaborative approach to address ongoing health access issues, simplify complicated telehealth policy and regulatory environments, ensure that technology solutions meet clinical needs in a cost-resourceful manner, and leverage efficiencies in cost and resource utilization.

While this issue is one that affects all Maine residents, and all Northern Border Region communities, Maine island residents in particular face significant barriers to accessing in-person health care services, including travel time, availability of travel, and other social determinants. As such, consortium facilitators and members will improve implementation and access to telehealth services and ultimately improve both the chronic and acute care needs of island residents.

By implementing this consortium, the project will not only expand formal engagement and commitment among existing stakeholders but will also bring new partners to the table. This will allow for a more in-depth expansion and improvement of existing telehealth programs and better identification of shared resources and best practices for new services, including both members who currently provide some telehealth services and other members who do not currently offer telehealth. Funding this consortium will launch a common mission, function, and ongoing collaborative efforts, while also building capacity to drive innovative, evidence-based telehealth and collaborative planning program models that can help address key population health needs and enhance the rural health system overall.

Expected Outcomes

The Seacoast Care Collaborative consortium aims to facilitate access to and provide health care services through a strong collaborative and consortium; expand the delivery of new or enhanced health care services through evidence-based or evidence-informed telehealth models; and improve population health, health outcomes, and sustainability.

Outcomes to improve access to health care for unbridged island communities will be monitored and measured on access to care, quality of care, telehealth operations and process outcomes, and care coordination and network infrastructure measures.

The Seacoast Care Collaborative will develop a collaborative evaluation plan to monitor project activities and evaluate outcomes and process measures. This will include four primary domains: (1) access to care, (2) quality of care, (3) telehealth process, and (4) care coordination and network infrastructure

The Seacoast Care Collaborative will also support island residents' engagement in Maine's Shared Community Health Needs Assessment processes and surveys to increase the strength of the island resident voice in the medical and behavioral health needs of island communities, including understanding of the impact of island living on some social determinants of health.

The project will disseminate best practices identified through the work of the collaborative across the Northern Border Region and develop a program sustainability plan.

Consortium Partners

Organization	County	State	Organization Type
MDI Hospital	Hancock County	ME	Critical Access Hospital
MaineHealth	Statewide	ME	Hospital
Northern Light	Statewide	ME	Hospital
St. Joseph's Hospital	Penobscot County	ME	Hospital
MaineGeneral Health	Kennebec County	ME	Hospital
Islands Community Medical Center	Knox County	ME	Federally Qualified Health Center

Partnership for Public Health Inc.

Nonprofit

G59RH53707

Primary focus area:
Chronic Disease Management, Community Health Workers, Mobile Integrated Health/Community Paramedicine

Grantee Contact Information

Address: 11 Academy Square, Laconia, NH, 03246
Website: www.pphnh.org

Target Population

Laconia, N.H., is a medically underserved area facing significant health care challenges, including high rates of chronic disease, frequent emergency department visits, and hospital readmissions. The target population prioritizes individuals with barriers to accessing traditional health care services, including older adults and individuals experiencing homelessness. The project aims to conduct 425 unique encounters and 600 preventive services or screenings with patients over the course of the project period.

Project Goals

1. Increase the number of preventive health care visits conducted by community paramedics for the target population in Laconia, N.H.
2. Reduce the 30-day hospital readmission rate for target population patients with chronic disease by 20% by the end of the project period.

Evidence-Based or Promising Practice Model Being Used or Adapted

- Community health worker serving the Winnipesaukee region.
- Mobile integrated health care and community paramedicine serving Laconia, N.H., only.

Project Description

Using a collaborative approach, the project will focus on increasing access to preventive services and chronic disease management in underserved populations, including older adults and individuals experiencing

homelessness or housing insecurity. A specially trained paramedic will provide home- and community-based care, including health assessments, chronic disease management, minor urgent care, and the like. Community health workers will complement these services by addressing social determinants of health, providing patient education, and connecting individuals to essential resources. To ensure seamless care transitions and comprehensive support for high-utilization patients, the program will establish partnerships with local hospitals, primary care providers, and social service agencies. Additionally, a robust data collection system will be implemented to monitor program outcomes, patient satisfaction, and overall impact on community health.

Expected Outcomes

- Improve access to care and increase preventive visits conducted by community paramedic and community health worker in Laconia, N.H., and surrounding region.
  - Target Year 1 — 100 services or screenings
  - Target Year 2 — 200 services or screenings
  - Target Year 3 — 300 services or screenings
- Improved management of chronic conditions among participants and a reduction in nonemergent emergency department visits and hospital readmissions.
  - Target Year 1 — 75 unique encounters with patients
  - Target Year 2 — 150 unique encounters with patients
  - Target Year 3 — 300 unique encounters with patients
- Enhanced patient satisfaction and engagement with health care services.
- Strengthened community partnerships and resource utilization.

Consortium Partners

Organization	County	State	Organization Type
Partnership for Public Health Inc.	Belknap, Merrimack	NH	Community-Based Organization
Laconia Fire Department	Belknap	NH	Municipal Fire Department
Concord Hospital–Laconia/Franklin	Belknap, Merrimack, Grafton	NH	Hospital
Lakes Region Mental Health Center	Belknap, Grafton	NH	Community Mental Health Center
Navigating Recovery of the Lakes Region	Belknap	NH	Community-Based Organization
Community Action Program Belknap-Merrimack	Belknap, Merrimack	NH	Community-Based Organization
Laconia Police Department	Belknap	NH	Municipal Police Department

Rangeley Region Health and Wellness Partnership

Primary focus area:
Community Health Workers, Other: Health Disparities

Critical Access Hospital

G59RH53708

Grantee Contact Information

Address: 25 Dallas Hill Road, Rangeley, ME, 04970
Website: https://rrhwp.org/

Target Population

The Northern Franklin County target service area includes all the towns in Franklin County except the following towns that are in the southern part of the county, which is the hub of medical and social service agencies for West Central Maine: Avon, Chesterville, Farmington, Industry, New Sharon, New Vineyard, Strong, Temple, Weld, and Wilton. All the service areas are designated as rural. The region is sparsely populated and is approximately the size of Rhode Island. Most of the towns in this service area are geographically isolated from any type of health care services.

Project Goals

There are four goals for this project:

1. Expand the delivery of health care services to include new and enhanced services exclusively in the Northern Border rural community of focus.
2. Deliver health care services through a strong consortium in which every consortium member organization is actively involved and engaged in the planning and delivery of services.
3. Utilize community engagement and evidence-based or innovative, evidence-informed models in the delivery of health care services.
4. Improve population health outcomes and sustainability.

Evidence-Based or Promising Practice Model Being Used or Adapted

Evidence-based models used will be Screening and Health Educator Model, Member of Care Team Delivery Model, Community Organizer and Capacity Builder Model.

Project Description

This project will implement a creative means to meet the unique needs of the targeted region utilizing a combination of evidence-based practice models and promising practice models to (1) address key public health issues in the rural service area, (2) support and maintain an effective, dynamic rural health network, (3) expand and enhance a multisector community health worker program, (4) reduce health disparities by providing accessible health care services to the rural targeted region, (5) promote healthy lifestyle choices through education and resources, (6) improve health outcomes, (7) develop sustainability, and (8) ensure program viability and strength.

The methods to achieve these goals and objectives involve a multifaceted approach under the overarching strategy of maintaining a strong, adaptive, and diverse integrated rural health network. The project methods have originated from innovative ideas shared through the most recent community health needs assessment and the community responsive planning grant, funded by the Maine Health Access Foundation, during which community members identified the top health needs and possible solutions to address these needs. These ideas, combined with evidence-based practice models and promising practice models, will address health gaps in this underserved area.

Expected Outcomes

Expected outcomes include (1) increased access to medical and dental health care, including pharmaceuticals; (2) early disease detection and improved overall health outcomes; (3) improved dietary habits and increased physical activity, and reduction in obesity rates, fall rates, and related premature deaths; (4) enhanced mental health awareness with increased access to mental health care; and (5) increased life expectancy.

Consortium Partners

Organization	County	State	Organization Type
Rangeley Region Health and Wellness	Franklin	ME	Health and Wellness
MaineHealth d/b/a Healthy Community Coalition	Franklin	ME	Community Health
Rangeley Family Dentistry	Franklin	ME	Dental
Health Reach Community Health Centers d/b/a Rangeley Family Medicine	Franklin	ME	Medical
Western Maine Community Action	Franklin	ME	Community Health

The Harry E. Davis Partnership for Children's Oral Health

Nonprofit

G59RH53709

Primary focus area:
Access: Specialty Care, Oral Health, Other: Community-based teledentistry-connected care

Grantee Contact Information

Address: PO Box 11, Yarmouth, ME, 04096

Website: www.mainecohn.org

Target Population

With early pilots first launched in spring 2021, the Maine Dental Connection (MDC) — Maine's Virtual Dental Home initiative — has to date been focused on the Head Start and Early Head Start population with active programs in nine counties — six Northern Border Regional Commission (NBRC) counties — serving more than 600 children aged 0-5 in the 2023-2024 school year. Ninety-three percent of these patients have been MaineCare-insured. The number of Maine children with consistent coverage through MaineCare or a commercial dental plan has increased over the past five years from about 167,000 kids in 2018 to more than 205,000 kids in 2022; this represents just over two-thirds of Maine's approximately 300,000 children under age 21. Maine's dental system, which even prior to the pandemic was providing an active dental home (measured conservatively as having at least one routine dental exam and at least one cleaning) for less than half of insured children in 2019 has not been able to keep even that pace. In 2022, the rate had dropped to only 35% of insured children having an active dental home. This average hides the disparity between commercially insured children and MaineCare-insured children, which has widened to a gap of 56% versus 20%. Based on MaineCare claims data, the Children's Oral Health Network knows that there are more than 60,000 children without dental homes in Maine's 12 NBRC counties, and almost 60% of them live in the six counties covered by the founding MDC clinical consortium members.

In addition to these challenges facing children across the state, adults in the NBRC region face an even bigger dental access crisis. There are very few providers trying to serve the 150,000-plus adults who are newly eligible (as of July 2022) for comprehensive Medicaid dental services, on top of the children they are already trying to reach. Statewide, there are only 20 large-volume MaineCare dental providers serving as dental homes for at least 1,000 MaineCare members. Five of them are the five MDC clinical consortium members, another six are in other NBRC counties, and nine are in non-NBRC counties. When it comes to the need for referrals to specialists, the situation is stark. As of September 2023, there were only nine oral surgery offices with any MaineCare claims in the past year. Three of them are in NBRC counties, one of which is no longer taking

MaineCare, and six of them are in non-NBRC counties. For orthodontic practices, only six had MaineCare claims in the past year, and while three of them were in NBRC counties, the only three that are still taking new patients are the three that are in non-NBRC counties. There are eight pediatric dental practices in the entire state with active MaineCare providers, and only two of them are in NBRC counties (both with a hold on new patients and estimating at least a one-year waiting list on referrals). There are no endodontists or periodontists statewide who are taking MaineCare.

Project Goals

The project goals detailed below are designed to empower the MDC clinical consortium members to streamline their overall workflows and staff capacity to better serve their existing MDC patients and to expand their proven community-based care delivery models into more community sites to reach more Maine children with the full continuum of oral health care. The MDC clinical consortium has defined four primary goals:

1. Strengthen, sustain, and grow MDC care delivery partnerships with Head Start centers. This will be achieved in part through a learning collaborative to continue supporting the current local implementation teams, while adding the development of a mentor-mentee partnership strategy to support at least one newly implementing MDC dental center per year. The measurable objective of this goal is to keep at least 75% of MDC-enrolled Head Start patients healthy in the community setting without the need for in-office follow-up care.
2. Expand MDC services into other child care settings, preschools, and public schools. In addition to the above-mentioned mentor-mentee partnership, school expansion will lean heavily on the Children's Oral Health Network's consortium coordinator to inventory clinical capacity, build new community partner relationships, and provide training and technical assistance as implementation expands. The measurable objective of this goal is to double the number of children receiving comprehensive care through an MDC consortium member compared to baseline enrollment from 2023-2024 school year.
3. Grow the workforce of independent practicing dental hygienists (IPDHs) who are trained and equipped to implement community-based care in the MDC initiative. Building on the success of a new registered dental hygienist–to-IPDH course, consortium partner MCD Global Health will develop and deliver an IPDH incubator program to train and coach a cohort of IPDHs with the specific skills and knowledge needed for MDC implementation in consortium member regions. The measurable objective of this goal is to increase the MDC-trained IPDH workforce by six hygienists coming on board to work with MDC practices in NBRC regions.
4. Optimize the capacity of the MDC clinical consortium members to more efficiently and effectively address the full range of patient needs. To this end, the consortium is creating a new, innovative specialist referral coordinator position to streamline the process of connecting patients with specialist care by centralizing this workflow and skill set in one person to be employed by Mainly Teeth and to work collaboratively across all consortium member practices. The measurable objective of this goal is to improve the specialist referral process for MDC patients with the aim of achieving a referral-to-treatment time of under six months

Woven into each of these goals is a multipart strategic evaluation plan to be managed by Partnerships for Health (PFH), an independent evaluator team that has been leading the evaluation of the MDC pilot, designing and conducting patient health impact evaluation, conducting parent and caregiver experience surveys, facilitating focus groups, and developing financial analysis. Expanding their evaluation to also assess the outcomes of the IPDH incubator and specialist referral coordinator, the PFH team will track relevant measures and will build on the tools developed through the MDC pilot implementation. This strong existing foundation ensures the success of the ongoing evaluation process and the availability of baseline data.

Evidence-Based or Promising Practice Model Being Used or Adapt

This project proposes to expand implementation of the virtual dental home model, which has been named a promising practice in the Association of Maternal & Child Health Programs MCH Innovation Database. As Maine's virtual dental home initiative, MDC increases access to the full continuum of oral health care by integrating care delivery into places children already spend their days and overcoming so many of the barriers to care that Maine families face. This model empowers the community-based provider (most typically a dental hygienist) to work to the full extent of their license, performing preventive and early intervention care on a continuous, risk-assessment driven basis. The community-based provider works with a remote dentist through asynchronous teledentistry to ensure the completion of a full dental exam and treatment planning process. If a patient is identified as needing in-office care, their record is already established with the dental office and the referral process is coordinated by this multipartner care team. The MDC operationalizes the patient-centered dental home as "a model of care that is accessible, comprehensive, continuous, coordinated, patient- and family-centered, and focused on quality and safety as an integrated part of a health home for people throughout the lifespan" .

To keep children healthy in their community settings and minimize the need to visit the dental office, MDC local implementation teams are striving to catch emerging disease early while it can still be arrested and reversed with nonsurgical methods such as silver diamine fluoride and interim therapeutic restorations. These are evidence-based, minimally invasive treatment methods within the scope of a hygienist in Maine, but most patients in Maine do not have access to dental hygienists working within the confines of traditional dental offices. Since the inception of the additional license authority of IPDHs in Maine two decades ago, relatively few dental hygienists have chosen this route. A primary barrier to this career path has been the lack of formal support and education to empower dental hygienists to move beyond the confines of a traditional dental practice. The IPDH incubator will provide structured coaching and peer support through a learning collaborative for a cohort of new registered dental hygienists interested in community-based care who will gain their IPDH license authority and be matched with and hired by one of the MDC clinical consortium members.

Project Description

The MDC clinical consortium has been formed by and for active MDC providers to grow the next strategic phase of expansion for Maine's virtual dental home initiative. This initiative connects Maine's most vulnerable populations with the full continuum of oral health care in a patient-centered, community-engaged delivery system. The founding MDC clinical consortium members are those Maine Oral Health Center Alliance members and MDC-implementing practices that have self-identified as ready to strategically expand their MDC implementation beyond the scope and scale of their Head Start pilot of the past two years. This consortium is a new concept that arose from shared work on the virtual dental home pilot over the past five-plus years. All of these nonprofit oral health providers are mission-driven to increase equitable access in their communities, and the leadership of these practices has been at the table for all of the discussions that have defined this proposal's goals, objectives, and activities. Working together through the existing Maine Oral Health Centers Alliance structure and within the MDC statewide planning group, these providers have developed an intrinsically collaborative and mutually supportive approach to working together across regions to find solutions to shared challenges. Likewise, the Children's Oral Health Network, as well as MCD Global Health's Public Health division and the PFH evaluation firm, all have long-standing working relationships with each consortium member.

Expected Outcomes

The MDC clinical consortium provides an essential space for peer support and collaborative effort to expand this patient-centered promising practice, even in the face of the deeply entrenched status quo. In order to achieve the overarching outcome of expanded capacity to reach more sites with the MDC model, the consortium members identified four specific goals and objectives:

- Strengthen, sustain, and grow partnerships with Head Start centers. Objective — Keep at least 75% of Head Start MDC-enrolled children healthy in the community, without needing a treatment appointment at the dental office.
- Expand MDC services into additional childcare settings, preschools, and public schools. Objective — Increase the number of MDC service sites and the number of enrolled children in Head Start and school settings by 100% over the 2023-2024 baseline.
- Grow the workforce of independent practicing dental hygienists who are trained and equipped to implement community-based care in the dental connection initiative. Objective — Six new IPDHs licensed and onboarded to work with MDC implementing practices in NBRC regions.
- Optimize the capacity of the MDC clinical consortium members to more efficiently and effectively address the full range of patient needs. Objective — Improve specialist referral processes to get patients the treatment appointments they need within six months of referral.

Consortium Partners

Organization	County	State	Organization Type
Community Dental	Franklin, Oxford	ME	Nonprofit dental center
Kennebec Valley Family Dentistry	Kennebec	ME	Nonprofit dental center
Mainely Teeth	Androscoggin, Franklin, Oxford	ME	Nonprofit dental center
St. Apollonia Dental Clinic	Aroostook	ME	Nonprofit dental center
Waterville Community Dental Center	Kennebec, Somerset	ME	Nonprofit dental center
MCD Global Health	Statewide	ME	Nonprofit

University of Rochester Medical Center

Hospital

G59RH53710

Primary focus area:
Access: Primary Care, Care Coordination, Health Information Technology

Grantee Contact Information

Address: 601 Elmwood Avenue, Rochester, NY, 14642
Website: www.urmc.rochester.edu

Target Population

The target population is the residents of Genesee, Livingston, Orleans, Seneca, Wayne, and Yates counties in Upstate New York. This area is a subset of the service area of the consortium, the Finger Lakes Rural Health Network. Within these counties, this project will focus on the following subpopulations: older adults, women and children, veterans (Livingston County only), people with a disability or living in poverty, residents with chronic disease, Black and Hispanic residents, and members of the Amish and Mennonite communities.

Project Goals

The Finger Lakes Rural Health Network is a consortium based in rural Upstate New York that will focus its funding on integrating health information technology, specifically the Epic electronic health record (EHR), into new and existing clinical practice and hospital workflows at the Finger Lakes Health (FLH) system and the Tri-County Family Medicine (TCFM) FQHC to:

1. Improve cybersecurity, business operations, and financial performance of each organization by assessing and upgrading clinical and operations infrastructure where necessary.
2. Support patients and providers through significant change by designing a change-management plan and training curriculum for staff and patients, based on discovery, documentation, and modification of clinical and business process workflows, with a communication plan that supports change management.
3. Minimize any disruptions to health care delivery during go-live by building, configuring, and testing the eRecord environment for each client (TCFM and FLH) in a virtual environment where unforeseen issues can be resolved. It will conduct readiness assessments and provide other support in the final stages of go-live preparation.
4. Manage the EHR transition to the proposed budget and timeline using process metrics and milestones, displayed in a dashboard with quarterly progress review with leadership.

5. Improve access to primary care, women's health, and various specialty service lines in alignment with the organization's strategic plan and reflecting the community needs assessment.
6. Improve health outcomes for disadvantaged populations in the project service area.

Evidence-Based or Promising Practice Model Being Used or Adapted

The project uses the evidence-based dyad leadership model to implement a large-system EHR and all the associated foundational infrastructure, at both a rural community health system and at an FQHC. Both FLH and TCFM have designated a clinical and operations workflow integration partner who is well versed in the existing workflows of the respective organizations. The integration partner will advise and collaborate with the University of Rochester Medical Center (URMC) Information Systems Division business relationship partner, who is an expert on eRecord implementation.

Based on URMC's experience, the project team knows that this kind of project is not just a technical system installation. It is a major change-management initiative for the organizations involved. It is critical to navigate this major change in a manner that is cognizant that physician burnout can lead to turnover and disruption to patient care, which is counter to project goals. The integration partners will help to identify pain points in the proposed EHR system implementation that could significantly disrupt existing workflows or cause providers to overlook patient needs. Working with practicing physicians and the Information Systems Division business relationship partner, the integration partners will find modifications to clinical workflows and system implementation that achieve better care and better patient health outcomes.

This promising dyad leadership change management practice has been successfully applied to other rural practices and hospitals in URMC's network and may help more rural communities maximize the promise of their EHR as a tool to really engage and support patients in achieving their best health.

Project Description

The Finger Lakes Rural Health Network will use grant funding to support a major change-management project at two essential rural organizations that are members of the network. The project involves transitioning each organization to a new EHR. TCFM has one EHR used in five sites, and their transition will be foundational to their new role as a rural family medicine residency training site. FLH has 10 EHRs over two hospitals, four long-term care facilities, and many outpatient practice sites. FLH will begin by transitioning their underlying financial, operating, and cybersecurity infrastructure and then their EHR.

Expected Outcomes

The most important outcome in both organizations will be the ability to capture and use more granular data to identify and engage patients whose chronic disease outcomes are suboptimal, thereby driving down morbidity and mortality. That engagement may occur at home when the patient is viewing their record, during a conversation with a trusted provider, or during a hospital admission. The patient engagement will be supported by accessible, understandable health information.

By focusing on workflow during this technology transition, the project expects to make it significantly easier for the clinical care team to find and use data (especially because there will be a transition from 10 EHRs to two and installing a system-level unique medical record number). This should positively impact job satisfaction and reduce provider turnover, which in turn improves access to care. The project also expects improvements in

patient safety, with the ability for care teams to manage medications and recommendations as a team, rather than in silos.

For FLH, it will also remove the information/communication barrier thar has prevented patients and providers from using their clinical services. This will help to improve the bottom line. In addition, there are expected improvements in operational efficiency and cost savings by avoiding administrative and clinical duplication.

TCFM expects the EHR to create an integrated clinical communications system between rural residency training sites at URMC, Highland Hospital, Highland Family Medicine, Noyes Memorial Hospital, St. James Hospital, and TCFM. It would also foster increased communication with community-based organizations, particularly around maternal-child health.

The project anticipates the Connect system to be installed at TCFM by February 2026 and the FLH eRecord to be implementation by November 2026.

Consortium Partners

Organization	County	State	Organization Type
Tri-County Family Medicine	Livingston/ Southern Region	NY	FQHC-LAL
Strong Memorial Hospital	Monroe	NY	Hospital
F.F. Thompson Hospital	Ontario/Finger Lakes Region	NY	Hospital
Geneva General Hospital	Ontario/Finger Lakes Region	NY	Hospital
Noyes Memorial Hospital	Livingston/ Southern Region	NY	Hospital
Jones Memorial Hospital	Allegany/ Southern Region	NY	Hospital
St. James Hospital	Steuben/ Southern Region	NY	Hospital
Soldiers and Sailors Memorial Hospital	Yates/Finger Lakes Region	NY	Critical Access Hospital
Highland Hospital	Monroe	NY	Hospital
Accountable Health Partners	Monroe	NY	Accountable Care Organization
Center for Community Health and Prevention	Monroe	NY	Public Health

Vermont Program for Quality in Health Care Inc.

Primary focus area:
Other: Sexual assualt/violence

Nonprofit

G59RH53711

Grantee Contact Information

Address: 132 Main Street, Suite 1, Montpelier, VT, 05602
Website: www.vpqhc.org

Target Population

The statewide Sexual Assault Nurse Examiner (SANE) Care Collaborative & Innovation Network will directly help 156,000 Vermont women and 103,000 Vermont men estimated to have experienced contact sexual violence in their lifetimes. The program aims to enhance SANE services throughout numerous rural Vermont counties.

Project Goals

1. Improve the capacity of SANE services in Vermont.
2. Enhance the quality of SANE services in Vermont.
3. Foster collaboration and innovation in Vermont SANE services.

Evidence-Based or Promising Practice Model Being Used or Adapted

*F*or this program, the Institute for Healthcare Improvement's Collaborative Model for Achieving Breakthrough Improvement will be implemented. It involves bringing together diverse teams to work on improving a specific area of health care. These teams use a structured framework that includes identifying a clear aim, developing and testing changes through plan-do-study-act (PDSA) cycles, measuring outcomes, and sharing learnings.

Project Description

The SANE Care Collaborative & Innovation Network aims to enhance the capacity, quality, and collaborative innovation of SANE services throughout Vermont. Integral to this initiative is the establishment of an ongoing engagement of a robust rural consortium, including four key Vermont-based rural organizations. Five rural

hospitals with SANE programs will be enrolled and representatives will undergo foundational quality-improvement training, attend professional conferences, and engage in clinical competency training. Each enrolled site will design and implement a quality-improvement project in PDSA format with regular networking meetings to share and foster the spread of best practices as well as establish sustainability plans. In addition, a SANE Care Collaborative & Innovation Network web page will be built to facilitate collaboration and information sharing.

Expected Outcomes

The expected impact of the SANE Care Collaborative & Innovation Network in Vermont includes significant improvements across three key areas: capacity, quality, and collaboration in SANE services.

- **Increasing the Capacity of SANE Services in Vermont**. This section focuses on improving clinical skills, maintaining certifications, and ensuring participants' satisfaction with training. It also emphasizes hospitals applying new knowledge and increasing networking within their systems.
  - Improve clinical competency: By the end of the training, 90% of participants will demonstrate an increase in clinical competency scores compared to their pretraining assessments.
  - Maintain SANE certifications: Eighty-five percent of participants who complete the training will maintain their SANE certification for at least 12 months post-training, as tracked by follow-up surveys.
  - Training satisfaction: Ninety percent of training participants will report being "satisfied" or "very satisfied" with the content and delivery of the SANE training, as measured by post-training surveys, within one month.
  - Knowledge application: Eighty percent of hospitals will report applying new knowledge gained from the training in clinical practice within three months, as measured by follow-up interviews with hospital leads.
  - Increase networking opportunities: At least 70% of hospitals will report increased networking opportunities as a direct result of participating in the initiative, as tracked by a semiannual hospital survey.
  - ACHS RAC North Country NH | Resilient American Communities

- **Enhancing the Quality of SANE Services in Vermont**. This section evaluates how the initiative improves hospital satisfaction, increases knowledge of service gaps, and enhances collaboration and dissemination of best practices.
  - Hospital satisfaction: By the end of the first year, 85% of enrolled hospitals will report being "satisfied" or "very satisfied" with the SANE care collaborative initiative, as measured by an annual hospital satisfaction survey.
  - Increase capacity and quality: Seventy-five percent of hospitals will report an increase in their SANE service capacity and quality of care within 12 months of joining the initiative, as measured by self-assessments and performance reports.
  - Identify key areas for improvement: By the end of the first quarter, 90% of hospitals will identify at least three key areas for improvement in their SANE services through a needs assessment survey.
  - Understanding service gaps: Eighty percent of enrolled hospitals will demonstrate an increased understanding of gaps and needs in their SANE services within six months of joining the initiative, as reported in project evaluation forms.

- Quality-improvement projects: Seventy percent of hospitals will show measurable improvement in at least one area of SANE services through a PDSA quality-improvement project within 12 months, as evaluated by project outcome data.
- Collaboration and shared learning: Seventy-five percent of hospitals will report increased collaboration and shared learning through quarterly meetings, as measured by post-meeting feedback forms.
- Best practice dissemination: By the end of the second year, 80% of hospitals will report that they are disseminating best practices learned through the initiative across other departments or sites, as tracked by an annual best practices dissemination report.

Consortium Partners

Organization	County	State	Organization Type
Vermont Program for Quality in Health Care Inc.	Addison, Bennington, Caledonia, Chittenden, Essex, Franklin, Grand Isle, Lamoille, Orange, Orleans, Rutland, Washington, Windham, and Windsor	VT	501(c)(3) nonprofit; statewide quality-improvement organization in health care
Vermont Network Against Domestic and Sexual Violence	Addison, Bennington, Caledonia, Chittenden, Essex, Franklin, Grand Isle, Lamoille, Orange, Orleans, Rutland, Washington, Windham, and Windsor	VT	501(c)(3) nonprofit; Vermont's leading voice on domestic and sexual violence; leads the Vermont Forensic Network
Vermont Association of Hospitals and Health Systems	Addison, Bennington, Caledonia, Chittenden, Franklin, Lamoille, Orange, Orleans, Rutland, Washington, Windham, and Windsor	VT	501(c)(3) nonprofit; member-owned organization comprising Vermont's network of not-for-profit hospitals
BiState Primary Care Association	Addison, Bennington, Caledonia, Chittenden, Essex, Franklin, Grand Isle, Lamoille, Orange, Orleans, Rutland, Washington, Windham, and Windsor	VT	501(c)(3) nonprofit; primary care association serving Vermont and New Hampshire, providing technical assistance to FQHCs and similar organizations to improve programmatic, clinical, operational, and financial performance
University of Illinois Extension	Alexander, Franklin, Gallatin, Hamilton, Hardin, Jackson, Johnson, Massac, Perry, Pulaski, Pope, Randolph, Saline, Union, and White	IL	University


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