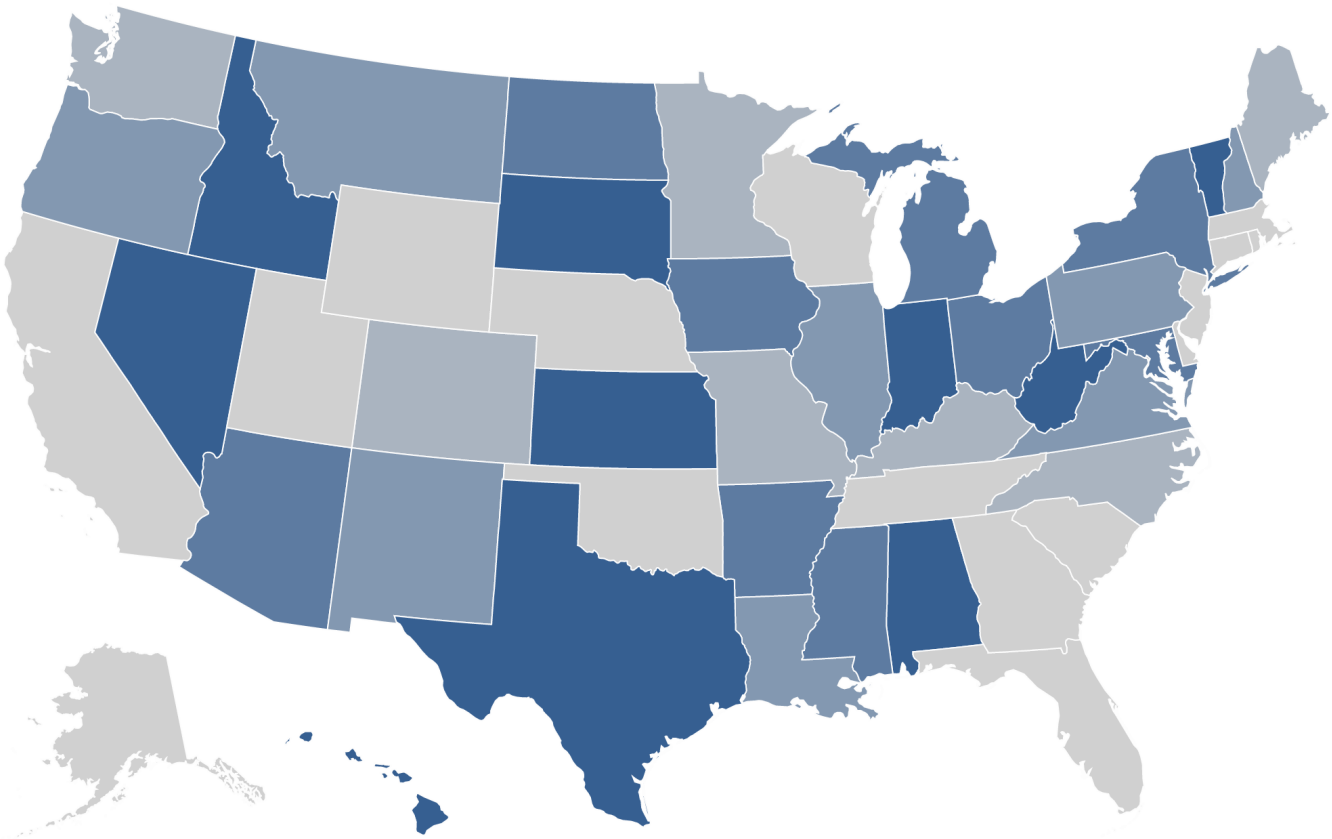
Directory

Rural Health Outreach Grant Program

2018 - 2021



Health Resources and Services Administration • 5600 Fishers Lane, Rockville, MD 20857 • 301-443-0835

Date of publication: January 2020

Grantee Directory

2018-2021 Rural Health Care Services Outreach Grant

The Rural Health Care Services Outreach Program is authorized by Section 330A of the Public Health Service Act (42 U.S.C. 254c), as amended. The program supports projects that demonstrate creative or effective models of outreach and service delivery in rural communities. Funding can be used to meet a broad range of health care needs from health promotion and disease prevention to expanding oral and mental health services to case management for rural HIV patients. These projects address the needs of a wide range of population groups including, but not limited to, low-income populations, the elderly, pregnant women, infants, adolescents, rural minority populations and rural populations with special health care needs. The community being served must be involved in the development and ongoing operations of the program, to appropriately address the needs of the population. All projects are responsive to any unique cultural, social, religious and linguistic needs of the target population.

The emphasis of this grant program is on service delivery through collaboration, adoption of an evidence-based or promising practice model, demonstration of health outcomes, replicability and sustainability. Proposed projects have an outcomes-oriented approach that will enhance and sustain the delivery of effective health care in rural communities by tracking specific health indicators that will demonstrate the impact of their project at the end of their grant period. Projects are based on evidence-based or promising practice models and demonstrate health status improvement in rural communities. Outreach projects can take the framework of an evidence-based or promising practice model and tailor it to their community's need and organization.

This Directory provides contact information and a brief overview of the sixty initiatives funded under the Rural Health Care Outreach Services grant program in the 2018 – 2021 funding cycle.

2019 – 2021 Rural Health Outreach Grantees
(listed by state)

Alabama

Rural Alabama Prevention Center

Grant Number:	D04RH31646					
Organization Type:	Community-based Organization					
Grantee Organization Information:	**Name:**	Rural Alabama Prevention Center				
	Address:	301 Prairie Avenue				
	City:	Eutaw	**State:**	Alabama	**Zip code:**	35462
	Tel #:	205-372-3514				
	Website:	http://www.ruralalabamaprevention.org				
Primary Contact Information:	**Name:**	Loretta W. Wilson				
	Title:	Principal Director				
	Tel #:	205-496-0562				
	Email:	Lowwebb9@aol.com				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	New Generation Church, Inc.*	Greene	AL	Faith-based
	Hill Hospital of Sumter County*	Sumter	AL	Hospital
	Community Health Resource and Education Center (CHEAR)*	Sumter	AL	Community-based
	Hale Empowerment Revitalization Organization (HERO)*	Hale	AL	Community-based
	Abundant Life Wellness Center*	Hale	AL	Wellness Health Clinic

The communities/counties the project serves:	
	Greene County
	Hale County
	Sumter County

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☒	Pregnant Women	☐
	Caucasians	☒	School-age children (elementary)	☐
	Elderly	☐	School-age children (teens)	☐
	Infants	☐	Uninsured	☒
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐

	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☒	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☐
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The Tri-County Health Improvement Special Project (TCHISP) is a three-year project aimed at preventing healthy hearts from developing Cardiovascular Disease (CVD). The program has a specific focus on African Americans who have no history of CVD. The overarching goal of TCHISP is to integrate Community Health Workers (CHW) into churches in Greene, Hale, and Sumter counties to support church members in making healthy lifestyle choices to prevent or reduce the onset of CVD. The overall objective of the TCHISP is to increase knowledge of church members regarding the risks associated with cardiovascular disease, while reducing their chances of developing CVD.

Expected Outcomes:

Trained Community Health Workers will utilize culturally-tailored, evidence-based curriculum to improve heart health knowledge and behavior of church members from churches in Greene, Hale, and Sumter Counties with a primary focus on heart disease risk factors, such as high blood pressure, high blood cholesterol, overweight/obesity, diabetes, and smoking. By addressing the risk factors and behaviors that contribute to CVD, the project can make a profound impact on reducing the harm caused by the disease, and achieve the following outcomes: 1) more coordinated system of care for those at-risk of developing CVD; 2) an increase in the number of trained Community Health Workers; 3) improved blood sugar control, blood pressure, lipid levels, BMIs, smoking rates; 4) improved patient communication with doctors, medication compliance, and health literacy; and 5) incorporation of heart age calculator in communities where CVD is prevalent, but preventable. The long-term goal is to have 60% of program participants' heart age aligned with their actual age or younger by the end of the 3-year project.

Evidence Based/ Promising Practice Model Being Used or Adapted:

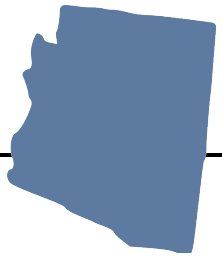
The evidence-based curricula that are the driving force behind achieving the goals and objectives of the "Tri-County Health Improvement Special Project (TCHISP)" are:

- National Heart Lung Blood Institute (NHLBI) CHW Health Disparities Initiative - *The Community Health Worker Health Disparities Initiative* is an evidence-based curriculum aimed to help reduce health disparities in underserved and minority communities across the United States. Community Health Workers (CHWs) are engaged to deliver heart health education and skill-building strategies to encourage community members to make healthy behavior changes so they can enjoy their lives and raise their families. The Initiative's current focus is heart disease, which is responsible for one out of every three deaths in the country. This curriculum consists of 12 sessions that will be implemented in a church setting by CHWs.
- *Centers for Disease Control and Prevention (CDC) Heart Age Calculator*. This tool will be used to measure the change in a participant's heart age through the three-year project. An individual can work to improve their heart age and lower their risk for experiencing a cardiovascular event when they are knowledgeable of the risks.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Meriam Mikre				
	Tel #:	301-945-3110				
	Email:	MMikre@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Amanda Phillips Martinez				
	Tel #:	404-413-0314				
	Email:	aphillipsmartinez@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Arizona

Mariposa Community Health Center



Grant Number:	D04RH31638					
Organization Type:	Federally Qualified Health Center					
Grantee Organization Information:	**Name:**	Mariposa Community Health Center				
	Address:	825 N. Grand Ave.-Suite 100				
	City:	Nogales	**State:**	Arizona	**Zip code:**	85621
	Tel #:	520-375-6050				
	Website:	www.mariposachc.net				
Primary Contact Information:	**Name:**	Patty Molina				
	Title:	Senior Director of Community Health Services				
	Tel #:	520-375-6050				
	Email:	pmolina@mariposachc.net				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$199.951
	May 2019 to Apr 2020	$199,921
	May 2020 to Apr 2021	$199,978

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	UA Prevention Research Center	Pima	AZ	University
	Southeast Arizona Area Health Education Center	Santa Cruz	AZ	Health Education Center
	Pinal Hispanic Council	Santa Cruz	AZ	Behavioral Health Provider
	Nogales Community Food Bank	Santa Cruz	AZ	Food Bank
	Nogales Community Development	Santa Cruz	AZ	Economic Development Organization
	Nogales Women's Club	Santa Cruz	AZ	Volunteer Service Organization
	Rio Rico Community Center	Santa Cruz	AZ	Community Center

The communities/counties the project serves:	Santa Cruz County

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☐
	Elderly	☒	School-age children (teens)	☐
	Infants	☐	Uninsured	☐
	Latinos	☒	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☒	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☒
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☐
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The Vivir Mejor! Consortium promotes heart health among 75 adults, ages 50-74 years in order to prevent heart disease through the implementation of this Outreach grant initiative. This 3-year effort offers a 13-week intervention that uses Meta Salud, an evidence-based, promotora-delivered curriculum. Participants also engage in physical activity sessions and walking groups led by lay leaders. Cooking classes, behavioral health support, and intergenerational healthy hearts projects are other promising practices that are utilized to promote and sustain lifestyle change among participants.

Expected Outcomes:

The Centers for Disease Control and Prevention Heart Age Calculator is used at intake and at every 6-month follow-up interval for the duration of the program. The expected program outcomes are: increased fruit & vegetable consumption, reductions in salt & sugar intake, increase in consumption of healthy fats, increase in physical activity and use of monitoring devices (e.g. Fitbits), and increase in self-efficacy through behavioral health services.

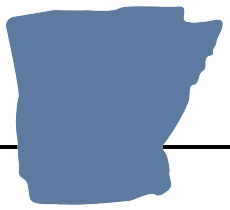
Evidence Based/ Promising Practice Model Being Used or Adapted:

The following evidence based/promising practices are being implemented: use of the evidence-based MetaSalud Curriculum, Community Health Workers and Lay Leaders, fruit & veggie prescriptions, walking clubs, cooking classes, technology (tracking activity), and behavioral health support and intergenerational healthy hearts projects.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Meriam Mikre				
	Tel #:	301-945-3110				
	Email:	mmikre@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	John Butts				
	Tel #:	404-413-0314				
	Email:	jbutts@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Arkansas

ARCare



Grant Number:	D04RH31629					
Organization Type:	Federally Qualified Health Center					
Grantee Organization Information:	**Name:**	ARCare				
	Address:	117 South 2nd Street				
	City:	Augusta	**State:**	Arkansas	**Zip code:**	72006
	Tel #:	870-347-2534				
	Website:	www.arcare.net				
Primary Contact Information:	**Name:**	Frank Vega				
	Title:	Behavioral Health Director				
	Tel #:	870-347-2534				
	Email:	frank.vega@arcare.net				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Stanley Pharmacy	White	AR	Pharmacy
	Arkansas Foundation for Medical Care (AFMC)	All AR counties	AR	Foundation

The communities/counties the project serves:	
	Independence (Years 2-3)
	Izard (Years 2-3)
	White (Years 1-3)

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☒	Pregnant Women	☒
	Caucasians	☒	School-age children (elementary)	☐
	Elderly	☐	School-age children (teens)	☐
	Infants	☐	Uninsured	☒
	Latinos	☒	Other: Click here to enter text.	☐
	Native Americans	☒	Other: Click here to enter text.	☐
	Pacific Islanders	☒	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐

	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☒
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The purpose of this proposed project is to enhance/expand the Integrated Primary Care/Behavioral Health and Substance Abuse services to include Independence, Izard, and White counties in Arkansas. Services to be provided through this project include behavioral/mental health counseling and education, care coordination, and Medication Assisted Treatment. The proposed services will be provided in an integrated care model located in the primary care facility and in collaboration with the Preferred Family Health behavioral health team. This will make for a seamless interdisciplinary (medical, behavioral, and pharmacy) care approach for all aspects of the patient's needs and true coordination of care for the best outcomes. There is no other model like this in the proposed service area.

Expected Outcomes:

The overarching goal of the proposed project is to *increase access to behavioral/mental health and/or substance abuse services for rural Arkansans.* The expected outcomes include increasing access to Medication Assisted Treatment for eligible patients, patients self-reported reduction on opioid dependence, improved access to behavioral/mental health counseling, implementation of integrated health care services, and decreased medication errors and interactions of the proposed target population that will ultimately improve their general health and quality of life.

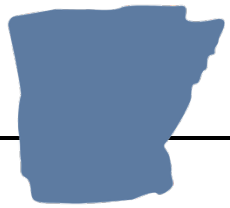
Evidence Based/ Promising Practice Model Being Used or Adapted:

The evidence-based model(s) that will be used for this proposed project include Cognitive Behavioral Therapy, Motivational Interviewing, and Comprehensive Opioid Response (COR-12).

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Robyn Williams				
	Tel #:	301-443-0624				
	Email:	RWilliams@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Lisa McGarrie				
	Tel #:	404-413-0298				
	Email:	lmcgarrie@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Arkansas

Arkansas Rural Health Partnership



Grant Number:	D04RH31630					
Organization Type:	Nonprofit 501©3 Network of Hospitals					
Grantee Organization Information:	**Name:**	Arkansas Rural Health Partnership				
	Address:	2729 Highway 65 & 82 South				
	City:	Lake Village	**State:**	Arkansas	**Zip code:**	71653
	Tel #:	870-265-9392				
	Website:	https://www.arruralhealth.org/				
Primary Contact Information:	**Name:**	Mellie B. Bridewell				
	Title:	Executive Director				
	Tel #:	870-265-9392				
	Email:	mbbridewell@uams.edu				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Ashley County Medical Center*	Crossett	AK	Critical Access Hospital
	Baptist Health-Stuttgart*	Stuttgart	AK	Critical Access Hospital
	Bradley County Medical Center*	Warren	AK	Critical Access Hospital
	Chicot Memorial Medical Center*	Lake Village	AK	Critical Access Hospital
	Dallas County Medical Center*	Fordyce	AK	Critical Access Hospital
	Delta Memorial Hospital*	Dumas	AK	Critical Access Hospital
	DeWitt Hospital & Nursing Home*	DeWitt	AK	Rural Health Clinic and Nursing Home
	Drew Memorial Hospital*	Monticello	AK	Critical Access Hospital
	Jefferson Regional Medical Center*	Pine Bluff	AK	Medical Center
	McGehee Hospital*	McGehee	AK	Critical Access Hospital

The communities/counties the project serves:		
	Arkansas	Dallas
	Ashley	Desha
	Bradley	Drew
	Chicot	Jefferson

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☒	Pregnant Women	☐

	Caucasians	☒	School-age children (elementary)	☐
	Elderly	☐	School-age children (teens)	☐
	Infants	☐	Uninsured	☐
	Latinos	☒	Other: Immigrant farmworkers and their families	☐
	Native Americans	☒	Other: Click here to enter text.	☐
	Pacific Islanders	☒	Other: Click here to enter text.	☐
Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☐
	Coordination of Care Services	☐	Telehealth	☒
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☒	Other: Click here to enter text.	☐

Description of the Project:

Through Rural Health Care Services Outreach Program (RHCSOP) funds, the Arkansas Rural Health Partnership plans reduce morbidity and mortality due to mental or behavioral health conditions in adults (age 18-64) by 15% in rural southeast Arkansas Delta by April 2021. This will be accomplished through the following objectives: 1) share the responsibility of achieving and sustaining outreach program activities, 2) establish the ARHP Behavioral Health Task Force to address ongoing and emerging needs related to mental health service delivery, 3) conduct a public awareness campaign to promote the early detection of mental illness symptoms and how to access services, 4) train 1,900 front line responders in Mental Health First Aid, and 5) establish a mental health crisis service at ten partner Emergency Departments via telemedicine.

Expected Outcomes:

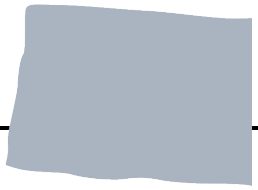
Short-term outcomes of the project include: 1) increase in patients with access to mental health crisis services, 2) increase in mental health professionals within the service area, 3) increased understanding among providers, patients, and community members related to mental health concerns and how to access resources, and 4) increased mental health literacy among healthcare professionals and law enforcement.

Long-term project outcomes include: 1) improved system of care for patients with behavioral/mental health concerns, 2) overall decrease in patients experiencing a mental health crisis in the service area, 3) mental health patients access needed care within local community, 4) decrease in ER admissions for behavioral health issues, and 5) improved mental health outcomes of residents.

Evidence Based/ Promising Practice Model Being Used or Adapted:						
The project adopted Mental Health First Aid as a population health, evidence-based approach to increase prevention and early intervention to mental health services. The project also uses the telemedicine component of the Madison Outreach & Services through Telehealth (MOST) Network model to provide new mental health crisis services.						
Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Sara Afayee				
	Tel #:	301-945-4169				
	Email:	SAfayee@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Lisa McGarrie				
	Tel #:	404-413-0314				
	Email:	lmcgarrie@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Colorado

HCP Systems



Grant Number:	D04RH31779					
Organization Type:	501(c)3 Non-Profit Organization					
Grantee Organization Information:	**Name:**	HCP Systems				
	Address:	502 W 8th Street				
	City:	Julesburg	**State:**	Colorado	**Zip code:**	80737
	Tel #:	719- 250-3243				
	Website:	www.hcpfoundation.com				
Primary Contact Information:	**Name:**	Rita Torres				
	Title:	Project Director				
	Tel #:	719- 250-3243				
	Email:	rita.torres@hcpfoundation.com				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Health Care Partners Foundation, Inc.	Sedgwick	CO	501(c)3 Non-Profit
	Las Animas County Detention Center	Las Animas	CO	County Government
	Logan County Detention Center	Logan	CO	County Government
	Colfax County Detention Center	Colfax	NM	County Government
	San Miguel County Detention Center	San Miguel	NM	County Government

The communities/counties the project serves:	
	Colfax County/Raton NM
	Las Animas County/Trinidad, CO
	Logan County/Sterling, CO
	San Miguel County/Las Vegas, NM

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☒	Pregnant Women	☒
	Caucasians	☒	School-age children (elementary)	☐
	Elderly	☒	School-age children (teens)	☐
	Infants	☐	Uninsured	☒
	Latinos	☒	Other: Inmates	☒
	Native Americans	☒	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☒

	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☒
	Coordination of Care Services	☒	Telehealth	☒
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☒	Other: Click here to enter text.	☐

Description of the Project:

The purpose of the project is to collaboratively design and implement a system, using telehealth connectivity, to link trained professionals with rural jails, hospitals, law enforcement and residents to improve response to behavioral health crisis, reduce health care costs and support individuals in their recovery and transition from detention centers to the community; utilize standardized training, screening and assessments among network partners; implement telehealth interventions (tele-counseling, tele-psychiatry, tele-medicine and crisis response, triage and care coordination, addiction counseling/MAT, and client education); and ensure policy and systems change through joint efforts of the network.

Expected Outcomes:

Expected outcomes of the project include:

- Increase cost effectiveness by reducing, streamlining and/or stabilizing costs associated with individuals with mental health and/or substance use disorders who are transitioning from jail to the community.
- Reduce recidivism/reoffending in jails and repeat visits to local emergency rooms.
- Improve health outcomes of individuals with Serious Mental Illness and/or substance use disorder who are detained in and released from county jails. (e.g. medication compliance, reduced substance use, increased social functioning).
- Increase systems collaboration and resource expansion by pooling knowledge and resources among network partners.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The project integrates three evidence-based practices: 1) Transition from Jail to Community (TJC) model developed by the National Institute of Corrections (NIC) and the Urban Institute Justice Policy Center and the Assess, Plan, Identify, and Coordinate (APIC) approach developed by SAMHSA. The TJC Initiative was founded on the belief that it was possible, through collaboration between jails and the communities they serve, to more strategically allocate existing intervention resources so that people leaving jail would be more successful in transitioning to the community and therefore that their communities would be safer and healthier. The TJC model was intended to guide the systems change work necessary to realize better outcomes. The TCJ model's organizational structure has been streamlined to meet rural needs. For example, Medication Assisted Treatment will be available via telehealth, along with several other treatment options. APIC is a framework that directs behavioral health, justice system, and community stakeholders to work collaboratively across systems to design and implement evidence-based programming to forward the dual goals of individual recovery and risk reduction. The APIC model provides guidance to assist jurisdictions in this task.

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	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Tamanna Patel				
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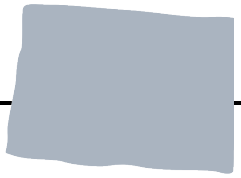
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Colorado

Tri-County Health Network



Grant Number:	D04RH31649					
Organization Type:	Network					
Grantee Organization Information:	**Name:**	Tri-County Health Network				
	Address:	PO Box 4178				
	City:	Telluride	**State:**	Colorado	**Zip code:**	81435
	Tel #:	970-708-7096				
	Website:	www.tchnetwork.org				
Primary Contact Information:	**Name:**	Lynn Borup				
	Title:	Executive Director				
	Tel #:	970-708-7096				
	Email:	lynn@tcnetwork.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Telluride Medical Center*	San Miguel	CO	Community Clinic
	Uncompahgre Medical Center*	San Miguel	CO	FQHC
	Montrose Memorial*	Montrose	CO	Hospital
	Basin Clinic*	Montrose	CO	Rural Health Clinic
	Mountain Medical Center	Montrose	CO	Community Clinic
	River Valley Family Health Center*	Montrose	CO	FQHC
	Telluride Foundation*	San Miguel	CO	Community Foundation
	Center for Mental Health*	Montrose	CO	Mental Health Center

The communities/counties the project serves:	
	Delta
	Montrose
	Ouray
	San Miguel

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☒	Pregnant Women	☐
	Caucasians	☒	School-age children (elementary)	☐
	Elderly	☒	School-age children (teens)	☐
	Infants	☐	Uninsured	☒
	Latinos	☒	Other: Click here to enter text.	☐
	Native Americans	☒	Other: Click here to enter text.	☐
	Pacific Islanders	☒	Other: Click here to enter text.	☐

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☒	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☒	Physical Fitness and Nutrition	☒
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☐
	Coordination of Care Services	☐	Telehealth	☒
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Social Determinants of Health Screenings/ Referrals	☒
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

Tri-County Health Network is in the Health Improvement Special Project (HISP) track of the Outreach program that focuses on centralized metrics to describe cardiovascular disease (CVD) risk for certain individuals. The Community Health Workers Coordinating Assessments, Resources, & Education to Improve Heart Health Program (CHWs CARE) partners with a range of local businesses and community-based organizations in four rural Colorado counties to provide health screenings for their employees to assess risk of heart disease. Through these partnerships, CHWs monitor the health of the same set of clients over a three-year period and evaluate changes in CVD risk based on our interventions. In addition to assessing cardiovascular health, CHWs will systematically screen clients for behavioral health issues and social determinants of health, generating a comprehensive understanding of each client's needs so that we can connect them to resources that break down barriers to health. CHWs will also improve early detection of diabetic retinopathy by conducting Diabetic Retinopathy Tele-screening and empower residents to cook healthy meals on a budget by conducting evidence-based Cooking Matters classes.

Expected Outcomes:

The following are expected outcomes of the CHWs CARE program:

- Improved population health and health status of community members
- Reduction in risk for CVD, leading to reduced deaths from CVD-related factors
- Increased engagement and motivation in self-management of chronic conditions
- Increased employer engagement in the health and wellbeing of their employees
- Engaged stakeholders and providers working collaboratively to improve the overall health of the region by using a consortium approach.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The CHWs CARE program is implementing the following evidence-based/promising practice models: (1) Community Health Worker (CHW) model; (2) Colorado Heart Health Solutions (CHHS) Program - created by the Colorado Prevention Center to reduce risk of CVD in rural communities; (3) Cooking Matters - six-week cooking based nutrition education program that empowers individuals with the skills, knowledge, and confidence needed to identify and prepare healthy and affordable meals; (4) Diabetic Retinopathy Tele-screening - offered to remove barriers to care and are critical for early detection and intervention to prevent the progression of diabetic retinopathy; 5) Check. Change. Control. – an evidence-based hypertension management program that encourages participants to self-monitor their blood pressure and gives them the ability to use an online tracking and remote monitoring system.

(6) Addressing social determinants of health – CHWs systematically screen clients using a social needs screening tool. Addressing social determinates of health can result in health benefits and decreased healthcare expenditures.						
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	Organization:	Federal Office of Rural Health Policy				
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	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Hawaii

Lana'i Health Network

Grant Number:	D04RH31637					
Organization Type:	FQHC					
Grantee Organization Information:	**Name:**	Lana'i Health Network				
	Address:	P O Box 630142, 333 Sixth Street				
	City:	Lana'i City	**State:**	Hawaii	**Zip code:**	96763
	Tel #:	808-565-67919				
	Website:	Lanaicommunityhealthcenter.org				
Primary Contact Information:	**Name:**	Diana M V Shaw, PhD, MPH, MBA, FACMPE				
	Title:	Executive Director				
	Tel #:	808-565-6919				
	Email:	dshaw@lanaihealth.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	University of Hawaii	Honolulu	HI	501c3
	Cardiology Queens Heart	Honolulu	HI	501c3
	Hawaii Public Health Institute (HPHI)	Honolulu	HI	501c3
	Lāna'i High and Elementary School Foundation (LHES)	Maui	HI	501c3
	Lāna'i Community Health Center (LCHC)	Maui	HI	501c3

The communities/counties the project serves:	The Island of Lāna'i

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☒
	African Americans	☒	Pregnant Women	☒
	Caucasians	☒	School-age children (elementary)	☒
	Elderly	☒	School-age children (teens)	☒
	Pacific Islanders	☒		☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☒
	Access: Specialty Care	☒	Integrated Systems of Care	☒
	Children's Health	☒	Telehealth	☒
	Coordination of Care Services	☒	Health Information Technology	☒
	Health Education and Promotion	☒		

Description of the Project:

This project focuses on access to affordable, high quality health care through the use of telemedicine. Services include Obstetrics/Gynecology (OB/GYN) and Cardiology, with an educational/screening relationship with the only school on island. Consortium members will provide telephone consultation for urgent specialty need, consultation and input on quality of care and program development at LCHC. The school-based program includes the development of an intense school & community-based childhood obesity program.

Expected Outcomes:

Using the Patient Centered Medical Home model with vertical integration, the project hopes to generate outcomes of improved cost-effective care and increased wellness education.

- **Goal - Consortium**: to provide high quality access to services not available on island due to small size of the community (3,102 population); focus for this project include OB/GYN (to include co-management of high risk cases, curbside consults, meet-and-greet with delivering OB, etc.), and Cardiology (including echo cardiology)
- **Goal - Pediatrics**: Improved decision making of students in choosing health lifestyles
  - ***Objective***: Increased education regarding wellness (working with LHES and HPHI to develop, implement and manage an obesity program and an obesity prevention program, in addition to teaching the routine health curriculum)
- **Goal - OB/GYN**: Increased percent of patients who receive timely prenatal care and management of high risk pregnancies and complex GYN problems.
- **Goal - Cardiology**: Improved access to cardiology consultation and co-management of post hospitalized patients and patients with cardiac conditions requiring diagnostic evaluation and/or co-management.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Patient Centered Medical Home, with vertical integration. The promising practice model of Patient Centered Medical Home (PCMH) with vertical integration is being used. PCMH is focused on the patient – a critical component of good health care. PCMH primarily relates to the delivery model for the primary care specialties (i.e., pediatrics, internal medicine and family practice). In addition, the PCMH model uses a longitudinal, integrated and comprehensive view. A major goal of PCMH is to also consistently utilize evidence-based and best practices along with promoting prevention and wellness. The integrated PCMH model, in addition, provides the framework for consortium members to collaborate in a transparent fashion, where quality patient care, best practices and outcomes, access to services, and cost efficiency are the focus.

Modification or deviation from the actual model: Today's health care system is complex, and often disjointed. Especially for the rural population, there is the added challenge of time and money involved in seeking specialty services. The key to success and improved quality of care is to develop and implement an integrated PCMH and an "end-to-end vertical integration of the care-delivery process" - that is, a process in which the provider network management, automation, information exchange, and analytics solutions are tightly integrated with patient and provider information. With so much complexity and so many "moving parts" in the delivery of the PCMH model, this end-to-end vertical integration is a practical solution that enables effective coordination of care and accurate measurement of quality. With system integration, the provider can bring economies of scale to even the smallest provider offices to optimize the quality of care delivery", including (and especially) for a remote, rural community such as Lāna'i.

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Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Tanisa Adimu				
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	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Idaho

Family Health Services Corporation

Grant Number:	D04RH31634					
Organization Type:	Federally Qualified Health Center (FHQC)					
Grantee Organization Information:	**Name:**	Family Health Services Corporation				
	Address:	794 Eastland Dr.				
	City:	Twin Falls	**State:**	Idaho	**Zip code:**	83301
	Tel #:	208-734-3312				
	Website:	www.fhsid.org				
Primary Contact Information:	**Name:**	Jennifer Yturriondobeitia				
	Title:	Project Director				
	Tel #:	208-899-9012				
	Email:	jeny@ynotinnovators.com				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Family Health Services Corporation	Twin Falls	ID	FQHC
	Valley Community Counseling	Twin Falls	ID	Mental health and substance abuse services
	IHC Health Services dba Cassia Regional Medical Center	Salt Lake	UT	Non-profit critical access hospital
	Y Not Innovators, Inc.	Ada	ID	Independent consultant and grant management
	Idaho Department of Health and Welfare, Division of Behavioral Health	Twin Falls	ID	State Office

The communities/counties the project serves: (list alphabetically)
Cassia
Gooding
Jerome
Lincoln
Minidoka
Twin Falls
Shoshone

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☒	School-age children (elementary)	☐
	Elderly	☒	School-age children (teens)	☐
	Infants	☐	Uninsured	☒
	Latinos	☒	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐

	Pacific Islanders	☐	Other: Click here to enter text.	☐
Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☒
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☒
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☒
	Coordination of Care Services	☒	Telehealth	☒
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☒	Other: Click here to enter text.	☐

Description of the Project:

"Rural Health Care Outreach Collaborative" (RHCOC) based out of Twin Falls, Idaho is piloting a rural "Virtual Health Neighborhood" model for the integration of behavioral health, clinical pharmacy, and physical health care with an emphasis on medication management utilizing telehealth in order to improve chronic disease management in south central Idaho. RHCOC builds upon the Patient Centered Medical Home to develop a "Virtual Health Neighborhood" which is a community-based continuum of care that wraps services around patients and families and enhances natural supports in the most remote areas. The project leverages and builds upon the strengths of our rural communities to develop networks who work for the good of the whole, where scarce resources and services are shared. This is how rural/frontier communities have historically worked and Rural Health Care Outreach Collaborative (RHCOC) is constructed on this common theme to deliver a continuum of quality services.

Expected Outcomes:

Project Goals: Family Health Services (FHS) intends to lead a regional consortium called the "Rural Health Care Outreach Collaborative" (RHCOC). The project will develop and pilot a rural "Virtual Health Neighborhood" model for the integration of behavioral health, clinical pharmacy, and physical health care with an emphasis on medication management utilizing telehealth in order to improve chronic disease management in rural/frontier, low resource, medically underserved communities in south central Idaho.

Project Objectives: Develop a regional Patient Centered Medical Home (PCMH) and Virtual Health Neighborhood based on Patient Centered Medical Home Neighborhood (PCMH-N) Model to coordinate care across outpatient treatment continuum and medical subspecialties.

1st Year Behavioral Heath Integration in Primary Care: Develop and implement a Primary Care Behavioral Health (PCBH) model in the Team-Based Care program at FHS that embeds new Behavioral Health Consultants in rural primary care clinics in Jerome and Burley.

2nd Year Clinical Pharmacy Integration in Primary Care: Develop and implement clinical pharmacy program hub with added care team of Pharmacist, Pharmacy Technician, and Pharmacy Liaison to Team-Based Care program in primary care clinic in Rupert.

3rd Year Integrate Telehealth in Primary Care Locations: Develop Telehealth hub and spoke model for Pharmacy and Behavioral Health Consultant services that would be available to all of the smaller rural clinics in our region.

Evidence Based/ Promising Practice Model Being Used or Adapted:						
The grant funding provides implementation resources, staffing, technical assistance and training, to develop the integration of behavioral health, pharmacy, and telehealth by developing a pilot for "Virtual Health Neighborhood" based on the Patient Centered Medical Home (PCMH) and Patient Centered Medical Home Neighborhood (PCMH-N) models based on National Committee for Quality Assurance (NCQA). The framework for team based care and population health management is based on the Ed Wagner's Chronic Care model. Additionally, integrated behavior health, Primary Care Behavioral Health model based on Veterans Association and the Airforce Optimization model and integrated clinical pharmacy will utilize promising practice for clinical pharmacy based on recommendations from Advisory Board.						
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	Organization:	Federal Office of Rural Health Policy				
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	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Idaho

Southwest District Health

Grant Number:	D04RH31647					
Organization Type:	Public Health District					
Grantee Organization Information:	**Name:**	Southwest District Health				
	Address:	13307 Miami Lane				
	City:	Caldwell	**State:**	Idaho	**Zip code:**	83607
	Tel #:	(208) 455-5300				
	Website:	https://phd3.idaho.gov/				
Primary Contact Information:	**Name:**	Rachel Blanton				
	Title:	Program Director				
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	Email:	Rachel.Blanton@phd3.idaho.gov				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$199,999.00
	May 2019 to Apr 2020	$199,999.00
	May 2020 to Apr 2021	$199,999.00

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Valley Family Health Care	Payette	ID	Health Care Center
	Central District Health Department	Ada	ID	Public Health Department
	Y Not Innovators	Ada	ID	Consultation Firm

The communities/counties the project serves:			
	Adams	Owyhee	
	Canyon	Payette	
	Gem	Washington	

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☒	School-age children (elementary)	☐
	Elderly	☒	School-age children (teens)	☐
	Infants	☐	Uninsured	☐
	Latinos	☒	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☒
	Access: Specialty Care	☐	Integrated Systems of Care	☒
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐

Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
Chronic Disease: Asthma/COPD	☐	School Health	☐
Community Health Workers /Promotoras	☒	Substance Abuse	☐
Coordination of Care Services	☐	Telehealth	☒
Emergency Medical Services	☐	Transportation to health services	☐
Health Education and Promotion	☐	Other: Click here to enter text.	☐
Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

A consortium of public health districts and primary care provider groups created the Rural Integrated Behavioral Health Hub Network (RIBHHN) model to develop a network of local technical assistance resources for behavioral health integration as well as a workforce development infrastructure to train future behavioral health consultants and supplement clinician time. This training includes ancillary and non-formal partners such as IIBHN, St. Luke's Health Partners, Valor Health, Boise State University, Idaho State University, Northwest Nazarene University, Lifeways, and other local agencies invested in developing integrated behavioral health capacity. This work is crucial for the rural communities of Idaho that face both behavioral health provider and primary care provider shortages. Integrated behavioral health is a proven mechanism for extending care, improving outcomes, and maximizing contact with vulnerable patients.

Expected Outcomes:

At the individual level, improvement of chronic disease outcomes and increase patient activation for self-care is anticipated. For the clinic level, improvement of professional satisfaction through provider engagement in the Patient Centered Medical Home (PCMH) is expected as well as increased adoption of integrated behavioral health models. At the consortium level, improvement in referrals and coordination of care to home, to clinic, to hospital and returning home is anticipated.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The evidence base for these strategies includes extensive literature in: The Chronic Care Model, The Patient Centered Medical Home, Team-Based Care and Integrated Behavioral Health. Despite the extensive knowledge base in related areas, it is crucial for RIBHHN to conduct a thorough evaluation as the project team believes that the approach is novel not only locally but nationally and could potentially serve as a model for other states with provider shortages and integrated behavioral health development needs. Evaluation findings assist the project team in assessing function throughout the process and allow team members to adjust the approach as needed.

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

Illinois

Mercer County

Grant Number:	D04RH31786					
Organization Type:	Local Government Health Department					
Grantee Organization Information:	**Name:**	Mercer County				
	Address:	305 NW 7th St				
	City:	Aledo	**State:**	Illinois	**Zip code:**	61231
	Tel #:	309-582-3759				
	Website:	http://www.mercercountyil.org				
Primary Contact Information:	**Name:**	Jennifer Hamerlinck				
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	Email:	jennhamerlinck@gmail.com				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$191,755
	May 2019 to Apr 2020	$184,358
	May 2020 to Apr 2021	$184,358

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Mercer County Health Department	Mercer	IL	Health Department
	Genesis Medical Center-Aledo	Mercer	IL	Hospital
	Genesis Rural Health Group	Mercer	IL	Health Clinic
	Mercer Foundation for Health	Mercer	IL	Not-for-Profit
	City of Aledo	Mercer	IL	Law Enforcement

The communities/counties the project serves:	Mercer County	

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☒
	Caucasians	☐	School-age children (elementary)	☒
	Elderly	☐	School-age children (teens)	☒
	Infants	☐	Uninsured	☒
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☒
	Access: Specialty Care	☒	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐

	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☒
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☒
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The focus area of the project is to improve access to mental health care through the implementation of a nurse navigator program and utilization of mental health service providers of the consortium. Services concentrate on four areas of program development, program implementation, evaluation, and project management. A completed mental health needs assessment establishes local baseline data and is used to develop target population specific benchmarks upon which to measure program successes. A mental health navigator program reduces barriers to care and delays in service, bridges gaps between existing health services and new/enhanced programming, incorporates best practices, and provides a team approach to client case management involving family/social support systems, available resources, and key partners in community care. Additional services include a Nurse Navigator and case manager for care coordination; clinical office visits with a Licensed Clinical Social Worker and/or Mental Health Nurse Practitioner; and supplemental staff and consortium members for program delivery and ongoing evaluation.

Expected Outcomes:

Provision of a clear and consistent method for referrals, utilization of mental health resources, and a bridge between primary care and mental health care providers; less time between referral and appointment, improved compliance with treatment recommendations; reducing suicide and depressive episodes rates; improved rates of good mental health days, improved access to care, and addition of depression screenings.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The evidence-based model chosen for this initiative is Boston Medical Center's Patient Navigation model. The Boston Medical Center *Patient Navigation Toolkit* is designed "to help plan and implement a Patient Navigation program with the best chance of reducing health disparities and improving health outcomes for your patients". Through a combination of evidence-based examples, case studies, tools and resources, the *Patient Navigation Toolkit* provides guidance from establishment of the program, to needs assessment, best practices, staffing, navigating the care of patients with health disparities, and through the evaluation and dissemination of results. The information and tools developed are adaptable to any disease or condition and are appropriate for mental health services.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Michele Pray Gibson				
	Tel #:	301-443-7320				
	Email:	mgibson@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Tamanna Patel				
	Tel #:	404-413-0306				
	Email:	tpatel25@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Illinois

Stephenson County Health Department

Grant Number:	D04RH31648					
Organization Type:	Health Department					
Grantee Organization Information:	**Name:**	Stephenson County Health Department				
	Address:	10 West Linden Street				
	City:	Freeport	**State:**	Illinois	**Zip code:**	61032
	Tel #:	815 235-8271				
	Website:	http://www.co.stephenson.il.us/health/				
Primary Contact Information:	**Name:**	Craig Beintema				
	Title:	Public Health Administrator				
	Tel #:	815 235-8271				
	Email:	craig.beintema@aeroinc.net				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$199,789
	May 2019 to Apr 2020	$197,888
	May 2020 to Apr 2021	$198,100

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Stephenson County Health Department	Stephenson	IL	County Health Department
	Carroll County Health Department	Carroll	IL	County Health Department
	FHN	Stephenson	IL	Health System
	Monroe Clinic	Stephenson	IL	Health System
	Freeport School District #145	Stephenson	IL	School District
	United Way of Northwest Illinois	Stephenson	IL	Social Service Organization
	OSF Healthcare Saint Anthony College of Nursing	Winnebago	IL	Higher Education Institution
	University of Illinois College of Medicine Rockford	Winnebago	IL	Higher Education Institution

The communities/counties the project serves:	
	Carroll County
	Stephenson County

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☒	Pregnant Women	☐
	Caucasians	☒	School-age children (elementary)	☐
	Elderly	☒	School-age children (teens)	☐
	Infants	☐	Uninsured	☐
	Latinos	☒	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐

Access: Specialty Care	☐	Integrated Systems of Care	☐
Aging	☐	Maternal/Women's Health	☐
Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
Children's Health	☐	Oral Health	☐
Chronic Disease: Cardiovascular	☒	Pharmacy Assistance	☐
Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☒
Chronic Disease: Asthma/COPD	☐	School Health	☐
Community Health Workers /Promotoras	☐	Substance Abuse	☐
Coordination of Care Services	☐	Telehealth	☐
Emergency Medical Services	☐	Transportation to health services	☐
Health Education and Promotion	☒	Other: Community-level policy change	☐
Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

Enhanced Win With Wellness (E-WWW) is a multi-level, community-based, collaborative initiative to address obesity and chronic disease risk, specifically cardiovascular disease risk in Carroll and Stephenson counties located in northwest Illinois. E-WWW uses an ecological framework to support multiple evidence-based programs and promising practices focused on behavior change and cardiovascular disease (CVD) risk reduction. The model has four intervention levels: individual, interpersonal, organizational, and community/policy. E-WWW's individual and interpersonal-level programs will address CVD risk factors identified during CDC Heart Age calculator assessments with HISP participants. The organizational and community/policy-level programs are designed to create a community and culture that supports healthy behaviors.

Expected Outcomes:

The overall goal of E-WWW is to reduce the burden of (CVD) in adults in Stephenson and Carroll counties by promoting healthy lifestyles and reducing obesity and chronic disease. Specifically, E-WWW, a Health Improvement Special Project (HISP), will address personal CVD risk factors identified by the CDC Health Age calculator in a cohort of 325 eligible adults, ages 30-74 who will engage in community or worksite-based interventions for the 3 years of the project. The evidence-based and promising-practice models used in E-WWW have been shown to positively impact the behavioral factors effecting CVD risk. Specifically, it is expected that HISP enrollees will demonstrate reduced tobacco use (in smokers), increased physical activity, decreased weight, decreased BMI, decreased prevalence of high blood pressure, and increased use of community prevention/wellness resources. The food environment scans and walkability assessments will enable implementation of long-term policy level changes to improve the health of the broader community.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Using an ecological framework, E-WWW interventions address CVD risk factors at the individual, interpersonal, organizational, and community/policy levels. Individual-level interventions include: CDC Heart Age assessment with feedback, referrals to a primary care provider, referrals to the state tobacco Quitline, and physical activity monitors with feedback. Interpersonal-level interventions include the evidence-based Take Off Pounds Sensibly (TOPS) weight loss groups. Organizational-level interventions include health education sessions in worksites using Heart-to-Heart Worksite (HHW) interventions. Community and policy-level interventions include improving the physical activity and nutrition environments based on the results of environmental assessments and a community-wide social media campaign.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Meriam Mikre				
	Tel #:	301-945-3110				
	Email:	MMikre@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	John Butts				
	Tel #:	404-413-0314				
	Email:	jbutts@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Indiana

Indiana Rural Health Association

Grant Number:	D04RH31782					
Organization Type:	Non-Profit					
Grantee Organization Information:	**Name:**	Indiana Rural Health Association				
	Address:	2901 Ohio Boulevard, Suite 240				
	City:	Terre Haute	**State:**	Indiana	**Zip code:**	47803
	Tel #:	812-478-3919				
	Website:	https://www.indianaruralhealth.org/				
Primary Contact Information:	**Name:**	Cindy Large				
	Title:	Project Director				
	Tel #:	812-478-3919 X 229				
	Email:	clarge@indianarha.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Putnam County Hospital	Putnam	IN	CAH
	Greene County General Hospital	Greene	IN	CAH
	Sullivan County Community Hospital	Sullivan	IN	CAH
	Rural Health Innovations Collaborative /Simulation Center	Vigo	IN	Non-Profit
	Valley Professionals Community Health Center	Vermillion & Parke	IN	FQHC
	Indiana Health Center	Owen	IN	Clinic
	Union Hospital Health Group	Vigo & Clay	IN	Hospital/Physician Practice
	Lugar Center for Rural Health	Vigo	IN	Non-Profit
	Hamilton Center	Vigo	IN	Behavioral Health Clinic/Hospital
	Terre Haute Regional Hospital	Vigo	IN	Hospital

The communities/counties the project serves:
Clay County
Greene County
Owen County
Parke County
Putnam County
Sullivan County
Vermillion County
Vigo County

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☒	Pregnant Women	☒
	Caucasians	☒	School-age children (elementary)	☐
	Elderly	☐	School-age children (teens)	☐
	Infants	☒	Uninsured	☒

	Latinos	☒	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☒	Integrated Systems of Care	☒
	Aging	☐	Maternal/Women's Health	☒
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☒	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☐
	Coordination of Care Services	☒	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The project is implemented within the Central Southwest (CSW) region to establish a network of Obstetrician (OB) Navigators to increase and enhance perinatal care to pregnant women in the geographic area. Through the consortium and community partners, pregnant women are targeted to provide OB education before and after birth to decrease premature birth, low birth weight and decrease infant mortality.

Expected Outcomes:

Expected outcomes of the project are: increase education to pregnant women, and increase availability of resources in surrounding community; decrease infant mortality; prevent premature birth and low birth weight; develop a system of OB Navigators through consortium partners to serve the CSW communities.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The evidence-based model used is the Healthy Start Initiative from the Health Resources and Services Administration. This model is based off a five-year demonstration phase to identify and develop community-based systems approaches to reducing infant mortality and to improve the health and well-being of women, infant, children and their families. The main principles of the model include: 1) innovations in service delivery 2) community commitment and involvement 3) personal responsibility demonstrated by expectant parents 4) integration of health and social services 5) multi-agency participation 6) increased access to care and 7) public education.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Michele Pray Gibson				
	Tel #:	301-443-7320				
	Email:	MPray@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Tamanna Patel				
	Tel #:	404-413-0314				
	Email:	tpatel25@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Iowa

Monroe County Hospital

Grant Number:	D04RH31790					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	Monroe County Hospital				
	Address:	6580 165th Street				
	City:	Albia	**State:**	Iowa	**Zip code:**	52531
	Tel #:	641-932-2134				
	Website:	www.mchalbia.com				
Primary Contact Information:	**Name:**	Veronica Fuhs				
	Title:	Chief Executive Officer				
	Tel #:	641-932-1755				
	Email:	vfuhs@mchalbia.com				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	June 2018 to May 2019	$199,849
	June 2019 to May 2020	$199,503
	June 2020 to May 2021	$199,237

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Monroe County Public Health	Monroe	Iowa	Public Health
	Every Step Hospice (Formerly HCI)	Monroe	Iowa	Hospice
	Brees Rest Home	Monroe	Iowa	Residential Care Facility

The communities/counties the project serves:	Monroe County

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☐	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☐
	Elderly	☒	School-age children (teens)	☐
	Infants	☐	Uninsured	☐
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☒	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐

	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☐
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Advance Care Planning	☒
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

Monroe County Hospital and Clinics (MCHC), in collaboration with its Consortium and community partners, is utilizing the Rural Health Care Services Outreach Program project to expand health care delivery by increasing access to and use of advance care planning (ACP) services. ACP is a process of documenting decisions about the care a patient wishes to receive when they are unable to make decisions for themselves. The overarching goal of the project is to advance a culture of understanding and use of ACP among all Monroe County residents and healthcare providers. The project focuses on improving access to advance care planning services in Monroe County, increasing the number of residents who have a documented advance care plan, and creating a successful network of community partners who understand and utilize advance care plans in everyday practice. This initiative empowers people to think about the healthcare they would want, document those decisions, and share their wishes with their health care providers and loved ones. MCHC Health Coaches, Consortium organization staff, and community lay persons provide a network of trained facilitators throughout the community to aid Monroe County residents in completing advance care planning.

Expected Outcomes:

By increasing the use of advance care plans, people are more informed of their health conditions and health care options, and have a better relationship with health care providers. Advance care plans also provide guidelines for health care providers for patient care, ensuring their patients' wishes are being followed, even if they are unable to communicate them at the time of need. For patients who choose to forgo treatment and/or extreme measures, avoiding unwanted procedures will also decrease their healthcare costs at the end of life. A goal of the project is to change the way the community thinks of ACP and end-of-life care; to create a culture that values the positive health outcome of patients receiving the care they would choose even in situations when they are unable to communicate their decisions. County residents will expect patient-centered care to extend through health crises and the end-of-life. They will understand the importance of planning and documenting their plans so that their wishes are honored in all situations, not just when they are healthy enough to participate in their treatment decisions.

Evidence Based/ Promising Practice Model Being Used or Adapted:

This program is implementing the *Respecting Choices* evidence-based advance care planning model

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Jillian Causey				
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	Email:	JCausey@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	John Butts				
	Tel #:	404-413-0283				
	Email:	jbutts@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Iowa

North Central Iowa Mental Health Center

Grant Number:	D04RH31640					
Organization Type:	Community Mental Health Center (CMHC)					
Grantee Organization Information:	**Name:**	North Central Iowa Mental Health Center				
	Address:	720 Kenyon Road				
	City:	Fort Dodge	**State:**	Iowa	**Zip code:**	50501
	Tel #:	515-955-7171				
	Website:	https://www.unitypoint.org/fortdodge/berryhill-center-of-mental-health.aspx				
Primary Contact Information:	**Name:**	Kim Hayes				
	Title:	Accreditation and Grants Coordinator				
	Tel #:	515-574-6144				
	Email:	Kimberly.Hayes@unitypoint.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000.00
	May 2019 to Apr 2020	$200,000.00
	May 2020 to Apr 2021	$200,000.00

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Berryhill Center	Webster	IA	CMHC
	Trinity Regional Medical Center	Webster	IA	Hospital
	UnityPoint at Home	Webster	IA	Home Care
	UnityPoint Clinics	Webster	IA	Health Clinics
	Webster County Public Health Dept.	Webster	IA	Health Department

The communities/counties the project serves:	
	Buena Vista
	Calhoun
	Franklin
	Hamilton
	Humboldt
	Kossuth
	Pocahontas
	Sac
	Webster
	Wright

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☒	Pregnant Women	☐
	Caucasians	☒	School-age children (elementary)	☐
	Elderly	☐	School-age children (teens)	☐
	Infants	☐	Uninsured	☐
	Latinos	☒	Other: Adults ineligible for health home through other funding streams	☒
	Native Americans	☒	Other: Click here to enter text.	☐

	Pacific Islanders	☒	Other: Click here to enter text.	☐

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☒
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☒	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☒	Physical Fitness and Nutrition	☒
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☒
	Coordination of Care Services	☒	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

UnityPoint Health-Berryhill Center aims to improve the physical health of adults with mental and/or substance use disorders who have or are at risk of primary care conditions, emphasizing their cardiovascular health. This project will demonstrate the effectiveness of care coordinators addressing the rising risk population by providing evidence-based programs and interventions to demonstrate improved health outcomes.

Expected Outcomes:

*Berryhill will enhance care coordination for rising risk individuals with mental and/or substance abuse issues not currently served within existing funding streams, utilizing evidence base guidelines for care management.
*Through select evidence-based programs and interventions, the project will demonstrate improved health outcomes for the target population by implementing the Health Improvement Special Project (HISP).
*Berryhill will expand the delivery of health care services including new and enhanced mental health and substance services to residents in its 10-county rural north central Iowa region through five targeted outreach efforts to address growing SUD issues.

Evidence Based/ Promising Practice Model Being Used or Adapted:

- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Cognitive Behavioral Therapy for Managing Pain (CBT)
- Nurturing Skills for Families
- Whole Health Action Management (WHAM)
- Tobacco-Learning About Healthy Living (Smoking Cessation)
- Nutrition and Exercise for Wellness and Recovery (NEW-R)
- CDME/Better Choices, Better Health

Federal Office of Rural Health Policy Project Officer (PO):						
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	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Lisa McGarrie				
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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Kansas

Susan B. Allen

Grant Number:	D04RH31801					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	Susan B. Allen				
	Address:	720 W Central				
	City:	El Dorado	**State:**	Kansas	**Zip code:**	67042
	Tel #:	316-321-3300				
	Website:	www.sbamh.com				
Primary Contact Information:	**Name:**	Pam Cartwright				
	Title:	Director of Community Services				
	Tel #:	316-321-8784				
	Email:	pcartwright@sbamh.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$192,479
	May 2019 to Apr 2020	$188,989
	May 2020 to Apr 2021	$188,989

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	School USD 490	Butler	KS	School
	School USD 396	Butler	KS	School
	School USD 402	Butler	KS	School
	Kansas University School of Medicine	Sedgwick	KS	School
	School Nurse Advisory Council	Shawnee	KS	Advisory Council
	Butler County Health Department	Butler	KS	Medical Provider

The communities/counties the project serves: (list alphabetically)
Augusta, KS Butler County
Douglass, KS Butler County
El Dorado, KS Butler County

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☐	Pre-school children	☒
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☒
	Elderly	☐	School-age children (teens)	☒
	Infants	☐	Uninsured	☐
	Latinos	☒	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☒	Oral Health	☐

	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☒	School Health	☒
	Community Health Workers /Promotoras	☐	Substance Abuse	☐
	Coordination of Care Services	☒	Telehealth	☒
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

With the implementation of specific strategies and evidence-based models, Susan B. Allen and the School Nurse Navigator works to improve health education and health care access services, specifically regarding childhood asthma. The School Nurse Navigator works with each school district and the nurses at each school within the district. There are days when schools do not have a school nurse available (most school nurses are assigned to more than one school), therefore, the School Nurse Navigator is available via telehealth or in person to assess the sick child. Telehealth equipment is used in schools to create an increased access to healthcare for the children. The School Nurse Navigator will have a specific focus on asthma. Education will be provided to the child affected, their parents and caregivers, and the school faculty to try and prevent asthma flare ups and costly emergency room visits.

Expected Outcomes:

The anticipated outcomes for this project are decreased absenteeism among school-aged children, increased school performance, decreased asthma related Emergency Room visits/hospitalizations due to increased patient adherence to written asthma plan, increased timely management of asthma exacerbation, increased number of students with Asthma Action Plans (AAP), and increased number of schools deploying Asthma Emergency Plans (AEP).

Evidence Based/ Promising Practice Model Being Used or Adapted:

Susan B. Allen will implement the School-based Asthma Management Program (SAMPRO) toolkit which was created by the American Academy of Allergy Asthma and Immunology and the UW Health Initiative Program.

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	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Hailey Reid				
	Tel #:	404-413-0314				
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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Kansas

Valley Heights School District

Grant Number:	D04RH31650					
Organization Type:	School District					
Grantee Organization Information:	**Name:**	Valley Heights School District				
	Address:	121 East Commercial, PO Box 89				
	City:	Waterville	**State**	Kansas	**Zip code:**	66548
	Tel #:	785-363-2398				
	Website:					
Primary Contact Information:	**Name:**	Philisha Stallbaumer				
	Title:	Director				
	Tel #:	785-292-4453				
	Email:	philishas@bluevalley.net				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$199,487
	May 2019 to Apr 2020	$188,848
	May 2020 to Apr 2021	$192,126

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	USD #380 Vermillion	Marshall & Nemaha	Kansas	School District
	Pawnee Mental Health Services	Marshall	Kansas	Mental Health Care Facility
	Blue-Valley Telecommunications	Marshall & Nemaha	Kansas	Telecommunication Business
	School-Business Educational Consortium, Inc.	Marshall & Nemaha	Kansas	Non-Profit
	USD #498	Marshall	Kansas	School District

The communities/counties the project serves:	
Blue Rapids	Marshall County
Frankfort	Marshall County
Vermillion	Marshall County
Waterville	Marshall County
Centralia	Nemaha County
Corning	Nemaha County

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☒
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☒
	Elderly	☐	School-age children (teens)	☒
	Infants	☒	Uninsured	☐
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☐
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

In an ongoing collaborative effort within Marshall and Nemaha Counties of Northeast Kansas, Unified School District #498 Valley Heights, Unified School District #380 Vermillion, Pawnee Mental Health Services, Blue Valley Telecommunications, and the School-Business Educational Consortium have partnered to implement an expansion project of the original *Schools That Care* initiative. This program expands services to Pre-Kindergarten students, Parents as Teachers (PAT) families, and school district families of the two previously mentioned partner school districts. The approach includes acquisition of a Family Advocate; availability of professional development; provision of MTSS evidence-based programs/activities; utilization of media promotion; development of a community collaboration and creation of a Mobile Family Resource Center.

During the planning and early implementation phase of the project, the Family Advocate position is employed to provide outreach and access to mental health services for students and families, training for curriculum implemented by preschool & PAT instructors and acquisition and customization of the Mobile Family Resource Center. Subsequent phases of implementation focus on the bullying prevention curriculum in the preschool setting, the Mobile Family Resource Center operations, and mental health activities/special events and sustainability.

Expected Outcomes:

Overall, the expected outcomes of the *Schools That Care* expansion project include, but are not limited to the following:

1) An increased number of mental health services offered to Pre-Kindergarten students.
2) An increased number of families utilizing the Mobile Family Resource Center.
3) Decreased percentage in the preschool chronic absence rate.
4) Increased school district collaboration with business and community partners.

Additionally, it is anticipated that the impact of the *Schools That Care* expansion project will ultimately lead to the following:

1) Decreased student mental health problems.
2) Increased quality of life for students and their families.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The overall framework of the expansion project builds on the evidence-based model, the Kansas Multi-Tier System of Supports. One specific evidence-based program and service integrated into the initiative is the Second Step Social Emotional Learning and Bullying Program for preschool students. Other programs/activities that are incorporated within the MTSS framework include professional development for preschool and Parent as Teacher instructors; special events for mental health awareness; the development of a Mobile Family Resource Center (MFRC); targeted group interventions through early childhood programs; and individual assessment/screening-based referrals.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Michele Pray Gibson				
	Tel #:	301-443-7320				
	Email:	MPray@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Deana Farmer				
	Tel #:	404-413-0299				
	Email:	dfarmer13@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Kentucky

Lake Cumberland District Health Department

Grant Number:	D04RH31636					
Organization Type:	Public Health					
Grantee Organization Information:	**Name:**	Lake Cumberland District Health Department				
	Address:	500 Bourne Avenue				
	City:	Somerset	**State:**	Kentucky	**Zip code:**	42501
	Tel #:	606-678-4761				
	Website:	www.lcdhd.org				
Primary Contact Information:	**Name:**	Jamie Lee				
	Title:	Wellness Outreach & Education Coordinator				
	Tel #:	606-678-4761 EXT 1157				
	Email:	Jamiel.lee@lcdhd.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$199,996
	May 2019 to Apr 2020	$198,155
	May 2020 to Apr 2021	$195,170

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Centerpoint Church of the Nazarene	Cumberland	KY	Faith Based
	Dunnville Christian Church	Casey	KY	Faith Based
	Marshall University Research Cooperation	Cabell	WV	University
	Lake Cumberland Regional Hospital	Pulaski	KY	Health Care

The communities/counties the project serves:	
	Casey County
	Cumberland County

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☐
	Elderly	☐	School-age children (teens)	☐
	Infants	☐	Uninsured	☐
	Latinos	☐	Other: Appalachian	☒
	Native Americans	☐	Other: Faith-Based	☒
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☒	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☒	Physical Fitness and Nutrition	☒

	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☐
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The Heart4Change program integrates primary prevention educational programs into the faith-based setting. The program focus is on reducing the risk factors associated with cardiovascular disease among the target population (two churches and communities in rural, Appalachian Kentucky). It is supplemented by including additional activities such as lipid screenings, blood pressure monitoring, blood pressure control education, as well as other wellness education and activities, such as cooking classes, diabetes education classes, and physical activity programs. Wellness Committees are established and members are trained in various programs to build their capacity to lead the congregations toward better health and continue wellness activities after the grant period ends.

Expected Outcomes:

The implementation of this program aims to achieve several objectives, with a primary outcome being that individuals participating in one or more offered educational activity will reduce at least one cardiovascular risk factor as a result of their engagement with this project. Additionally, the project will indirectly impact 500 adults in the target population through video wellness segments played during church services, health topics included in weekly church bulletin, monthly newsletters that reinforce concepts, and other communication and outreach strategies.

Evidence Based/ Promising Practice Model Being Used or Adapted:

A promising practice, the *Jackson County Health Department Closing the Gap Cardiovascular Disease Program* model, is being used as the guide for developing cross-agency collaborations that integrate primary educational programs that are traditionally community-based education programs into the faith-based setting. Programs such as *Gentle Yoga, Cooking Matters, Heart Saver First Aid CPR, Check Change, Control, Kentucky Diabetes Prevention and Control Program's Diabetes Self-Management Education,* and *Freedom from Smoking* are used to modify the proposed model and form the primary educational components of this program.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Meriam Mikre				
	Tel #:	301-945-3110				
	Email:	MMikre@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	John Butts				
	Tel #:	404-413-0314				
	Email:	jbutts@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Kentucky

Mountain Comprehensive Care Center

Grant Number:	D04RH31791					
Organization Type:	FQHC					
Grantee Organization Information:	**Name:**	Mountain Comprehensive Care Center				
	Address:	104 South Front Avenue				
	City:	Prestonsburg	**State:**	Kentucky	**Zip code:**	41653
	Tel #:	606-886-8572				
	Website:	www.mtcomp.org				
Primary Contact Information:	**Name:**	Rachel Willoughby				
	Title:	Project Director, HomePlace Clinic				
	Tel #:	606-886-4319				
	Email:	Rachel.Willoughby@mtcomp.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Carter County Health Department	Carter	KY	Health Department
	PrimaryPlus	Regional	KY	FQHC

The communities/counties the project serves: (list alphabetically)
Carter County
Grayson
Olive Hill

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☐
	Elderly	☐	School-age children (teens)	☐
	Infants	☐	Uninsured	☐
	Latinos	☐	Other: Homeless	☒
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐

	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☒
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Case Management	☒
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

Mountain Comprehensive Care Center has expanded the reach of its healthcare for the homeless clinics to Carter County, Kentucky, an eligible rural area in Central Appalachia and a designated MUA and HPSA for primary and mental health care. The Carter County HomePlace Clinic offers integrated preventative and primary medical and behavioral health care, case management, and enabling services to ensure a holistic service system for homeless and very low-income persons (150% of FPL and below) of all ages.

Expected Outcomes:

Through expansion of the HomePlace Clinic to Carter County, MCCC and its partners will continue to: 1) improve access to and use of quality, culturally competent and appropriate integrated primary and behavioral health care as well as health promotion/disease prevention. Case management and enabling services (e.g., transportation) strengthens this model. As a result, patients now have an ongoing, affordable source of care, with savings to the community by decreasing unnecessary ER/hospital visits for preventable and/or treatable conditions. Patients experience continuity of care for long term maintenance and monitoring of their health; 2) decrease the cost burden as enabling services link patients with an ongoing payor source. This leads to increased use of an ongoing source of care; and 3) decrease patients' health disparities through implementation of CCM and PCMH leading to greater achievement of personal health care goals and achievement of Healthy People 2020 goals (long-term). As a result of this program, the goal is to impact at least 425 homeless and very low-income patients of all ages in Carter County over the three-year period.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The model of integrated primary and behavioral health care using CCM and PCMH has been successfully implemented in MCCC's other rural HomePlace Clinics. The Project Director has been trained in integrated care through Cherokee Health Systems (which utilizes the tenants of the CCM and PCMH) as will other project staff. The clinic also has agreements with Primary Plus and the Health Department for services outside the scope of clinic services as proposed in this project. The project by MCCC replicates these operational and program policies, procedures as well as referral mechanisms to expand services to Carter County.

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	Tel #:	301-443-1493				
	Email:	JCausey@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Wade Hanna				
	Tel #:	404-413-0314				
	Email:	hannaw@bellsouth.net				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Kentucky

Pennyroyal Healthcare Service

Grant Number:	D04RH31644					
Organization Type:	Federally Qualified Health Center					
Grantee Organization Information:	**Name:**	Pennyroyal Healthcare Service				
	Address:	310 Hawthorne Street				
	City:	Princeton	**State:**	Kentucky	**Zip code:**	42445
	Tel #:	270-365-0227				
	Website:	communitymedicalclinic.org and www.4HeartsSake.com				
Primary Contact Information:	**Name:**	Kecia Fulcher				
	Title:	CEO				
	Tel #:	270-365-0227				
	Email:	kfulcher@communitymedicalclinic.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$192,542
	May 2019 to Apr 2020	$192,542
	May 2020 to Apr 2021	$192,542

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Pennyroyal Healthcare Services, Inc.	Caldwell, Christian, Lyon	KY	FQHC
	Christian County Health Department* (CCHD)	Christian	KY	Clinic
	Pennyrile District Health Department* (PDHD)	Caldwell, Christian, Lyon,	KY	Clinic
	Pennyroyal Center Regional Prevention Center*	Caldwell, Christian, Lyon	KY	Non-Profit
	American Cancer Society – North Central Region (ACS)*	Caldwell, Christian, Lyon	KY	Non-Profit
	Kentucky Cancer Program (KCP)*	Caldwell, Christian, Lyon	KY	Non-Profit
	American Heart Association (AHA)*	Caldwell, Christian, Lyon	KY	Non-Profit

The communities/counties the project serves: (list alphabetically)	
	Caldwell
	Christian
	Lyon

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☒
	African Americans	☒	Pregnant Women	☒
	Caucasians	☒	School-age children (elementary)	☒

	Elderly	☒	School-age children (teens)	☒
	Infants	☒	Uninsured	☒
	Latinos	☒	Other: Click here to enter text.	☐
	Native Americans	☒	Other: Click here to enter text.	☐
	Pacific Islanders	☒	Other: Click here to enter text.	☐
Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☒	Integrated Systems of Care	☒
	Aging	☒	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☒	Pharmacy Assistance	☒
	Chronic Disease: Diabetes	☒	Physical Fitness and Nutrition	☒
	Chronic Disease: Asthma/COPD	☒	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☒
	Coordination of Care Services	☒	Telehealth	☒
	Emergency Medical Services	☐	Transportation to health services	☒
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The project targets rural residents of Lyon, Caldwell, and Christian counties in the Pennyroyal region of southwestern Kentucky, who are at risk for cardiovascular disease. These rural communities are characterized as "economically distressed." In keeping with the Rural Health Care Services Outreach Program goals and the purpose of the Health Improvement Special Project (HISP) purpose, Pennyroyal Healthcare Service (PHS) and its consortium partners execute a comprehensive, coordinated project to enhance access to and delivery of prevention, screening, and treatment services that will improve the target community's cardiovascular health. The project, "4HeartsSake", addresses obesity, diabetes, physical activity and nutrition, and cancer screening, with a special emphasis on tobacco use prevention and cessation. PHS and the consortium partners will offer coordinated services and outreach, and to complete a marketing campaign to advertise services and influence the target population's health-related attitudes and behaviors. The project will offer screening, direct services via primary care treatment, a seamless referral network, and enabling assistance to promote accessibility and empower patients to take charge of their health.

PHS will use network of partners to share the process and outcome evaluation findings. Some of our regional and statewide partners include the Kentucky Health Center Network for Federally Qualified Health Centers and the Kentucky Department of Public Health's Cabinet for Health and Family Services, which manages public health departments across the state. The American Cancer Society and American Heart Association partners are also part of larger statewide and national networks.

Expected Outcomes:

The project's expected outcomes are to improve the target population's cardiovascular health by reducing the incidence of hypertension, obesity, diabetes, and tobacco use. This project will reduce or eradicate barriers related to geography and affordability that prevent patients from seeking care and complying with treatment. It will create a shift in attitudes by providing education and tools that *empower* the area's residents to take charge of their own health, and advocate for policies that improve health across their community. It will identify and triage patients by risk, helping providers to collaborate on ways to provide the most appropriate and timely treatment.

The outcomes include systemic changes as well as shifts that will occur for the target population. They are organized by short-term (within the project period), long-term (beyond the project period within approximately 3-5 years), and broad scale impacts that will result within 5-10 years of sustained efforts. The consortium set three major impact goals to complete as a result of the project:

1. The rate of smoking is lowered from 27% to 19%, moving the service area into the top 10% of Kentucky counties with the lowest rates of tobacco use.
2. As evidence of the change in attitudes and awareness of risk factors for cardiovascular disease, cities and counties within the service area enact 2-3 new healthy policies such as no-smoking ordinances, new public green spaces that promote recreation and exercise, and expanded access to affordable public transportation.
3. The service area has *lower* rates of hypertension, obese adults, lung and oral cancers, and diabetes; and *higher* rates of people who seek and receive treatment for health factors related to cardiovascular disease than state and national averages.

On the whole, we anticipate that the project will enhance any local efforts that impact cardiovascular health, and strengthen a referral network and systemic approach to prevention and care. Other providers and outreach organizations who are not part of the consortium may experience an increase in patients seeking screening, diagnosis, resources, and treatment for diabetes, nutrition, tobacco use, and other behavioral health factors that increase cardiovascular health.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The consortium selected the Franklin Cardiovascular Health Program (FCHP), a model rated "effective" in Rural Health Information Hub's Community Health Gateway. The partners are adapting the model to account for equipment screening tools and outreach strategies. We will conduct outreach and education activities at community events where we are specifically offering the CDC Heart Age calculator screening tool. Finally, we are providing 125 patients with Carematix machines for telemonitoring, and we will use telehealth equipment to help serve rural patients. This project and model are ideal for the proposed HISP project because it focuses on hypertension, cholesterol, smoking, diet, and physical activity to overcome the cardiovascular issues facing low-income, rural communities. Additionally, it uses a collaborative, community-based approach and assistance with accessing screening and health care.

Another best practice model that PHS is integrating into its programming is the Chronic Care Model, which has been used to develop specific approaches for serving individuals with chronic conditions, such as diabetes, cardiovascular disease, asthma, depression, and other chronic disorders. One of the key elements of this model is to educate and involve patients in their care.

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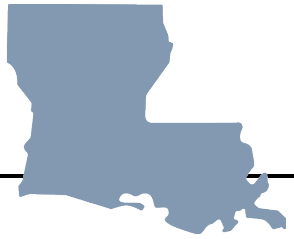
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Amanda Phillips Martinez				
	Tel #:	404-413-0314				
	Email:	aphillipsmartinez@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Louisiana

Innis Communtiy Health Center



Grant Number:	D04RH31783					
Organization Type:	Community Health Center					
Grantee Organization Information:	**Name:**	Innis Communtiy Health Center				
	Address:	6450 Louisiana Highway 1, Suite B				
	City:	Batchelor	**State:**	Louisiana	**Zip code:**	70747
	Tel #:	225-492-3775				
	Website:	https://arborfamilyhealth.org				
Primary Contact Information:	**Name:**	Cindy Peavy				
	Title:	Chief Executive Officer				
	Tel #:	225-492-3775				
	Email:	cpeavy@inchc.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Morehouse Community Health Center	Morehouse	TX	Community Health Center
	Winn Community Health Center	Winn	TX	Community Health Center
	Delhi Community Health Center	Richland	TX	Community Health Center
	RKM Primary Care Center	East Feliciana	TX	501(c)3 not-for-profit organization

The communities/counties the project serves:		
	East Feliciana	Morehouse
	Grant	Pointe Coupee

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☐	Pre-school children	☒
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☒
	Elderly	☐	School-age children (teens)	☒
	Infants	☐	Uninsured	☒
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☒	Oral Health	☒

	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☒
	Community Health Workers /Promotoras	☐	Substance Abuse	☐
	Coordination of Care Services	☒	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☒
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

Innis Community Health Center is implementing an expanded School-Based Health Center for oral health in the rural Louisiana parishes of Grant, Richland, East Feliciana, Pointe Coupee, and Morehouse, Children of these parishes experience high rates of dental caries which frequently goes untreated. The project focuses on children age 3 to 16 years of age. The long-term, overarching goals are to prevent dental caries, improve oral health status, decrease the number of schools days missed by children in rural Louisiana and identify for each child a dental home.

Expected Outcomes:

Case management activities will support the individual elements of achieving a dental home and will assist families in overcoming barriers to engagement in that dental home. In making the dental home more accessible to families of the children referred the case manager will help find transportation; complete any Medicaid paperwork; schedule appointments; and following-up with prevention, future appointments and after-care instructions. Community outreach and health literacy instruction will also help address and possibly influence family motivation by correcting oral health misinformation and lack of knowledge on oral health issues. In addition, the case management approach will attempt to ensure that care is coordinated across providers and that the child's access to available community resources will be supported.

Fluoride varnish applications will be successfully implemented. Further, the cost-benefit analyses conducted by the Washington State Dental Service and the University of Alabama suggest that Louisiana would also experience net savings over time, as children who receive fluoride varnish require fewer treatments for cavities.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The promising practice which is the foundation for the project is dental case management. The Butler County Dental Care Program is a Dental Case Management Program which is staffed by a two-thirds time dental case manager. The dental case manager provides all program services and performs administrative duties including maintaining communications, client records, and data collection, as well as conducting program analysis and preparing reports. The patient case management component consists of the following: oral assessments, dissemination of assessment results, interactive case management, expedited treatment, and oral health monitoring.

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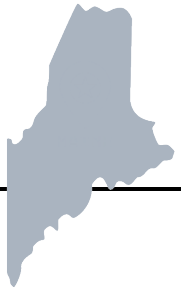
	Email:	mmikre@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	John Shoemaker				
	Tel #:	404-413-0314				
	Email:	TA@jasmph.com				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Maine

Aroostook County Action Program



Grant Number:	D04RH31769					
Organization Type:	Nonprofit 501©3 Organization					
Grantee Organization Information:	**Name:**	Aroostook County Action Program				
	Address:	771 Main Street				
	City:	Presque Isle	**State:**	Maine	**Zip code:**	04769
	Tel #:	207-764-3721				
	Website:	https://www.acap-me.org/				
Primary Contact Information:	**Name:**	Susan Deschene				
	Title:	Project Director				
	Tel #:	207-768-3056				
	Email:	sdeschene@acap-me.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Aquinnah Nation*	Aquinnah	MA	Tribal Health Clinic
	Aroostook Band of MicMacs*	Aroostook	ME	Tribal Health Clinic
	Houlton Band of Maliseet*	Aroostook	ME	Tribal Health Clinic
	Penobscot Nation*	Hampden	ME	Tribal Health Clinic
	Passamaquoddy of Pleasant Point*	Washington	ME	Tribal Health Clinic
	St. Regis Mohawk Tribe*	Akwesasne	NY	Tribal Health Clinic
	Passamaquoddy of Township*	Township	ME	Tribal Health Clinic

The communities/counties the project serves:		
	Aquinnah	Houlton
	Aroostook	Township
	Franklin	Washington
	Hampden	

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☐
	Elderly	☐	School-age children (teens)	☐
	Infants	☐	Uninsured	☐
	Latinos	☐	Other: Immigrant farmworkers and their families	☐
	Native Americans	☐	Other: Click here to enter text.	☐

	Pacific Islanders	☐	Other: Click here to enter text.	☐
Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☒	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☐
	Coordination of Care Services	☒	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The project, Northeast Tribes United for Diabetes (NE TUB), targets seven tribal communities located in the Northeast and builds on the success of the Wabanaki Telepthalmology Consortium Project (WTCP) in two ways. First, the project continues to provide eye examinations but has expanded to include life coaching and an insulin pump program supported by Medtronic. Second, NE TUB will be an inter-tribal study expanding beyond the Wabanaki in Maine to include additional tribes covering three Northeastern states: Maine, Massachusetts, and New York.

Expected Outcomes:

The goal of the project is adopted from Healthy People 2020, reduce the proportion of persons with diabetes with an A1c greater than 9 percent. The project also plans to reduce vision impairment due to diabetes retinopathy. While not typical, the new and secondary goals will serve as measurable long-term outcomes for the NE TUB. The goals include process and outcome measures.

<u>Process Measures</u>

- Conduct diabetes screening and education days twice per year
- Conduct training of Diabetes Liaisons as Lifestyle Coaches
- Increase the number of person with or at-risk for diabetes who are counseled in self-management techniques

<u>Short-Term Outcomes</u>

- Increase detection of pre-diabetes from baseline
- Improve HbA1c among those initiated on insulin pumps
- Increase the rate of those with annual eye exams among those with diabetes
- Increase rate of lifestyle coaching for diabetes self-management and prevention

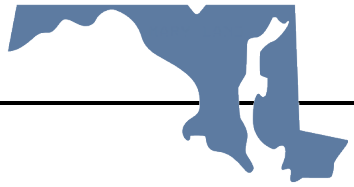
<u>Intermediate Outcomes</u>

- Decreased incidence rate of individuals with pre-diabetes and diabetes
- Decrease prevalence rates of diabetes complication and co-morbidities

Evidence Based/ Promising Practice Model Being Used or Adapted:						
NE TUB is grounded in the socioecological model and systems approach to health promotion which emphasizes the multiple spheres of influence on health. Under this framework, diabetes is thought to be a function of individual, interpersonal, institutional and organizational, community and broader policies and systems. Further, a systems approach addresses the dynamic interplay between the different levels of influences and posits that health improves when environment and policies provide access and individual are motivated and educated.						
Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Meriam Mikre				
	Tel #:	301-945-3110				
	Email:	MMikre@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	John Shoemaker				
	Tel #:	404-413-0314				
	Email:	TA@jasmph.com				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Maryland

Garett County Memorial Hospital



Grant Number:	D04RH31777					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	Garett County Memorial Hospital				
	Address:	251 North Fourth Street				
	City:	Oakland	**State:**	Maryland	**Zip code:**	21550
	Tel #:	301-533-4356				
	Website:	www.grmc-wvumedicine.org				
Primary Contact Information:	**Name:**	Kimi-Scott McGreevy				
	Title:	Assistant Vice President Marketing & Development				
	Tel #:	301-533-4356				
	Email:	kmcgreevy@gcmh.com				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Mountain Laurel Medical Center	Garrett County	MD	Federally Qualified Health Center
	West Virginia University (WVU) Medicine Department of Behavioral Medicine and Psychiatry	Monongalia County	WV	Outpatient & Inpatient Behavioral Health and Psychiatric Center; teaching hospital behavioral health department
	Garrett County Memorial Hospital, DBA Garrett Regional Medical Center	Garrett County	MD	Hospital

The communities/counties the project serves: (list alphabetically)
Allegany County, MD
Fayette County, PA
Garrett County, MD
Grant County, WV
Mineral County, WV
Preston County, WV
Somerset County, PA
Tucker County, WV

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☒	Pregnant Women	☒
	Caucasians	☒	School-age children (elementary)	☒
	Elderly	☒	School-age children (teens)	☒
	Infants	☐	Uninsured	☒
	Latinos	☒	Other: Click here to enter text.	☐

	Native Americans	☒	Other: Click here to enter text.	☐
	Pacific Islanders	☒	Other: Click here to enter text.	☐
Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☒
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☒
	Coordination of Care Services	☐	Telehealth	☒
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The proposed Behavioral Medicine and Addictions Treatment Center (BMATC) will provide evidence-based behavioral health and addictions treatment to patients from Garrett Regional Medical Center's primary and secondary service areas. Based on strategies from the University of New Mexico's Evidence-Based Project ECHO, WVU Behavioral Medicine staff will provide psychiatric consultative services, including direction and training on flagged cases, to staff at the proposed behavioral health facility in Garrett County using telehealth technology. Primary care wellness checks will be provided to all BMATC patients in an effort to integrate behavioral health and primary care services, and patients will be provided community wellness services by connecting them with resources available through agencies including Social Services, the Community Action Committee, and the Garrett County Health Department. The BMATC program will also address delays in addictions treatment through creation of a 2-bed detox unit within acute care hospital for addictions patients requiring more intense intervention.

Expected Outcomes:

The program will reform the delivery of behavioral health and addictions services in the 3-state, 8-county GRMC service area. The ability to track patient data, and to use that data to inform patient care coordination and management, will help reduce health care costs while streamlining health care delivery and engaging patients in their own health care decisions. The direct impact on behavioral health patients in the service area will include:

- Immediate care for behavioral health patients in crisis;
- Improved outcomes for behavioral health patients in addressing needs of daily living;
- Improved outcomes for behavioral health patients in addressing physical health issues;
- Improved outcomes for behavioral health patients in addressing diagnosis;
- Detox and ongoing support services for addictions patients within the community.

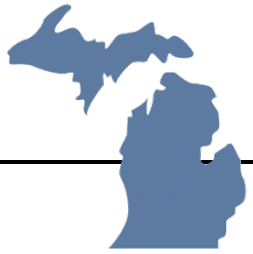
Evidence Based/ Promising Practice Model Being Used or Adapted:

The evidence-based model chosen for the Behavioral Medicine and Addictions Treatment Center (BMATC) is the University of New Mexico's Project ECHO. Project ECHO – Project Extension for Community Care Outcomes – connects rural health care professionals with specialists at an accredited teaching hospital via a secure telemedicine network. The psychiatric staff at WVU Medicine's Department of Behavioral Medicine and Psychiatry will work with BMATC staff through weekly patient consultations over a secure telemedicine network that will provide psychiatric input on highly complicated cases and will train BMATC personnel on new approaches to patient care. These weekly meetings will help BMATC staff stay current on new advances in treating behavioral health issue.

During those meetings, cases will be presented and discussed, with WVU Medicine personnel providing insight, suggested treatment models, and direction that can help BMATC staff not only with that particular patient, but other patients that may present at the center with similar conditions and/or needs. The model will create an environment in which WVU Medicine personnel will co-manage complicated cases with clinical personnel.						
Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Meriam Mikre				
	Tel #:	301-945-3110				
	Email:	MMikre@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Hailey Reid				
	Tel #:	404-413-0314				
	Email:	hreid3@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Michigan

District Health Department #10



Grant Number:	D04RH31633					
Organization Type:	County Health Department					
Grantee Organization Information:	**Name:**	District Health Department #10				
	Address:	521 Cobb Street				
	City:	Cadillac	**State:**	Michigan	**Zip code:**	49601
	Tel #:	231-876-3841				
	Website:	www.Dhd10.org				
Primary Contact Information:	**Name:**	Donna Norkoli				
	Title:	Health Promotion Program Coordinator				
	Tel #:	231-876-3841				
	Email:	dnorkoli@dhd10.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Spectrum Health Big Rapids Hospital*	Mecosta	MI	Hospital
	My Community Dental Center*	Mecosta	MI	Dental Clinic
	Baldwin Family Health Care*	Lake	MI	Federally Qualified Health Center
	Ferris State University*	Mecosta	MI	University

The communities/counties the project serves:	Lake County, MI
	Mecosta County, MI

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☒	Pregnant Women	☐
	Caucasians	☒	School-age children (elementary)	☐
	Elderly	☒	School-age children (teens)	☐
	Infants	☐	Uninsured	☒
	Latinos	☒	Other: Click here to enter text.	☐
	Native Americans	☒	Other: Click here to enter text.	☐
	Pacific Islanders	☒	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☒
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☒
	Chronic Disease: Cardiovascular	☒	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☒	Physical Fitness and Nutrition	☒

	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☐
	Coordination of Care Services	☒	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Tobacco Cessation	☒
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The purpose of the "Dental Partnering for Heart Health" Project is to establish referral partnerships between dental clinics, primary care practitioners, and public health practitioners to reduce the risk of cardiovascular disease (CVD) in adults ages 30 to 74 with no history of cardiovascular events. Consortium members partner to demonstrate changes to cardiovascular risk through implementation of programming designed to increase adults' access to preventive dental care. The consortium also coordinates efforts to refer individuals identified as having a high risk of experiencing a cardiovascular event to primary care services and public health prevention services that will address the risk factors for cardiovascular disease.

Expected Outcomes:

The goal of this project is to reduce rates of cardiovascular disease in two counties in rural northwest Michigan - Mecosta County and Lake County. Expected outcomes include: 1) reduction of cardiovascular disease risk as demonstrated by implementation of the Centers for Disease Control and Prevention Heart Age Calculator; 2) increased percentage of adults accessing routine preventive dental care; 3) decreased rates of adult smoking; 4) decreased rates of Type 2 Diabetes in adults; 5) decreased rates of adult overweight and obesity; 6) decreased rates of hypertension; and 7) increased rates of adults managing their hypertension.

Evidence Based/ Promising Practice Model Being Used or Adapted:

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

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Meriam Mikre				
	Tel #:	301-945-3110				
	Email:	MMikre@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Amanda Phillips Martinez				
	Tel #:	404-413-0314				
	Email:	aphillipsmartinez@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Michigan

Harbor Beach Community Hospital, Inc.

Grant Number:	D04RH31778					
Organization Type:	Critical Access Hospital					
Grantee Organization Information:	**Name:**	Harbor Beach Community Hospital, Inc.				
	Address:	210 S. First St.				
	City:	Harbor Beach	**State:**	Michigan	**Zip code:**	48441
	Tel #:	989-479-3201				
	Website:	www.hbch.org				
Primary Contact Information:	**Name:**	Trish VanNorman				
	Title:	Grant Projects Director				
	Tel #:	989-479-3961				
	Email:	tvannorman@hbch.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Huron Behavioral Health	Huron	MI	County Mental Health Authority
	List Psychological Services	Huron	MI	Private Mental Health Services
	Professional Counseling Services	Huron	MI	Private Mental Health Services

The communities/counties the project serves:	
	Huron County
	Sanilac County

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☒
	Elderly	☒	School-age children (teens)	☒
	Infants	☐	Uninsured	☐
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐

	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☒
	Coordination of Care Services	☐	Telehealth	☒
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The purpose of the proposed project is to expand the delivery of behavioral health services to include access in the primary care setting and to expand access to specialty behavioral health services. The integrated behavioral health portion of the project will make behavioral health services available at two primary care clinics that serve more than two thousand patients. The addition of psychiatry and substance abuse services via tele-behavioral health will make access to these services available to the entire county and the neighboring county to the south.

Expected Outcomes:

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

Goal 1: Implement integrated behavioral health services in two primary care clinics located in Port Hope and Harbor Beach, Michigan.

Goal 2: Improve patient health outcomes in Port Hope and Harbor Beach primary care clinics.

Goal 3: Improve access to Behavioral Health Services by residents in the east part of Huron County.

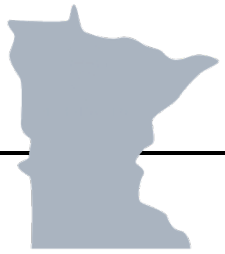
Evidence Based/ Promising Practice Model Being Used or Adapted:

Two evidence based programs have been adopted for this project. The Chronic Care Model and Primary Care Behavioral Health model will be utilized in tandem to address health from the Mind-Body connection.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Cassie Phillips				
	Tel #:	301-945-3940				
	Email:	CPhillips1@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Catherine Liemohn				
	Tel #:	770-641-9940				
	Email:	cliemohn@crlconsulting.com				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Minnesota

CentraCare Health System



Grant Number:	D04RH31632					
Organization Type:	Critical Access/ Rural Health					
Grantee Organization Information:	**Name:**	CentraCare Health System				
	Address:	50 CentraCare Drive				
	City:	Long Prairie	**State:**	Minnesota	**Zip code:**	56347
	Tel #:	320-251-2700; 71844				
	Website:	www.centracare.com				
Primary Contact Information:	**Name:**	Audrey O'Driscoll				
	Title:	Grants Program & Compliance Manager				
	Tel #:	320-251-2700; 71844				
	Email:	Audrey.ODriscoll@centracare.com				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$196,898
	May 2019 to Apr 2020	$199,625
	May 2020 to Apr 2021	$166,955

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	CentraCare Health – Long Prairie	Todd	MN	Clinic/Center Rural Health
	CentraCare Health – St. Cloud Hospital	Stearns	MN	General Acute Care Hospital
	CentraCare Health – Monticello	Wright	MN	Clinic/Center
	Appleton Area Health Services	Swift	MN	Rural Health
	CHI St. Gabriel's Health	Morrison	MN	Critical Access
	Douglas County Hospital	Douglas	MN	General Acute Care Hospital
	Madison Healthcare Services	Lac Qui Parle	MN	Critical Access/ Clinic/Center
	Renville County Hospitals and Clinics	Renville	MN	Clinic/ Center Rural Health
	Rice Memorial Hospital	Kandiyohi	MN	General Acute Care Hospital
	Riverwood Healthcare Center	Aitkin	MN	Critical Access/ Rural Health

The communities/counties the project serves: (list alphabetically)		
	Aitkin County	Renville County
	Douglas County	Stearns County
	Kandiyohi County	Swift County
	Lac Qui Parle County	Todd County
	Morrison County	Wright County

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☐
	Elderly	☒	School-age children (teens)	☐
	Infants	☐	Uninsured	☐

	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☒	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☐
	Coordination of Care Services	☐	Telehealth	☒
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The TEN Initiative serves rural Central Minnesotans with access to stroke specialty care treatment and post-stroke care. Currently, stroke or TIA patients present in a local community hospital are transferred more than an hour away to CentraCare Health – St. Cloud Hospital's Primary Stroke Center in St. Cloud, MN. When patients are ready for discharge, they return to their rural homes, with or without home healthcare support. The problems occur when these patients and their caregivers fail to participate in the recommended post discharge follow up neurology appointment. This is not due to the unavailability of resources, but in the understanding and navigation of the healthcare system. The TEN Initiative will offer navigation services and bridge the travel gap via telemedicine.

Expected Outcomes:

Expected outcomes of the project include:

1. Expand telehealth and post-stroke navigation services to 10 sites within the grant timeline
2. Decrease the degree of disability by 50 percent from enrollment to three months later
3. Enroll 80 percent of patients with a stroke diagnosis in the post-stroke clinic
4. Reduce readmissions among enrolled patients to fewer than 9 percent

Evidence Based/ Promising Practice Model Being Used or Adapted:

The evidence-based models used by the TEN Initiative are telemedicine and patient navigation.

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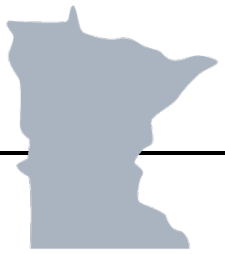
	Tel #:	301-443-1493				
	Email:	JCausey@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Catherine Liemohn				
	Tel #:	770-641-9940				
	Email:	cliemohn@crlconsulting.com				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Minnesota

Mississippi Headwaters Area Dental Health Center



Grant Number:	D04RH31639					
Organization Type:	Nonprofit Community Access Dental Clinic					
Grantee Organization Information:	**Name:**	Mississippi Headwaters Area Dental Health Center				
	Address:	1405 Anne Street NW				
	City:	Bemidji	**State:**	Minnesota	**Zip code:**	56601
	Tel #:	218-444-9646				
	Website:	www.northerndentalaccess.org				
Primary Contact Information:	**Name:**	Jeanne Edevold Larson				
	Title:	Executive Director				
	Tel #:	218-444-9646				
	Email:	jeanne.larson@northerndentalaccess.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Northern Dental Access Center		MN	community dental clinic
	Legal Services of Northwest Minnesota (LSNM)		MN	regional legal aid organization
	Dr. Joy's Dental Clinic		MN	dental practice

The communities/counties the project serves:	Minnesota counties of Norman, Polk, Mahnomen and Clay	North Dakota counties of Cass, Trail, Steele and Grand Forks

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☒
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☒
	Elderly	☐	School-age children (teens)	☒
	Infants	☐	Uninsured	☐
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☒
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐

	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☐
	Coordination of Care Services	☒	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☒
	Health Education and Promotion	☐	Other: Legal services	☒
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

In an effort to expand delivery of oral health care to low-income people in an unserved, rural area of Minnesota and North Dakota, and deliver dental care and wraparound support services through a consortium of providers committed to reducing oral health disparities, a community access dental clinic has been created providing dental care, care coordination, transportation assistance, and legal services—all within a culturally-competent and patient-centered environment.

Expected Outcomes:

The expected outcomes of this initiative include: an increase in number of people in need who have access to dental care; a decrease in children and adults who have untreated caries; an increase in children and adults who have preventive dental visit; an increase in children and adults who have oral cancer screening; and, an increase in people at risk receiving assistance with legal issues or other barriers to care or self-sufficiency.

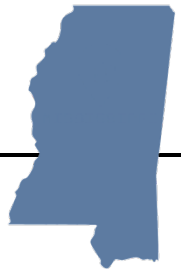
Evidence Based/ Promising Practice Model Being Used or Adapted:

Northern Dental Access Center has achieved success and national recognition for its approach to care, wraparound support services and community collaboration. It creatively blends several evidenced-based models and promising practices into a patient-centered and culturally competent access center. Through the dental home model, patients have access to support services that address barriers to care and help overcome socio-economic conditions that are barriers to overall health and self-sufficiency.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Meriam Mikre				
	Tel #:	301-945-3110				
	Email:	MMikre@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	John Shoemaker				
	Tel #:	404-413-0314				
	Email:	TA@jasmph.com				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Mississippi

Rural Alabama Prevention Center



Grant Number:	D042H31774					
Organization Type:	Community-based health and education non-profit organization					
Grantee Organization Information:	**Name:**	Delta Health Alliance				
	Address:	435 Stoneville Road				
	City:	Stoneville	**State:**	Mississippi	**Zip code:**	38776
	Tel #:	662-686-3944				
	Website:	www.deltahealtalliance.org				
Primary Contact Information:	**Name:**	Sha'Ketta Davis				
	Title:	Director				
	Tel #:	662-390-6666				
	Email:	sdavis@deltahealthalliance.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$199,803
	May 2019 to Apr 2020	$199,997
	May 2020 to Apr 2021	$99,896

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Delta Health Alliance, Inc.	Washington	MS	Community-based heath and education
	Leland Medical Clinic*	Washington	MS	Primary care clinic
	Parkwood Behavioral Health Center*	Desoto	MS	Behavioral health inpatient
	DeSoto Family Counseling Center*	Desoto	MS	Behavioral health outpatient

The communities/counties the project serves:	
	Sunflower County
	Washington County

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☐
	Elderly	☐	School-age children (teens)	☐
	Infants	☐	Uninsured	☐
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐

	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☒
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

This cooperative, rural health network initiative was developed to implement and evaluate the impact of integrating rural alcohol addiction treatment programs in outpatient and inpatient health care settings with coordination of local criminal justice systems. The objective is to improve access to and outcomes related to alcohol recovery and treatment in select rural communities in the Mississippi Delta. This initiative was developed as a collaborative program between Delta Health Alliance and three rural healthcare providers, including Parkwood Behavioral Health System, the Desoto Family Counseling Center, the Leland Medical Clinic, and two county court systems of Sunflower and Washington counties, with support from the Social Services collaborative, a 25-member consortium of social support agencies.

Expected Outcomes:

This cooperative endeavor has two specific aims: 1) To establish a system to help patients and clinicians make better informed health decisions about how to treat and manage persons who interact with local court systems because of alcohol abuse or addiction, and 2) To improve substance abuse outcomes by engaging patients in selecting specific behavioral health services with regular primary care. Improved substance abuse outcomes include: reduction in arrests post-treatment, reduction in opioid overdose post-treatment, increase in the number of days employed post-treatment, increase in the number of days working post-treatment, and reduction in domestic violence calls post-treatment.

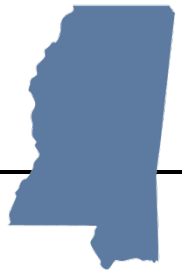
Evidence Based/ Promising Practice Model Being Used or Adapted:

The Delta STAR collaborative seeks to replicate and build upon the evidence-based Recovery-Oriented Systems of Care (ROSC) model which offers choice by providing a flexible menu of evidence-based services and supports to meet the specific needs of individuals with alcohol and drug problems. Proposed services include transportation for care, addiction / behavioral health counseling, inpatient services, peer-support groups, recovery support services, and care coordination.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Meriam Mikre				
	Tel #:	301-945-3110				
	Email:	MMikre@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Amanda Phillips Martinez				
	Tel #:	404-413-0314				
	Email:	aphillipsmartinez@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Mississippi

Greater Meridian Health Clinic



Grant Number:	D04RH31635					
Organization Type:	FQHC					
Grantee Organization Information:	**Name:**	Greater Meridian Health Clinic				
	Address:	2701 Davis Street				
	City:	Meridian	**State:**	Mississippi	**Zip code:**	39301
	Tel #:	601-693-0118				
	Website:	www.gmhcinc.org				
Primary Contact Information: (primary contact person for your grant)	**Name:**	LaTonya Horne-Agbagwu				
	Title:	MAGnet Director/Data Analyst				
	Tel #:	601-693-0118				
	Email:	lagbagwu@gmhcinc.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Partner Organization *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
Aaron E. Henry Community Health Center	Coahoma	Mississippi	FQHC
Jackson-Hinds Comprehensive Health Center	Hinds	Mississippi	FQHC
Dr. Arenia C. Mallory Community Health Center	Holmes	Mississippi	FQHC
Southeast Mississippi Rural Health Initiative	Forrest	Mississippi	FQHC
Greater Meridian Health Clinic, Inc.	Lauderdale	Mississippi	FQHC

The communities/counties the project serves: (list alphabetically)	
Coahoma	Noxubee
Copiah	Oktibbeha
Covington	Panola
Forrest	Pearl River
Hinds	Quitman
Holmes	Tunica
Kemper	Warren
Lamar	Leflore Winston
Lauderdale	

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☒
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☒	Pharmacy Assistance	☐

Focus areas of grant program:				
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☒
	Coordination of Care Services	☐	Telehealth	☐

Description of the Project:

The MAGnet Rural Health Services Community Outreach is a consortium of five chartered FQHC's in the state of Mississippi. These health centers have come together to focus on reducing health disparities within their communities. The purpose of MAGnet is to provide integrated comprehensive health services to underserved population in order to reduce health disparities.MS Cherokee Health Systems was contracted to train MAGnet member CEOs, providers, community health workers and other staff. This training provided insight into combining primary care and behavioral health systems. MAGnet is conducting continued training for providers/physician, nurses and community health workers with evidence-based programs from the National Heart, Lung, and Blood Institute, Centers for Disease Control and Prevention, American Heart Association and American Medical Association to implement within the community. Thus these trainings will help clinical staff have more tools to assist the patient with how to prevent and/or reduce heart attacks, strokes, diabetes, obesity, high blood pressure, cholesterol levels and depression who are being challenged with these health disparities.

Expected Outcomes:

The MAGnet Rural Health Services Community Outreach expected outcomes are as followed:

- Reduce risk factors of cardiovascular disease
- Lower high blood pressure scores to 140/90
- Heart healthy lifestyle choices (Nutrition & Exercise)
- Compliance with scheduled classes/meetings/integrated care services
- Lower diabetes A1c scores to <9
- Reduce obesity/overweight
- Reduce the number of strokes and heart attacks
- Lower blood cholesterol levels LDL levels to less than 100 mg/dL

Evidence Based/ Promising Practice Model Being Used or Adapted:

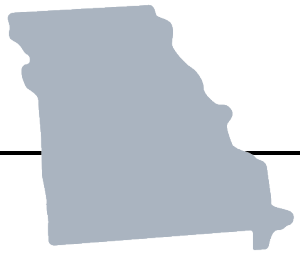
- **With Every Heart Beat Is Life"**- A 12-session evidence based manual designed by the National Heart Lung and Blood Institute targeted toward minorities and underserved communities.
- **Million Hearts 2022** - A self-monitoring blood pressure assisted program accompanied with clinical support that developed by The U.S. Department of Health and Human Services initiative, co-led by the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS).
- **Target Blood Pressure and Check Change Control Cholesterol** - The MAGnet Rural Health Services Community Outreach is administering an evidence based self-monitoring hypertension management program designed by The American Heart Association. Patients are trained by the clinical staff on how to document hypertension numbers, physical activity, and reduction of weight. Information is obtained from remote monitoring via an online tracking system.
- **Behavioral Health Integration with Primary Care (BHI)** - Patients will be able to obtain two services at one location without the prejudices, stereotyping or stigmatism that prevent them from seeking behavioral health support. The clinics will use depression screenings (PQ2/PQ9) and other tools and resources to assess and address behavioral health needs.

Federal Office of Rural Health Policy Project Officer (PO):						
	Name:	Meriam Mikre				
	Tel #:	301-945-3110				
	Email:	MMikre@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance (TA) Consultant's Contact Information:						
	Name:	Tanisa Adimu				
	Tel #:	404-413-0314				
	Email:	tadimu@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Missouri

Missouri Bootheel Regional Consortium



Grant Number:	D04RH31789					
Organization Type:	Rural Public Non-Profit Entity					
Grantee Organization Information:	**Name:**	Missouri Bootheel Regional Consortium				
	Address:	903 S. Kingshighway Boulevard, Suite A				
	City:	Sikeston	**State:**	Missouri	**Zip code:**	63801
	Tel #:	573-471-9400				
	Website:	www.mbrcinc.org				
Primary Contact Information:	**Name:**	Terrico Johnson				
	Title:	Project Director				
	Tel #:	573-471-9400 ext 312				
	Email:	tjohnson@mbrcinc.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	June 2018 to May 2019	$200,000
	June 2019 to May 2020	$200,000
	June 2020 to May 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Missouri Bootheel Regional Consortium	Dunklin, New Madrid, Mississippi, Pemiscot, and Scott	MO	Non- Profit
	Housing Authority of the City of Charleston	Mississippi	MO	Non- Profit
	Word of Faith Outreach Ministry Inc.	Pemiscot	MO	Non- Profit
	Southeast Missouri Rural Minority Health Coalition, Inc.	Dunklin, New Madrid, Mississippi, Pemiscot, and Scott	MO	Non- Profit
	Gibson Recovery Center, Inc.	New Madrid, Mississippi, and Scott	MO	Non- Profit

The communities/counties the project serves: (list alphabetically)		
	Dunklin	Pemiscot
	New Madrid	Scott
	Mississippi	

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☒
	African Americans	☒	Pregnant Women	☒
	Caucasians	☐	School-age children (elementary)	☒
	Elderly	☐	School-age children (teens)	☒
	Infants	☐	Uninsured	☒

	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☒
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☒	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☒
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☐
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The purpose of this project is to decrease disparities in health outcomes for African American Children in the Missouri Bootheel Area by offering health education and promotion, and opportunities for physical activities in their local communities.

Expected Outcomes:

Participants will report positive changes in behaviors such as increased physical activity, increased intake of fruits and vegetables, and increased family engagement in healthful behaviors.

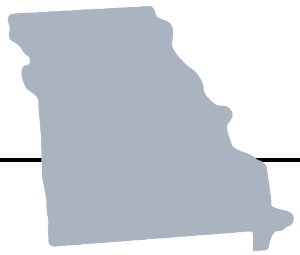
Evidence Based/ Promising Practice Model Being Used or Adapted:

The network partners implement the project using Community Health Workers as its evidence- based practice and Youth4Health as the Promising Practice. Youth4Health will be modified to fit the local communities' resources and by increasing the community health education component.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Jillian Causey				
	Tel #:	301-443-1493				
	Email:	JCausey@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Coleman Tanner				
	Tel #:	404-413-0091				
	Email:	ctanner18@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Missouri

Regional Health Care Clinic



Grant Number:	DO4RH31794					
Organization Type:	Federally Qualified Health Center					
Grantee Organization Information:	**Name:**	Regional Health Care Clinic				
	Address:	821 Westwood Drive				
	City:	Sedalia	**State:**	Missouri	**Zip code:**	65301
	Tel #:	660-826-4774				
	Website:	www.katytrailcommunityhealth.org				
Primary Contact Information:	**Name:**	Chris Stewart				
	Title:	Chief Executive Officer				
	Tel #:	660-851-7756				
	Email:	cstewart@katyhealth.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$191961
	May 2019 to Apr 2020	$181918
	May 2020 to Apr 2021	$155197

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Burrell Behavioral Health	Sedalia	MO	Community Mental Health
	Compass Health	Sedalia	MO	Substance Abuse Treatment
	Bothwell Regional Health Center	Sedalia	MO	Rural Health Hospital
	Sedalia #200 School District	Sedalia	MO	School System

The communities/counties the project serves: (list alphabetically)	Sedalia, Missouri

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☒
	Elderly	☐	School-age children (teens)	☒
	Infants	☐	Uninsured	☒
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐

	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☒
	Community Health Workers /Promotoras	☐	Substance Abuse	☐
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Suicide prevention	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The purpose of the project is for the West Central Missouri Zero Suicide Coalition to collaboratively implement a suicide prevention and intervention program, using the Zero Suicide model and toolkit in conjunction with other evidence based practices. The primary goals of the project are to improve screening and assessment in the school and primary care settings to identify individuals at risk for suicide so that early intervention and treatment can lead to improved outcomes; and to build workforce capacity competencies in suicide prevention in the West-Central Missouri region through awareness, training and education.

Expected Outcomes:

Expected outcomes include:

1. Increase the number of individuals with a suicide risk screen completed within the last 12 months whether they are screened at the school, hospital, emergency room, primary care, mental health setting
2. Increase the number of individuals who score a positive result on a validated suicide screening tool who receive an assessment during the same healthcare visit or school day
3. Increase the number of individuals who score a positive result on a validated suicide risk assessment tool who receive a referral to a behavioral health provider on the same day

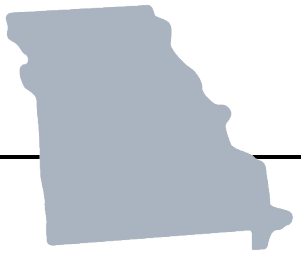
Evidence Based/ Promising Practice Model Being Used or Adapted:

Zero Suicide - The Zero Suicide framework is a system-wide, organizational commitment to safer suicide care in health and behavioral health care systems. The framework is based on the realization that suicidal individuals often fall through the cracks in a sometimes fragmented and distracted health care system. https://zerosuicide.sprc.org/toolkit

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Sara Afayee				
	Tel #:	301-945-4169				
	Email:	SAfayee@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Hailey Reid				
	Tel #:	404-413-0314				
	Email:	hreid3@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Missouri

Richland Medical Center



Grant Number:	D04RH31795-01-00						
Organization Type: (ex: hospital, FQHC, school, etc.)	FQHC						
Grantee Organization Information:	**Name:**	Richland Medical Center					
	Address:	304 W. Washington Ave					
	City:	Richland	**State:**	Missouri	**Zip code:**	65556	
	Tel #:	573-765-5141					
	Website:	www.centralozarks.org					
Primary Contact Information:	**Name:**	Lydia A. Jones					
	Title:	Director Ozarks Rural Health Network					
	Tel #:	573-836-2478					
	Email:	ljones@centralozarks.org					

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Richland Medical Center	Pulaski	MO	FQHC
	Lake Regional Health System	Camden	MO	Local hospital with primary care and specialty clinics
	Camdenton R -III	Camden	MO	School District
	Waynesville R-VI	Pulaski	MO	School District
	School of the Osage	Miller	MO	School District
	Eldon R-I	Miller	MO	School District
	Richland R-IV	Pulaski	MO	School District
	Crocker R-II	Pulaski	MO	School District
	Laquey R-V	Pulaski	MO	School District
	Plato R-V	Texas	MO	School District
	Camden County Health Dept.	Camden	MO	School District
	Miller County Health Dept.	Miller	MO	School District
	Pulaski County Health Dept.	Pulaski	MO	School District

The communities/counties the project serves: (list alphabetically)	
	Camden County, Missouri
	Miller County, Missouri
	Pulaski County, Missouri

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☒
	African Americans	☒	Pregnant Women	☐
	Caucasians	☒	School-age children (elementary)	☒
	Elderly	☐	School-age children (teens)	☒
	Infants	☒	Uninsured	☒
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐

	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☒	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☒
	Community Health Workers /Promotoras	☒	Substance Abuse	☒
	Coordination of Care Services	☒	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The project uses evidence based and promising practices to effect change at the individual and community level related to mental health and substance abuse. Project activities range from individual therapy to community-wide activities to meet the goal of improved mental health status and reduced substance use initiation and abuse among children and youth. The project will lead to important community-wide changes and will allow the development of further interventions focused on reducing addiction and improving access to treatment in our communities. The project is a partnership between five public health and health care providers in the coalition with the participation of eight school districts. It focuses on the behavioral health needs of children and adolescents in three countries in Central Missouri. The long-term goal of this consortium is to develop a comprehensive community-wide all ages approach to mitigate high rates of substance use, abuse and addition in the project area through education, prevention and treatment.

Expected Outcomes:

Expected outcomes of the project will be the development of a community-wide trauma informed approach. The end result will be long-term improvement in the quality of life for children, adolescents, family and caregivers and improved community health status, this will, in turn, lead to improved mental health status and reduced substance use initiation and abuse children and youth,

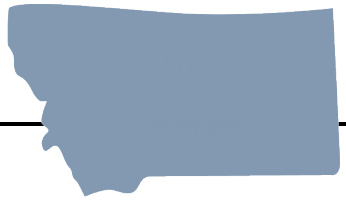
Evidence Based/ Promising Practice Model Being Used or Adapted:

Evidence-based practices utilized include Trauma Informed Care/Aware and the Adverse Childhood Experiences (ACE) screening tool. Promising practices include the use of community health workers and the use of rural school districts as community sites for mental health services.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Sara Afayee				
	Tel #:	301-945-4169				
	Email:	SAfayee@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Hailey Maier Reid				
	Tel #:	404-413-0210				
	Email:	Hreid3@gsu.edu				
	Organization:	Georgia Heath Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Montana

St. John's Lutheran Hospital



Grant Number:	D04RH31798					
Organization Type:	Critical Access Hospital					
Grantee Organization Information:	**Name:**	St. John's Lutheran Hospital dba Cabinet Peaks Medical Center				
	Address:	209 Health Park Drive				
	City:	Libby	**State:**	Montana	**Zip code:**	59923
	Tel #:	406-283-7000				
	Website:	www.cabinetpeaks.org				
Primary Contact Information:	**Name:**	Ahyoung Huff				
	Title:	Network Director				
	Tel #:	406-283-7239				
	Email:	ahuff@cabinetpeaks.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Center for Asbestos Related Disease	Lincoln	MT	Specialty asbestos pulmonary clinic
	Northwest Community Health Center	Lincoln	MT	FQHC
	Kalispell Regional Healthcare	Flathead	MT	Tertiary Hospital

The communities/counties the project serves: (list alphabetically)	Lincoln County, MT

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☒	School-age children (elementary)	☒
	Elderly	☒	School-age children (teens)	☒
	Infants	☐	Uninsured	☐
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐

	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☐
	Coordination of Care Services	☒	Telehealth	☒
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☒	Other: Click here to enter text.	☐

Description of the Project:

Cabinet Peaks Medical Center (CPMC), in collaboration with 3 other consortium members of Lincoln County Health Alliance, are enhancing patient access to team-based integrated behavioral health care and share transition of care information within LCHA in a timely, efficient manner using reliable, secure, and up to date technologies. Healthcare facilities in Lincoln County are utilizing electronic health records but the disparate systems prevent sharing of crucial information needed for transition of care in a meaningful way.

Lincoln County Community Health Needs Assessment identified mental health and substance abuse as the most pressing health concerns in our community, which has developed into a crisis with depleting resources. LCHA will implement Psychiatric Collaborative Care Services (CoCM) at Northwest Community Health Center (NWCHC) and Cabinet Peaks Family Medicine (CPFM) to bring needed mental health resources in a most effective and efficient manner according to evidence. The project will also improve outcomes for patients with behavioral health issues by increasing behavioral health screenings at partnering facilities for early detection and treatment. By working together as a rural health network, LCHA will increase the efficiency of the healthcare systems by aligning resources and strategies and to reduce the per capital cost of healthcare through the use of collaboration and coordination of services.

Expected Outcomes:

Expected outcomes of this project include improved patient satisfaction, improved population health, and decrease in cost of care by integrating physical and behavioral health care along with innovative utilization of HIT. Anticipated outcomes include:

- 1) Increased access to primary care, psychiatric services, and community resources for patients with behavioral health issues in Lincoln County;
- 2) Decreased inpatient readmission at Cabinet Peaks Medical Center for patients with behavioral health issues;
- 3) Increased population health as a result of early detection and treatment for patients with behavioral health issues;
- 4) Increased number of people receiving integrated behavioral health services;
- 5) Increased use of telehealth for behavioral health services in Lincoln County;
- 6) Increased provider satisfaction with more timely access to lab, imaging, and medication information;
- 7) Increased transitional care from hospital to primary care providers through the use of health information technology;
- 8) Implementation of patient/disease registry and outcome tracking/trending for population health management; and,
- 9) Increased strength and sustainability of a rural health network.

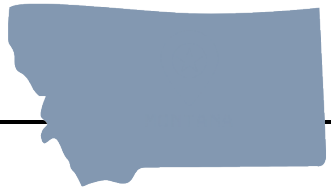
Evidence Based/ Promising Practice Model Being Used or Adapted:

Significant research spanning three decades has identified one model – the Collaborative Care Model (CoCM) – in particular, as being effective and efficient in delivering integrated care. The CoCM uses a team-based, interdisciplinary approach to deliver evidence-based diagnoses, treatment, and follow-up care. The project's Collaborative Care Model will have four core elements: 1) team-driven, 2) population-focused; 3) measurement-guided, and 4) evidence-based.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Jillian Causey				
	Tel #:	301-443-1493				
	Email:	JCausey@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Hailey Reid				
	Tel #:	404-413-0314				
	Email:	hreid3@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Montana

Summit Medical Fitness Center



Grant Number:	D04RH31800					
Organization Type:	Medical fitness facility					
Grantee Organization Information:	**Name:**	Summit Medical Fitness Center				
	Address:	205 Sunnyview Lane				
	City:	Kalispell	**State:**	MT	**Zip code:**	59901
	Tel #:	406-751-4100				
	Website:	https://www.krh.org/summit/				
Primary Contact Information:	**Name:**	Greg Vanichkachorn				
	Title:	Project Director				
	Tel #:	406-249-0962				
	Email:	gvanichkachorn@krmc.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000.00
	May 2019 to Apr 2020	$199,998.00
	May 2020 to Apr 2021	$199,997.00

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Northern Rockies Medical Center	Glacier	MT	Hospital
	Clark for Valley Hospital	Sanders	MT	Hospital

The communities/counties the project serves:	
Kalispell, MT	Flathead County
Cut Bank, MT	Glacier County
Plains, MT	Sanders County

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☒	Pregnant Women	☒
	Caucasians	☒	School-age children (elementary)	☐
	Elderly	☒	School-age children (teens)	☐
	Infants	☒	Uninsured	☒
	Latinos	☒	Other: Click here to enter text.	☐
	Native Americans	☒	Other: Click here to enter text.	☐
	Pacific Islanders	☒	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☒	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☒	Physical Fitness and Nutrition	☒
	Chronic Disease: Asthma/COPD	☒	School Health	☐

	Community Health Workers /Promotoras	☐	Substance Abuse	☐
	Coordination of Care Services	☒	Telehealth	☒
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

Summit Medical Fitness Center and the Montana Journey to Wellness Consortium (MJTWC) has a mobile screening and wellness lifestyle intervention program to Cut Bank and Plains MT. The primary purpose of the project is to decrease the incidence of cardiovascular disease and related risk factors in underserved rural communities by providing new access to primary prevention via a mobile and ongoing multidisciplinary lifestyle improvement program.

Expected Outcomes:

The intervention works to improve and foster healthy lifestyles. Specifically, MJTWC hopes to increase healthy cardiovascular exercise, improve anthropomorphic measurements, decrease smoking, increase mental positivity, decrease tobacco use, and increase primary care engagement.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The evidence-based model used is the Transtheoretical Model of Change, an adaptation of Engel's biopsychosocial model. The Transtheoretical Model assesses individual stages of change and provides strategies for stage progression, action, and maintenance. Using certified wellness coaches, the MJTWC will help participants develop their own personalized health goals, based on their readiness to change.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Robyn Williams				
	Tel #:	301-443-0624				
	Email:	RWilliams@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Tamanna Patel				
	Tel #:	404-413-0314				
	Email:	tpatel25@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Nevada

Healthy Communities Coalition of Lyon & Storey Counties

Grant Number:	D04RH31780					
Organization Type:	Coalition					
Grantee Organization Information:	**Name:**	Healthy Communities Coalition of Lyon & Storey Counties				
	Address:	PO Box 517				
	City:	Dayton	**State:**	Nevada	**Zip code:**	89403
	Tel #:	775-246-7550				
	Website:	www.healthycomm.org				
Primary Contact Information:	**Name:**	Wendy Madson				
	Title:	Executive Director				
	Tel #:	775-246-7550				
	Email:	roots@healthycomm.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	June 2018 to May 2019	$200,000
	June 2019 to May 2020	$200,000
	June 2020 to May 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Community Chest, Inc.	Storey	NV	Nonprofit
	Central Lyon Youth Connections	Lyon	NV	Nonprofit
	Turning Point, Inc.	Storey	NV	Evaluation Business

The communities/counties the project serves:	
	Lyon County
	• Dayton
	• Fernley
	• Silver Springs
	• Yerington

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☒
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☒
	Elderly	☐	School-age children (teens)	☒
	Infants	☐	Uninsured	☐
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☒
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☒

	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☒	Physical Fitness and Nutrition	☒
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☒
	Coordination of Care Services	☐	Telehealth	☒
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The purpose of this project is to continue to support and evolve the Health and Wellness Hub (HWH). The HWH is a consumer-centered school and community-based hub that coordinates the delivery of health care and social services for all members of the community, including the most vulnerable. Decision-makers and leadership from the schools, providers, county agencies, and community-based nonprofits comprise the HWH. The HWH has the infrastructure to connect individuals and families to health and social services that are evidence-based and/or documented as high quality, while avoiding duplication of services. This grant supports the HWH so that all available resources are utilized and leveraged for enhancing health care delivery in rural Nevada communities so that population health flourishes and collaboration is the norm amongst all -- local, regional, and state – providers in the county. This involves a deepening of partnerships within Healthy Communities Coalition (HCC) to implement a comprehensive patient-centered health system throughout Lyon County, Nevada. This system, which utilizes community health workers and resource coordinators as the central engines for health care service delivery, begins with prevention and has wellness as an outcome. To achieve this, HCC will implement the following evidence-based practices: Community Health Workers, Ages and Stages Questionnaire Developmental Screening, and the Signs of Suicide program for middle and high school students. To continue building on its demonstrated achievements thus far, HCC will continue its role as the primary convener and organizing influence of the Health and Wellness Hub. Two other partners – Central Lyon Youth Connections and Community Chest – are integrally involved in the delivery of this project, as will the evaluator, Turning Point, Inc.

Expected Outcomes:

The expected outcomes for this program are to enhance the rural health delivery model of care in Lyon County, Nevada. Specifically, the project goals are:

1. Expand the delivery of health care services to include new and enhanced services in rural communities.
2. Sustain and evolve the Health and Wellness Hub so that it continues to actively involve the voice and participation of multiple partners in planning and implementation.
3. Promote a rural Nevada health care environment that demonstrates improved population health and documents improved health outcomes, and continues to utilize innovation, and collaboration to meet the changing needs of rural Nevada people.
4. Utilize all available resources and partner with out-of-area resources to improve the Hub's ability to address systemic problems and readily identify available solutions, and share lessons learned with other partners so that other rural areas can benefit from improved knowledge and practices.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The Hub approach as described in this proposal is supported by many different EBPs and studies including: Caring School Community; Communities That Care; Coordinated, Intensive Medical, Social, and Behavioral Services; Integration of Behavioral Health Team & Consulting Psychiatrist; Cardiovascular Disease: Interventions Engaging Community Health Workers; Mental Health First Aid; Motivational Interviewing; Project Success, and Community Health Workers. Additionally, HCC is providing oral health services by partnering with the Lyon County Community Health nurses to offer fluoride varnish and oral health education at an elementary school in Dayton, Fernley, Silver Springs, and Yerington.

A mental health education and screening program, the Signs of Suicide (SOS), is also promoted at the middle and high schools in Lyon County. Youth identified as at moderate-high risk for depression or suicide via the BSAD screening tool are seen by a licensed clinician and recommendations are made, including referrals to community and school-based mental health clinicians.

Another key activity offered is the Ages and Stages Questionnaire (ASQ) for children up to five and a half years of age. This screening tool pinpoints developmental progress in children. The program is being piloted at a preschool in one of the communities in Lyon County and plans are underway to offer ASQ screenings in the other communities as well.						
Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Michele Pray Gibson				
	Tel #:	501-455-7520				
	Email:	MPray@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	John Butts				
	Tel #:	404-413-0314				
	Email:	jbutts@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

New Hampshire

North Country Health Consortium

Grant Number:	D04RH31641					
Organization Type:	Community Based 501©3 Independent Health Network					
Grantee Organization Information:	**Name:**	North Country Health Consortium				
	Address:	262 Cottage, Suite 230				
	City:	Littleton	**State:**	New Hampshire	**Zip code:**	03561
	Tel #:	603-259-3700				
	Website:	www.nchcnh.org				
Primary Contact Information:	**Name:**	Nancy Frank				
	Title:	Chief Executive Officer				
	Tel #:	603-259-3700				
	Email:	nfrank@nchcnh.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Northern Human Services	Coos, Northern Grafton	NH	Community Mental Health Center
	North Country Health Consortium	Coos, Northern Grafton	NH	Rural Health Network
	Androscoggin Valley Hospital	Coos	NH	Critical Access Hospital
	Weeks Medical Center	Coos	NH	Critical Access Hospital
	Upper Connecticut Valley Hospital	Coos	NH	Critical Access Hospital
	Littleton Regional Healthcare	Northern Grafton	NH	Critical Access Hospital
	Cottage Hospital	Northern Grafton	NH	Critical Access Hospital
	Indian Stream Health Center	Coos	NH	Federally Qualified Health Center (FQHC)
	Coos County Family Health	Coos	NH	FQHC
	Ammonoosuc Community Health Services	Northern Grafton	NH	FQHC

The communities/counties the project serves:	
	Coos County
	Northern Grafton County

The target population served:	Population	Yes	Population	Yes
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☐
	Elderly	☐	School-age children (teens)	☐
	Infants	☐	Uninsured	☐
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☒
	Coordination of Care Services	☒	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

This initiative, implementation of North Country Opioid Use Disorder Outreach Program, focuses on improving availability of opioid-related health care services to the North Country Health Consortium (NCHC) service area adult population. The approach to improve opioid use disorder intervention strategies and increase access to treatment includes utilization of a "warm handoff" model in emergency departments, enhanced care coordination practices by integrating community health workers/recovery coaches into treatment and referral protocols, and increasing knowledge and understanding by law enforcement regarding the best practices for identifying, screening, and linking opioid abusers to treatment.

Expected Outcomes:

The vision for sustaining the program is development of a system for individuals at-risk for overdose that includes the full continuum of care. Desired results of the program that will be sustained include: improvement in health outcomes of rural residents at-risk of opioid overdose with long-term recovery supports in place and accessible; improved transitions from the hospital emergency department to other settings and appropriate treatment options; increased care coordination utilizing teams that include Community Health Workers/Recovery Coaches; reduced # of population at-risk for opioid overdose; understanding of addiction stigma and the effects of stigma reduced and eventually eliminated; and increased access to local residential treatment.

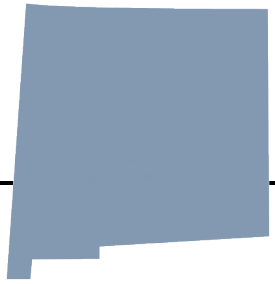
Evidence Based/ Promising Practice Model Being Used or Adapted:

The warm handoff model, supported by the Agency for Healthcare Research and Quality, described as a handoff between two members of a healthcare team and the patient. Community Health Worker/Recovery Coach model for peer support services is an evidenced-based mental health model consisting of qualified providers assisting individuals with recovery from substance use disorders and is adapted from the Affiliated Services Providers of Indiana Network.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Sara Afayee				
	Tel #:	301-945-4169				
	Email:	safayee@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	John Shoemaker				
	Tel #:	404-413-0314				
	Email:	TA@jasmph.com				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

New Mexico

El Centro Family Health



Grant Number:	D04RH31775					
Organization Type:	Federally Qualified Health Center					
Grantee Organization Information:	**Name:**	El Centro Family Health				
	Address:	538 Paseo de Onate				
	City:	Espanola	**State:**	New Mexico	**Zip code:**	87532
	Tel #:	505-753-7218				
	Website:	www.ecfh.org				
Primary Contact Information:	**Name:**	Lore Pease				
	Title:	CEO				
	Tel #:	505-753-7218				
	Email:	Lore.pease@ecfh.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	New Mexico Hope	Bernalillo	NM	Intensive Outpatient SUD Services
	Hoy Recovery	Rio Arriba	NM	Inpatient/Outpatient SUD Services
	Rio Arriba County Health and Human Services	Rio Arriba	NM	Health Department
	Northern New Mexico College	Rio Arriba	NM	Community College
	El Centro Family Health	Rio Arriba	NM	Community Health Center

The communities/counties the project serves:			
	Colfax	Rio Arriba	
	Guadalupe	San Miguel	
	Harding	Taos	
	Mora		

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☒
	Caucasians	☐	School-age children (elementary)	☐
	Elderly	☐	School-age children (teens)	☐
	Infants	☐	Uninsured	☐
	Latinos	☒	Other: Click here to enter text.	☐
	Native Americans	☒	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☒
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The Semillas de Esperanza project will utilize the evidence-based Peer Recovery Support Services model to assist individuals in substance abuse recovery with peer-led one-to-one and group support in an integrated primary care and behavioral health care environment that serves a seven-county rural region in northern New Mexico. The Semillas de Esperanza project expects to support long-term impacts that will increase sustained substance abuse recovery and reduce drug overdose deaths in a region that includes Rio Arriba County, one of the most affected areas in the nation by the opioid epidemic. Three Peer Recovery Specialists (PRS's) will be hired, trained and placed in centrally-located integrated primary and behavioral health care clinics in Española, Taos and Las Vegas operated by lead partner applicant El Centro Family Health, a Federally Qualified Health Center.

Expected Outcomes:

Expected outcomes of the project include: Substance abuse recovery outcomes will be improved; Increased number of substance abuse care providers will receive evidence-based trainings, ensuring consistency of care; More individuals with lived experience will earn certifications to provide peer-led support in a region lacking peer providers, and, Newly created peer recovery positions will become billable services to ensure program sustainability.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The evidence-based models we will be applying are:

- Peer Support Services Model- This model has established success to improve recovery outcomes and is well suited to work in a rural, multi county region. The addition of Peer Support Specialists with lived experience that can work one-to-one and offer peer support groups will resonate with many patients enrolled in the Medication Assistance Treatment program.
- Matrix Model- A style of treatment designed to aid in recovery from stimulant substances like methamphetamine and cocaine.
- Motivational Interviewing- A directive, client-centered counseling style for eliciting healthy behavior change.
- Seeking Safety Model- An evidence-based, present-focused counseling model to help people attain safety from trauma and/or substance abuse. It can be conducted in a group and/or individually

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Michelle Gibson				
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	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Tamanna Patel				
	Tel #:	404-413-0314				
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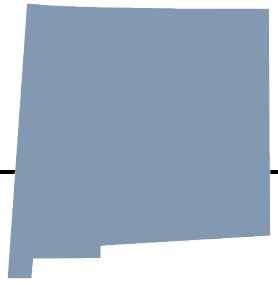
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

New Mexico

Miners Colfax Medical Center



Grant Number:	D04RH31788					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	Miners Colfax Medical Center				
	Address:	203 Hospital Drive				
	City:	Raton	**State:**	New Mexico	**Zip code:**	87740
	Tel #:	575-445-4546				
	Website:	http://www.minershosp.com/				
Primary Contact Information:	**Name:**	Charles L. Pollard				
	Title:	Black Lung Coordinator				
	Tel #:	575-445-4546				
	Email:	cpollard@minershosp.com				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$199,888
	May 2019 to Apr 2020	$199,965
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Miners' Colfax Medical Center	Colfax	NM	Hospital
	NOWCAP Services	Natrona	WY	Non-profit
	University of New Mexico	Bernalillo	NM	University
	Critical Nurse Staffing	Mesa	CO	Home Health Services

The communities/counties the project serves:		
	Billings, Montana	Price, Utah
	Columbus, Montana	Rock Springs, Wyoming
	Douglas, Wyoming	

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☒	Pregnant Women	☐
	Caucasians	☒	School-age children (elementary)	☐
	Elderly	☒	School-age children (teens)	☐
	Infants	☐	Uninsured	☒
	Latinos	☒	Other: Miners	☒
	Native Americans	☒	Other: Click here to enter text.	☐
	Pacific Islanders	☒	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☒	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐

	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☒
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☒	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☐
	Coordination of Care Services	☐	Telehealth	☒
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Miner Health	☒
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

This initiative builds off of an existing HRSA grant which serves rural areas of New Mexico. This Outreach grant includes the annual addition of five mobile screening clinics in WY, UT and MT to the 12 existing clinics in NM. The focus is a preliminary screening made up of a chest x-ray, pulmonary function test, and a meeting with a physician. The grant includes providing add-on telehealth services to half of the mobile screening clinics annually. Telehealth will be conducted with a Pulmonologist from the University of New Mexico. The primary target population is current and retired miners in NM, UT, WY, and MT. In addition to 20 communities in NM, the target service areas are the mining-intense communities of Rock Springs and Douglas, WY; Columbus and Billings, MT; and Price, and rural areas surrounding Salt Lake City, UT, by rotation over the 3-year grant period.

Expected Outcomes:

The project's key outputs over the three year grant period are 15 new screening mobile clinics outside NM (i.e. 5 annually), and 26 mobile clinics augmented with telehealth services within and outside NM (i.e., up to nine annually). Also, project outcomes will be measured by the Performance Improvement Measurement System (PIMS) measures and specific grant project measures at the patient and provider levels. For patients, the specific grant project measures are the index of new chronic conditions detected and patient satisfaction measures. For providers, the grant project specific measures are measures of satisfaction, self-efficacy, and competency related to telehealth services. Our expected outcomes are an increase in the medical knowledge of the mid-level providers within the grant as well as the satisfaction of the miners in these areas to be equal or higher than the miners seen within New Mexico.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The project combines three models specific to the perceived needs of the communities we serve. The first model is evidence-based screening. This model is necessary to comply with National Institute for Occupational Safety and Health (NIOSH) guidelines, however, the project does not restrict screening to dust-related lung disease but expand it to include hypertension and tobacco use. The second model used is the promising practice of mobile units. Like NIOSH, the clinic will help rural areas gain access to healthcare and screening for different diseases. The final model is the promising practice of telemedicine and telementoring to provide healthcare at a distance. This will help patients' access care and support physicians providing care in rural settings.

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	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	John Butts				
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	Email:	jbutts@gsu.edu				
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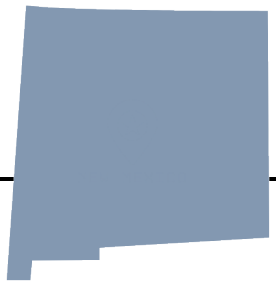
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

New Mexico

Rehoboth McKinley Christian Health Care Services



Grant Number:	HRSA-18-030 Rural Health Care Services Outreach Program					
Organization Type:	Private not-for-profit Health Care System					
Grantee Organization Information:	**Name:**	Rehoboth Mckinley Christian Health Care Services				
	Address:	1901 Red Rock Drive				
	City:	Gallup	**State:**	New Mexico	**Zip code:**	87301
	Tel #:	505-726-6908				
	Website:	www.rmch.org				
Primary Contact Information:	**Name:**	D. Wonda Johnson				
	Title:	Project Director				
	Tel #:	505-303-9773				
	Email:	dwjohnson@rmchcs.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000.
	May 2019 to Apr 2020	$200,000.
	May 2020 to Apr 2021	$200,000.

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Crownpoint Indian Health Service Junction Road 371 Route 9 Crownpoint NM 87313 P: 505-786-5291	McKinley	NM	Hospital
	Community Outreach & Patient Empowerment (COPE) 208 W Coal Avenue Gallup NM 87301 P: 505-722-2185	McKinley	NM	Collaborative preventive health care program
	Navajo Nation Community Health Representative (CHR) PO Box 1390 Window Rock AZ P: 928-871-6875	McKinley	NM	Patient Care Program
	Pine Hill Health Center 7 BIA 140 Pine Hill NM 87357 P: 505-775-7130	McKinley	NM	Health Clinic
	Gallup Indian Medical Center 516 E Nizhoni Blvd Gallup NM 87301 P: 505-722-1000	McKinley	NM	Hospital

The communities/counties the project serves:		
	Becenti Chapter	McKinley
	Casamero Lake Chapter (add on)	McKinley
	Coyote Canyon Chapter	McKinley
	Lake Valley Chapter	McKinley
	Little Water Chapter (add on)	McKinley
	Naschitti Chapter (add on)	McKinley
	Sheep Springs Chapter (add on)	McKinley

	Standing Rock Chapter (add on)		McKinley	
	Pine Hill/Ramah Chapter		McKinley	
The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☒
	African Americans	☐	Pregnant Women	☒
	Caucasians	☐	School-age children (elementary)	☒
	Elderly	☒	School-age children (teens)	☒
	Infants	☒	Uninsured	☒
	Latinos	☐	Other: Veterans	☒
	Native Americans	☒	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐
Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☒
	Aging	☒	Maternal/Women's Health	☒
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☒	Oral Health	☐
	Chronic Disease: Cardiovascular	☒	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☒	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☒	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☐
	Coordination of Care Services	☒	Telehealth	☒
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The project will deliver health care services to remote areas on the Navajo reservation in McKinley County, northwest New Mexico. The healthcare services will be provided from a mobile health unit which will travel to the heart of remote Navajo Chapter areas. The primary health care goal(s) of the project will be to provide a wide range of services tailored to specific community needs which will: 1) reduce health disparities by improving the overall health and well-being of underserved Native Americans living on the Navajo reservation; 2) expand access to health care services; 3) address ecological and social determinants of health and disease disparities; and 4) provide culturally sensitive trained clinical staff from the Navajo Community Health Workers. The mobile health unit will be equipped with a lab, portable x-ray and ultrasound equipment, satellite internet access. The preventive screening services will entail pre-op and post-op care, chronic disease management, health education and diabetes education.

Expected Outcomes:

Expected outcomes of this project include:

1) Earlier identification and treatment of health issues;

2) Improved management of chronic conditions;

3) Reduced overall cost of health care by reducing 30-day readmission rates, hospital admissions and use of emergency services;

4) Reduced barriers to accessing health care;

5) Reduced complications of preventable health issue(s);

6) Improved overall health status;

7) Increased coordination between providers and reduction in duplication of services;

8) Creation of a regional health care system; and,

9) Memorialized health care agreements among health and social providers in region.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The Collective Impact Model (CIM) will be used as the main evidenced-based practice for this project. The CIM has five components that contribute to its viability: (1.) The model envisions a number of diverse organizations that all agree on a common goal. In this project, the goal is to increase access and improve the health and well-being of the target communities. The project involves three different healthcare facilities, an outreach component, six different communities representing the diverse concerns of at least ten different organizations. (2.) Establishment of a shared measurement system. The project will establish priority data sets, medical and health information and establish quantifiable measures as to outcomes and impact on the communities served. (3.) Mutually reinforcing activities. The model describes the roles of different organizations, each having responsibilities for activities that reduces duplication and fragmentation. The project is composed of ten different organizations each having dissimilar roles that contribute to the accomplishment of the goal. (4.) Continuous communication. The project will institute monthly face-to-face meetings between medical/healthcare staff of the consortium in addition to the CHWs to resolve issues. In addition to these meetings, issues requiring the intervention of consortium members will be addressed and resolved in a joint meeting either by telephone, emails, or face-to-face. Moreover, the Project Director is tasked with the responsibility of providing monthly information and updates regarding health trends and progress of the project. (5.) A backbone support organization. The applicant organization serves in this capacity. It will provide guidance, support, technical assistance and conflict resolution capabilities to the overall administration and implementation of the project.

Other evidenced-based practices will include: health promotion and disease prevention theories and models, and the Community Health Workers Model for outreach.

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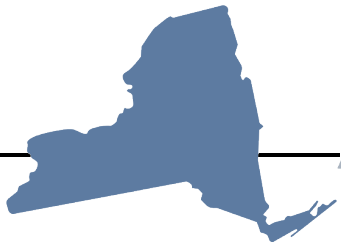
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Tamanna Patel				
	Tel #:	404-413-0314				
	Email:	tpatel25@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

New York

Mary Imogene Bassett Hospital



Grant Number:	D04RH31785					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	Mary Imogene Bassett Hospital				
	Address:	One Atwell Rd				
	City:	Cooperstown	**State:**	New York	**Zip code:**	13326
	Tel #:	607-547-3676				
	Website:	www.bassett.org				
Primary Contact Information:	**Name:**	David Strogatz, PhD				
	Title:	Director, Center for Rural Community Health, Bassett Research Institute				
	Tel #:	607-547-3676				
	Email:	David.Strogatz@bassett.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000.00
	May 2019 to Apr 2020	$200,000.00
	May 2020 to Apr 2021	$200,000.00

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Herkimer County HealthNet	Herkimer	NY	Rural health network
	Leatherstocking Education on Alcoholism/Addictions Foundation (LEAF)	Otsego	NY	Private, non-profit volunteer health organization
	Madison County Office for the Aging	Madison	NY	Non-profit community service agency
	Madison County Rural Health Council	Madison	NY	Non-profit rural health council
	Oneida Healthcare	Oneida	NY	Rural healthcare system
	Otsego County Community Services	Otsego	NY	Community service agency
	Mary Imogene Bassett Hospital	Otsego	NY	Rural healthcare system

The communities/counties the project serves:		
	Chenango	Madison
	Herkimer	Otsego

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☐
	Elderly	☒	School-age children (teens)	☐
	Infants	☐	Uninsured	☐
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐

	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☒
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☒
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Chronic Pain	☒
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The Mary Imogene Bassett Hospital will lead a consortium of six health care providers and human service agencies to deliver the Chronic Pain Self-Management Program at nine community-based locations. The workshop series, which consist of seven, two and a half hour sessions, are co-facilitated by two trainers. The curriculum content addresses the following pain management topics: self-management principles/responsibilities; goal setting and action planning; pain management tools (including appropriate use of medications and cognitive strategies); problem solving; physical activity and exercise for maintaining and improving strength, flexibility, and endurance; healthy eating; dealing with difficult emotions and depression; fatigue and sleep; communication with health care providers; and how to evaluate new treatments for pain. Program participants will create weekly action plans, share experiences, and help each other solve problems they encounter in creating and carrying out their self-management program.

Expected Outcomes:

The expected project outcomes are: 1) development of a consortium to sustain and promote the CPSMP; 2) delivery of the CPSMP program to 675 patients over the three-year project period; 3) improvements in measures of patient mental and physical health; 4) reduction in use of pain medication; and dissemination of project results through consumer events, clinical conferences, and published professional articles.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The chosen evidence-based practice is the Stanford Chronic Pain Self-Management Model (CPSMP), adapted as a promising practice for patients with or at risk for opioid dependence Bassett will modify the CPSMP by adding a seventh session, in which a pain specialist will address the group on medication issues.

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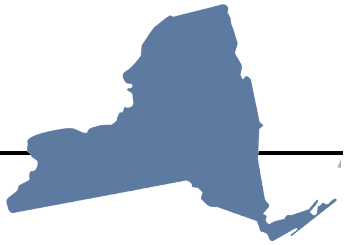
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Hailey Reid				
	Tel #:	404-413-0314				
	Email:	hreid3@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

New York

Westchester-Ellenville Hopsital



Grant Number:	D04RH31651					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	Westchester-Ellenville Hopsital				
	Address:	10 Healthy Way				
	City:	Ellenville	**State:**	New York	**Zip code:**	12428
	Tel #:	845-647-6400				
	Website:	http://www.ellenvilleregional.org/				
Primary Contact Information: (primary contact person for your grant)	**Name:**	Victoria Reid				
	Title:	Executive Director, Rural Health Network				
	Tel #:	845-647-6400				
	Email:	vreid@ellenvilleregional.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$199,973.00
	May 2019 to Apr 2020	$199,971.00
	May 2020 to Apr 2021	$199,971.00

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	The Institute for Family Health	Ulster	NY	Federally Qualified Health Center
	Ulster County Department of Health and Mental Health	Ulster	NY	Health Department
	HealthlinkNY Community Network	Dutchess	NY	Community Based Organization
	The Rose Women's Care Service Community Resource Center, Inc.	Ulster	NY	Community Based Organization
	Cornell Cooperative Extension	Ulster	NY	Community Based Organization

The communities/counties the project serves:	Wawarsing Region	Ellenville

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Elderly	☒

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Chronic Disease: Cardiovascular	☒		

Description of the Project:

Members of the Wawarsing Healthy Hearts Consortium work collaboratively to create integrated workflows designed to identify community residents at risk of developing Cardiovascular Disease (CVD), and to recruit and enroll those individuals into the Healthy Hearts program. Over the course of three years, organizations participating in the consortium will offer a range of physical activity and health education programs to enrolled cohort members and other community residents.

Providers also work collaboratively to develop communication protocols to share information more effectively between providers to maximize the effectiveness of provider interactions with clients/patients. A community health worker conducts phone and home visits with cohort members to ensure that they are utilizing available activities, following up with their primary care provider, and making lifestyle changes that reduce their risk of developing CVD.

Expected Outcomes:

Expected outcomes include increase in participants health knowledge of CVD; increase in behaviors that prevent CVD and reduction in behaviors that increase CVD risk; decreased incidence of cardiovascular disease, and its risks, within community; significant decline in ED visits, admissions and readmission for chronic disease; increased community access to opportunities for health promoting activities and services; and an empowered community that can build healthier families.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The decision to use a Community Health Worker model was based on a review of the findings of the Community Preventive Services Task Force (CPSTF) which, in 2015, found strong evidence of effectiveness for interventions that engage CHWs in a team-based care model to improve blood pressure and cholesterol in patients at increased risk of Cardiovascular Disease (CVD). The project also adapted elements of the Health Educator Model, as described in the Rural Health Community Health Gateway's evidence-based toolkit for CHWs. Program participants are able to attend evidence-based health management and prevention programs including Chronic Disease Self-Management (CDSMP) & National Diabetes Prevention Program (NDPP)

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Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Tanisa Adimu				
	Tel #:	404-413-0314				
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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

North Carolina

FirstHealth of The Carolinas

Grant Number:	D04RH31776					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	FirstHealth of The Carolinas				
	Address:	PO Box 3000, 155 Memorial Drive				
	City:	Pinehurst	**State:**	North Carolina	**Zip code:**	28374
	Tel #:	910-715-6275				
	Website:	www.firsthealth.org				
Primary Contact Information:	**Name:**	Cindy Laton				
	Title:	Project Director				
	Tel #:	910-715-6275				
	Email:	claton@firsthealth.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$197,749
	May 2019 to Apr 2020	$199,979
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	FirstHealth Behavioral Health Services	Moore/Richmond	NC	Hospital
	FirstHealth Community Health Services	Moore/Richmond	NC	Hospital
	Drug Free Moore County	Moore	NC	Community
	Moore County Health Department	Moore	NC	Public Health
	Richmond County Health Department	Richmond	NC	Public Health
	Richmond County Department of Social Services	Richmond	NC	Government
	Sandhills Center	Moore/Richmond	NC	Mental Health
	Community Care of the Sandhills	Moore/Richmond	NC	Medicaid Case Management Entity
	Moore County Sheriff's Office	Moore	NC	Law Enforcement
	Alcohol and Drug Services	Moore/Richmond	NC	Non-profit
	Village of Pinehurst Police Department	Moore	NC	Law Enforcement
	HealthNC+	Moore	NC	Clinical Aligned Network

The communities/counties the project serves:	Moore County	Richmond County

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☒	Pregnant Women	☐

	Caucasians	☒	School-age children (elementary)	☐
	Elderly	☒	School-age children (teens)	☐
	Infants	☐	Uninsured	☒
	Latinos	☒	Other: Individuals with Opioid Use Disorder	☒
	Native Americans	☒	Other: Families struggling with Opioid Use Disorder	☒
	Pacific Islanders	☒	Other: Click here to enter text.	☐
Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☒
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The overall goal of the project is to reduce opioid-related overdoses and deaths in Moore and Richmond counties through a multidisciplinary community coalition. FirstHealth is proposing five objectives to achieve project outcomes, including the following:

Objective One: Increase the individuals referred to the intensive inpatient and outpatient treatment programs available in Richmond and Moore counties by 35 percent for inpatient and 50 percent for outpatient.
Objective Two: Develop and implement a comprehensive Narcan and opioid awareness and outreach campaign to educate and increase awareness among Richmond and Moore County provider partners and residents.
Objective Three: Increase access to medication assisted treatment and care coordination. Ten primary care providers in the two-county region will become buprenorphine certified to provide medication assisted treatment to individuals who are discharged from an intensive inpatient or outpatient treatment program.
Objective Four: Support individuals in recovery, by establishing two peer-to-peer opioid use disorder mentor/support programs, with a goal of certifying 20 individuals as peer support specialists in the two-counties.
Objective Five: Increase the capacity of the consortium and develop a strong sustainability plan to ensure access to treatment and recovery resources for individuals with opioid use disorder.

Expected Outcomes:

Expected outcomes of the project include:

- 100 people in active recovery due to completion of treatment programs
- 139,789 reached with messaging; 150 providers and pharmacists exposed
- Increased dispensing of Narcan
- 300 individuals will have access to medication assisted treatment (30/provider)
- 100% increase in access to peer support programs
- Improved patient care/support for opioid use disorder

Evidence Based/ Promising Practice Model Being Used or Adapted:
The Project Lazarus model has been used as the framework for consortium partner efforts for the past five years. Partners have begun work in the public awareness, coalition action, and data/evaluation. In addition, they have initial momentum within the spokes of the model to include community education, provider education, hospital ED policies, diversion control and harm reduction. Partners deem this model as likely to succeed in the region because, like Project Lazarus' original target region, the area served through this project is located in rural North Carolina. Similarly, Moore and Richmond counties, which will be served by the project, are armed with similar resources (e.g. identical public health infrastructures), and operate under the same legislation that applies to Project Lazarus-served communities. The model provides a framework to address the opioid crisis with a comprehensive approach in all environments. Further, the consortium membership is representative of all aspects of the model, and will continue to recruit partners in each designated spoke focus area.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Michele Pray Gibson				
	Tel #:	301-443-7320				
	Email:	MPray@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Hailey Reid				
	Tel #:	404-413-0314				
	Email:	hreid3@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

North Dakota

City County Health District

Grant Number:	D04RH31772					
Organization Type:	Public Health Unit					
Grantee Organization Information:	**Name:**	City County Health District				
	Address:	415 2nd Avenue NE, Suite 101				
	City:	Valley City	**State:**	North Dakota	**Zip code:**	58072
	Tel #:	701-845-8518				
	Website:	http://www.citycountyhealth.org/home.html				
Primary Contact Information:	**Name:**	Theresa Will				
	Title:	Project Administrator				
	Tel #:	701-845-6670				
	Email:	twill@barnescounty.us				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	June 2018 to May 2019	$199,897
	June 2019 to May 2020	$199,965
	June 2020 to May 2021	$188,642

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	City-County Health District	Barnes	ND	Public Health Unit
	NDSU Extension	Barnes	ND	Education/University Division
	Valley City Public Schools	Barnes	ND	School District

The communities/counties the project serves:	Barnes County

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☒
	Elderly	☐	School-age children (teens)	☒
	Infants	☐	Uninsured	☐
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☒	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐

	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☒
	Chronic Disease: Asthma/COPD	☐	School Health	☒
	Community Health Workers /Promotoras	☐	Substance Abuse	☐
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The purpose of the proposed Barnes On The Move with Healthy Eating and Physical Activity Project (BOTMP) is to prevent the rapidly growing, childhood obesity epidemic from continuing its steady upward trajectory in the service county. The project is designed to decrease the rate of obesity/overweight for children ages 10-17 years and minimally. Utilizing well-honed population-based prevention skills, and proven evidence-based strategies, project staff aim to improve multiple policies, systems and environmental (PSE) concerns and; to develop new ones within the community as well as strengthen programming.

Expected Outcomes:

Expected outcomes include:

1) Enhanced availability of healthy food choices within the schools and at community events with a focus on more fruits/vegetables.

2) Children ages 10-17, daycare children, and community members will have increased physical activity levels.

3) Increased understanding of the value of health and wellness accompanied by needed policy, systems, and environmental changes to decrease childhood obesity.

4) An established system for doing heights/weights/BMI for at least grades 4,5,6,7,8 and 12 in Valley City Public Schools (VCPS) to generate the rate of obesity/overweight for those grades so objective data on obesity will be available instead of the present child reported data which is far less accurate.

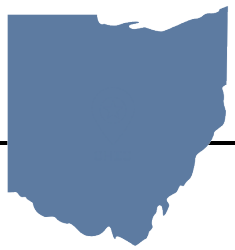
Evidence Based/ Promising Practice Model Being Used or Adapted:

BOTMP Project will adapt the CDC endorsed "Whole School, Whole Community, Whole Child Model" (WSCC). The model is an expansion and update of the Coordinated School Health (CSH) approach which incorporates the components of the CSH with the tenets of the whole child method to strengthen a unified and collaborative approach to learning and health. It emphasizes the relationship between educational attainment and health, by putting the child at the center of a system designed to support both. WSCC includes health education, physical education & physical activity, nutrition environment & services, health services, social and emotional climate, counseling, psychological and social services, physical environment, employee wellness, family engagement, and community involvement. Within Physical Education/Activity component of the WSCC model, the CDC's Comprehensive School Physical Activity Program (CSPAP) will be used. Within the Nutrition Environment/Services Component the "Obesity: Multicomponent Interventions to Increase the Availability of Healthier Foods & Beverages in Schools" (evidence-based per CDC's Community Guide) will be used.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Meriam Mikre				
	Tel #:	304-945-3110				
	Email:	MMikre@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Coleman Tanner				
	Tel #:	404-413-0314				
	Email:	ctanner18@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Ohio

Hopewell Health Centers



Grant Number:	D04RH31781					
Organization Type:	Federally Qualified Health Center					
Grantee Organization Information:	**Name:**	Hopewell Health Centers				
	Address:	1049 Western Avenue				
	City:	Chillicothe	**State:**	Ohio	**Zip code:**	45601
	Tel #:	740-773-1006				
	Website:	www.hopewellhealth.org				
Primary Contact Information:	**Name:**	Sherry Shamblin, Ph.D., PCC-S				
	Title:	Chief Strategy Officer				
	Tel #:	740- 590-1644				
	Email:	Sherry.shamblin@hopewellhealth.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	*Washington County Health Department	Washington	OH	Public Health
	Life and Purpose	Washington	OH	Mental Health
	*Washington County Behavioral Health Board	Washington	OH	Mental health and addictions board
	*Athens County Behavioral Health Board	Athens	OH	Mental health and addictions board
	*Nationwide Children's Hospital	Franklin	OH	Hospital
	*Federal Hocking School District	Athens	OH	School District
	*Fort Frye School District	Washington	OH	School District
	*Marietta City Schools	Washington	OH	School District
	*Wolf Creek Schools	Washington	OH	School District
	*Warren Schools	Washington	OH	School District
	Frontier Local Schools	Washington	OH	School District

The communities/counties the project serves:	Athens County , Ohio	Washington County, OH

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☒
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☒
	Elderly	☐	School-age children (teens)	☒
	Infants	☐	Uninsured	☐
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☒
	Community Health Workers /Promotoras	☐	Substance Abuse	☒
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

Hopewell Health Centers (HCC) and its collaborative partners are in rural Appalachian Ohio, which has been hard hit by the opiate crisis. The project aims to increase access to comprehensive school-focused opiate prevention and treatment services for students and their care givers. This will be accomplished by: (1) Implementing School-Based Universal/Prevention Strategies which include Early Childhood Mental Health Consultation and the PAX Good Behavior Game; (2) Implementing Targeted Strategies for At-Risk Students and Caregivers at schools including the Collaborative Decision-Making Model and the SOAR program, and SBIRT (Screening-Brief-Intervention-Referral-to-Treatment); (3) Expanding Substance Abuse Intervention/Treatment Services with care coordination; and (4) Sustain the comprehensive program post-grant funding.

Expected Outcomes:

It is anticipated that the project will result in the following impacts:

Short-Term:

- 12 new early childhood staff and 72 students have access to early childhood mental health consultation
- 90 teachers and 3,300 students have access to PAX Good Behavior Game.
- One Health Centers implement SBIRT with 300 teens and 100 adult caregivers receive the service
- 100 Families participate in a group-based program (Collaborative Decision Making and SOAR)
- 12 clinicians in Washington County are able to offer evidence-based treatment for Opiate Use Disorders with 150 served
- One new MAT Provider team is established in Washington County and 75 patients are served

Intermediate

- 80% of individuals identified by the SBIRT process receive treatment
- 75% have improved health outcomes
- A permanent system of care to address opiate addiction grounded in evidenced-based models, with a sustained community structure for shared decision-making for community stakeholders.
- Increased capacity within the regional HHC, the federally qualified health center, to be data driven in its behavioral health services.

Long-Term

- Improved health and behavioral health for residents living in Athens and Washington Counties.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The following evidence-based/promising practice models are being used as part of this project:

(1) Pax Good Behavior Game - Provides trauma-informed strategies for teachers to effectively manage and create a nurturing learning environment and teach students self-management skills.
(2) Early Childhood Mental Health Consultation (ECMH) - The model involves regular classroom consultation from ECMH clinician based on the Ohio Georgetown Model of Early Childhood Mental Health Consultation, a model utilized in early childhood settings where a clinician works collaboratively with center staff and administration to provide classroom observations and identify goals.
(3) SBIRT (Screening Brief Intervention Referral to Treatment) - An evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence, on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.
(4) Medication Assisted Treatment - Integrated medication assisted treatment program utilizing oral naltrexone and Vivitrol injection.
(5) Collaborative Decision-Making Model - Individuals collectively make a choice from the options before them.
(6) SOAR Program - A program designed to increase access to social security income/social security disability for eligible adults who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or a co-occurring substance use disorder.

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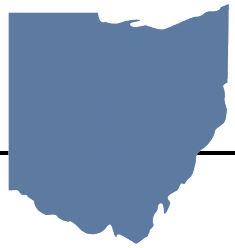
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Tamanna Patel, MPH				
	Tel #:	404-413-0314				
	Email:	Tpatel25@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Ohio

Ohio University



Grant Number:	D04RH31792					
Organization Type:	University					
Grantee Organization Information:	**Name:**	Ohio University				
	Address:	105 Research & Technology Center, 1 Ohio University				
	City:	Athens	**State:**	Ohio	**Zip code:**	45701
	Tel #:	740-593-1000				
	Website:	https://www.ohio.edu/				
Primary Contact Information:	**Name:**	Elizabeth A. Beverly				
	Title:	Assistant Professor of Family Medicine				
	Tel #:	740-593-4616				
	Email:	Beverle1@ohio.edu				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000.00
	May 2019 to Apr 2020	$200,000.00
	May 2020 to Apr 2021	$200,000.00

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Ohio University Heritage College of Osteopathic Medicine	Athens	OH	University
	Ohio University Diabetes Institute	Athens	OH	University
	Ohio University Psychology/Social Work Clinic	Athens	OH	University
	Athens City-County Health Department	Athens	OH	Health Department
	OhioHealth Care System	Athens	OH	Health Care System/Clinics/Hospital
	DOSES (Diabetes, Outreach, Support and Education for Students) Peer Mentors	Athens	OH	University

The communities/counties the project serves:			
	Athens County, Ohio	Perry County, Ohio	
	Hocking County, Ohio	Vinton County, Ohio	
	Meigs County, Ohio	Washington County, Ohio	
	Morgan County, Ohio		

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☒	School-age children (elementary)	☒
	Elderly	☒	School-age children (teens)	☒
	Infants	☐	Uninsured	☒
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☒	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☒	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☒
	Community Health Workers /Promotoras	☒	Substance Abuse	☐
	Coordination of Care Services	☒	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

Diabetes rates in rural Appalachian Ohio are more than double the national average (19.9% vs 9.4%). Appalachian diabetes patients are more likely to be diagnosed late, have lower empowerment and health literacy, and higher rates of diabetes complications. Further, nearly one-third of residents live below the poverty line and suffer from higher unemployment, food insecurity, and lower access to health care. Thus, there is a critical need to address the high-risk social determinants of health impacting Appalachians with diabetes. "A New Approach to Diabetes Navigation in Rural Appalachia" is a program designed to improve health outcomes (e.g., glycemic and blood pressure control, depressive symptoms, diabetes distress, quality of life) and lower health care expenditures for children and adults with diabetes in rural southeastern Ohio. The program includes three targeted arms: 1) Child Diabetes Navigation, 2) Community Health Workers, and 3) Peer Support. Each of these arms targets the high-risk social determinants that contribute to health disparities in the rural Appalachian region of southeastern Ohio. This program expands access to care, supports enhanced care coordination, and lowers barriers to diabetes management.

Expected Outcomes:

Anticipated outcomes for the children in the Child Diabetes Navigation Program and Peer Sup-port Program include the following: 1) a reduction of 0.5% point in mean A1C; 2) a 25% increase in school attendance; 3) a 25% decrease in hypoglycemic events; 4) a 25% increase in blood glucose checks; 5) a 25% increase in quality of life; 6) a 10% increase in positive nutrition and physical activity behaviors; 7) a 5% increase in in food insecurity; 8) a 50% decrease in emergency department visits; 9) a 50% decrease in hospitalizations; and, 10) a 50% decrease in hospital readmissions.

Anticipated outcomes for adult diabetes patients in the CHW Program include the following: 1) a reduction of 1.0% point in mean A1C, which can translate into a 30% reduction of a patient's risk of developing diabetes complications; 2) a 3 mmHg decrease in diastolic blood pressure and 4 mmHg decrease in systolic blood pressure, which are clinically meaningful differences in blood pressure reduction; 3) a 10% reduction in depressive symptoms and diabetes-related distress; 4) a 25% increase in frequency of diabetes self-care behaviors; 5) a 5% reduction in food insecurity; 6) a 50% decrease in emergency department visits; 7) a 50% decrease in hospitalizations; and, 8) a 50% decrease in hospital readmissions.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Patient Navigation Model was selected based on empirical evidence demonstrating reduced barriers and improved outcomes for cancer care. Created by Dr. Harold P. Freeman in 1990, patient navigation was developed to eliminate barriers to timely breast cancer care (e.g., financial barriers, communication and information barriers, medical system barriers, and emotional barriers) at the Harlem Hospital Center in New York City. Our Child Diabetes Navigation Program shares the principles of Freeman's model of patient navigation, with an intent to promote timely movement of patients through the fragmented healthcare system and eliminate barriers to diabetes care.

The Community Health Worker Model (CHW) Model was selected based on empirical evidence supporting its effectiveness for diabetes- and hypertension-related outcomes as well as improved health-, equity-, and efficiency-related outcomes. Similar to the Patient Navigation Model, the CHW Model is designed to address health disparities and improve outcomes by connecting patients to and navigating them through the healthcare system, supporting adherence to screening and diagnostic services, and providing social support and financial and community resources. CHWs provide a cost-effective strategy to help underserved populations managing chronic diseases in the home and community setting. CHWs develop connections with patients in their own communities, which enables them to communicate openly about barriers and needs for care.

The Peer Support Model was selected based on systematic evidence demonstrating the effectiveness of peer support in diabetes management for improving diet, exercise, blood glucose monitoring, and medication adherence. Peer support is defined as support from an individual who has experiential knowledge in the specific behaviors and/or practices of the target population. The success of the Peer Support Model is attributed to the non-hierarchical, reciprocal relationship formed between peers sharing similar life experiences.

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	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Tamanna Patel				
	Tel #:	404-413-0314				
	Email:	tpatel25@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Oregon

Mid-Valley Healthcare, Inc.

Grant Number:	DO4RH31787					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	Mid-Valley Healthcare, Inc.				
	Address:	100 Mullins Drive Ste C-1				
	City:	Lebanon	**State:**	Oregon	**Zip code:**	97355
	Tel #:	541-451-6381				
	Website:	www.Samhealth.org				
Primary Contact Information:	**Name:**	Kelley A Story				
	Title:	Director of Substance Abuse				
	Tel #:	541-451-6361				
	Email:	kstory@samhealth.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	June 2018 to May 2019	$199,997.00
	Sept 2019-Sept 2020	$199,989.00
	Sept 2020-Sept 2021	$199,935.00

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	CHANCE	Linn/Lincoln	OR	Behavioral Health Center
	Family Tree Relief Nursery	Linn	OR	Behavioral Health Center
	Linn County Alcohol and Drug	Linn	OR	Behavioral Health Center
	Milestones Family Recovery	Benton	OR	Behavioral Health Center

The communities/counties the project serves:	East Linn County	Lebanon

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☒
	Caucasians	☒	School-age children (elementary)	☐
	Elderly	☐	School-age children (teens)	☐
	Infants	☐	Uninsured	☒
	Latinos	☒	Other: Veterans	☒
	Native Americans	☒	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and	☐

			Retention/Workforce Development	
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☒
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☒
	Coordination of Care Services	☒	Telehealth	☐
	Emergency Medical Services	☒	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Overdose Prevention	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

Introduce Peer Support to hospital Emergency Department (ED) team to work with opioid users who are being brought in with overdose or severe consequence of use. Educate providers and community as to who are high risk users. Focus intensive services on first time Overdose survivors to reduce lethality in those users. Create a marketing campaign to educate community on opioid use.

Expected Outcomes:

- Decrease mortality and morbidity rates.
- Increase referrals to substance abuse treatment. Increase seamless transition of care between hospital and treatment.
- Increase education of medical providers, increase the number of physicians who have X-waivers.
- Increase family support systems.
- Have peer support specialist be a member of multi-disciplinary team and the position to be self-sustaining after grant funding runs out.
- Have ED providers become comfortable with introducing Bupenorphine in the ED.

Evidence Based/ Promising Practice Model Being Used or Adapted:

ED-Initiated Buprenorphine (BNI) Outperforms Screening, Brief Intervention, Referral to Treatment (SBIRT) for ED

To better fit in with the operational process of our ED, we have tweaked this intervention a bit to have the Peer Support Specialist ask to provide the BNI. The BNI procedure consists of 4 major steps: 1) Raise the Subject and Establish Rapport, 2) Provide Feedback, 3) Enhance Motivation and 4) Negotiate and Advice.

Peer Support:

Peer support services provide outreach to and engage individuals with substance use disorder by individuals who themselves have "lived experience." Because of their lived experience and successful recovery, peer support specialists can offer a level of support, understanding and hope that traditional behavioral health specialists and medical professionals are often unable to provide. Peer support specialists are able to bridge the cultural gap between the medical community, and the behavioral health system persons suffering from the consequences of substance abuse. Information provided by peers is often seen to be more credible than that

provided by mental health professionals. When peers are part of hospital-based care, the results indicate shortened lengths of stays, decreased frequency of admissions, and a subsequent reduction in overall treatment costs.

Motivational Interviewing and Enhancement

Change is hard, even positive change and making the decision to enter treatment is a difficult one. From the first visit in the emergency room with the Peer Support Specialist, to a warm hand off to treatment and MAT to a successful completion from treatment or just a cup of coffee to keep in touch, the STARS Outreach will assess a patient's Readiness to Change and interact with them appropriately. Stages of Change are assessed as follows: Pre-Contemplation, Contemplation, Preparation, Action, Maintenance, and Termination. Some of the tools that will be used to assess readiness include: Readiness Ruler Worksheet, Change Plan Worksheet, Decisional Balance Worksheet, What I Want for Treatment questionnaire, Personal Values Card Assignment. Patients and their families are taught about the dynamics of the stages of change and the best ways to interact with the patient depending on what stage of change they are experiencing.

Opioid overdose education and community naloxone distribution (OEND):

Naloxone is an opioid antagonist medication that reverses the effects of an opioid overdose. It is easily administered and has not been shown to increase opioid use where it is available. Distribution of Naloxone to high-risk users, family members and community laypersons, in conjunction with training in its use, has been shown to save lives. Increasing access to naloxone rescue kits is one of the US Health Department's priorities for addressing opioid-related overdose. Naloxone distribution to family, friends, and high-risk users through the STARS Outreach project saves lives in east Linn County, especially in the most rural communities, when administered after an overdose.

Medication Assisted Treatment

Medication assisted treatment (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders and is considered an Evidenced Based Practice. Working under the direction of the Medical Director of the Addiction program, Dr Rick Hindmarsh, a board certified Addictions specialist and the leadership of the Director of Emergency Medicine, Dr Daniel Sprague, patients are assessed for appropriateness or MAT after ED intervention.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Michele Pray Gibson				
		301-443-7320				
	Email:	MPray@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Wadia Hanna				
	Tel #:	866-434-5269				
	Email:	hannaw@bellsouth.net				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Oregon

Northeast Oregon Network

Grant Number:	1 D04RH31642-01-00					
Organization Type:	Community Based 501c3 Independent Health Network					
Grantee Organization Information:	**Name:**	Northeast Oregon Network				
	Address:	2008 Third Street, Suite A				
	City:	La Grande	**State:**	Oregon	**Zip code:**	97850
	Tel #:	(514) 624-5101				
	Website:	www.neonoregon.org				
Primary Contact Information:	**Name:**	Eric Griffith				
	Title:	Executive Director/ Project Director				
	Tel #:	(541) 910-4986				
	Email:	egriffith@neonoregon.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Center for Human Development	Union	OR	Public Health/ Mental Health
	Department of Human Services	Baker, Union, Wallowa	OR	Social Service Provider
	Winding Waters Medical Clinic	Wallowa	OR	Health Care Provider
	Wallowa Valley Center for Wellness	Wallowa	OR	Mental Health Provider
	Grande Ronde Hospital	Union	OR	Health Care Provider
	Valley Family Health Care	Malheur	OR	Health Care Provider
	Saint Alphonsus Medical Center	Malheur, Baker	OR	Health Care Provider
	Lifeways Inc.	Malheur, Umatilla	OR	Mental Health Provider
	Good Shepherd Hospital	Umatilla	OR	Health Care Provider
	Northeast Oregon Housing Authority	Union, Baker	OR	Housing Provider
	Elgin Health Center	Union	OR	Health Care Provider

The communities/counties the project serves:		
	Baker County	Union County
	Malheur County	Wallowa County
	Umatilla County	

The target population served:	Population	Yes	Population	Yes
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☐
	Elderly	☐	School-age children (teens)	☒
	Infants	☐	Uninsured	☐
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☒
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☒
	Coordination of Care Services	☒	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

Northeast Oregon Network (NEON) is strengthening and expanding an existing program called the Pathways Community Hub to include those that are misusing opioids or are at moderate to high risk of developing opioid misuse behaviors. The intervention used for the target population is to partner individuals that meet qualification standards with a Community Health Worker (CHW) to assess and address any social determinants of health barriers.

Identified barriers are addressed through linkages and warm handoffs with agencies capable of addressing the issues, such as social services providers or mental and health care providers. Participants in the program have a single point of contact, their assigned CHWs, to problem solve matters beyond their means to work through independently. Community Health Workers will also empower participants by building life-long skills to manage and address health-related issues.

Expected Outcomes:

This project will result in increased public awareness, increased Community Health Worker and care coordinator capacity to address opiate risks and addiction in the region, resource navigation, home visit, and referral services for 250 community members with Opiate Use Disorder or associated risk factors, and the integration of medication assessment protocols into care for at-risk community members. Over 3 years, the project will result in reduced opioid misuse and associated hospitalizations.

Evidence Based/ Promising Practice Model Being Used or Adapted:

This project utilizes the AHRQ Pathways Community Hub Model, with the integration of a validated tool titled the Opioid Risk Tool.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Cassie Phillips				
	Tel #:	(301) 945-3940				
	Email:	CPhillips1@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Deana Farmer				
	Tel #:	404-413-0299				
	Email:	dfarmer13@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Oregon

PeaceHealth

Grant Number:	D04RH31643					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	PeaceHealth				
	Address:	400 9th Street				
	City:	Florence	**State:**	Oregon	**Zip code:**	97439
	Tel #:	541-997-8412				
	Website:	Peacehealth.org				
Primary Contact Information:	**Name:**	Jason Hawkins				
	Title:	Chief Administrative Officer				
	Tel #:	541-997-8412				
	Email:	JHawkins2@peacehealth.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$199,996
	May 2019 to Apr 2020	$199,943
	May 2020 to Apr 2021	$199,921

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	PeaceHealth Peace Harbor Medical Center	Lane	OR	Critical Access Hospital (CAH)
	Mapleton School District	Lane	OR	School System
	Siuslaw School District	Lane	OR	School System
	Options Counseling & Family Services	Lane	OR	Behavioral Health
	The Child Center	Lane	OR	Behavioral Health
	Lane County Health & Human Services	Lane	OR	Public Health
	Trillium Community Health Plan	Lane	OR	Medicaid Managed Care Organization

The communities/counties the project serves:	Lane County, Oregon

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☐	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☒
	Elderly	☐	School-age children (teens)	☒
	Infants	☐	Uninsured	☒
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐

Aging	☐	Maternal/Women's Health	☐
Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
Children's Health	☒	Oral Health	☐
Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
Chronic Disease: Asthma/COPD	☐	School Health	☒
Community Health Workers /Promotoras	☐	Substance Abuse	☐
Coordination of Care Services	☒	Telehealth	☒
Emergency Medical Services	☐	Transportation to health services	☐
Health Education and Promotion	☒	Other: Click here to enter text.	☐
Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

A lack of child/adolescent behavioral health resources has significant impact on families in the proposed project service area. To address this issue, the Western Lane Behavioral Health Network (WLBHN) partners have collaborated on Community Health and Wellness Resource Centers on two school sites staffed by a health and wellness resource center coordinator and a licensed child/adolescent behavioral health specialist. The Center staff provide assessments and counseling services, emotional support, referrals, and a variety of social services interventions. This collaborative effort assures the integration of coordinated services and enhances family capacity and opportunity to manage their child/family behavioral health and decrease health, academic, and financial impacts of delayed or untreated child/adolescent behavioral health needs. Importantly, the Centers provide a home for outreach education and primary health prevention.

Expected Outcomes:

The further development of a sustainable network infrastructure will occur by continuing to build network operations, expanding, and maturing the network partnership for sustainability post HRSA grant. Improved service coordination will result from the implementation of health and wellness resource centers staffed by a coordinator that provides a focal point for children/families to receive assistance to navigate access to behavioral health and co-located wrap around services in a convenient, non-stigmatizing site. Child and adolescent behavioral health services will be expanded through the employment of qualified clinical staff; consultation of tele-psychiatry services; and offer of primary prevention, healthy parenting and other health and wellness education.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The Network has modeled their program on three promising practice models: The Family Resource Center (FRC) located in a rural Reedsport, Oregon since 1998; Oregon School Based Health Clinics Model; and the Health-e Schools telehealth model, created by the Center for Rural Health Innovation. These models will be adapted to incorporate improved proximity to the local school campuses, include warm referrals to Network provider organizations' behavioral health services, include telehealth capacity to enable telepsychiatry consults from out of area specialty providers, and provide information and support to patients and family for access and ease of navigation between behavioral health clinical and wrap-around services. The centers will be staffed by a local resource coordinator who will make warm referrals to social, health, behavioral health, and insurance navigation services.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Cassie Phillips, MPH				
	Tel #:	301-945-3940				
	Email:	Cphillips1@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Deana R Farmer				
	Tel #:	404-413-0314				
	Email:	dfarmer13@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Pennsylvania

Butler Healthcare Providers

Grant Number:	D04RH31771					
Organization Type:	Community Hospital					
Grantee Organization Information:	**Name:**	Butler Healthcare Providers				
	Address:	1 Hospital Way				
	City:	Butler	**State:**	Pennsylvania	**Zip code:**	16001
	Tel #:	(724) 283-6666				
	Website:	https://www.butlerhealthsystem.org/				
Primary Contact Information:	**Name:**	Erin Stewart				
	Title:	Program Manager				
	Tel #:	724-284-4414				
	Email:	Erin.Stewart@butlerhealthsystem.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Butler Healthcare Providers/DBA Butler Memorial Hospital	Butler	PA	Community Hospital
	Clarion Hospital	Clarion	PA	Community Hospital
	Indiana Regional Medical Center	Indiana	PA	Community Hospital
	Punxsutawney Area Hospital	Punxsutawney	PA	Community Hospital
	Butler Medical Providers	Butler	PA	Provider Group
	Clarion Hospital Employed Physician Practices	Clarion	PA	Provider Group
	Indiana Regional Medical Center Physician Group	Indiana	PA	Provider Group
	Butler County Area Agency on Aging	Butler	PA	Community Organization
	Clarion County Area on Aging	Clarion	PA	Community Organization
	Aging Services, Inc. Indiana County	Indiana	PA	Community Organization
	Jefferson County Area Agency on Aging	Brookville	PA	Community Organization
	Concordia Community Support Services	Cabot	PA	Home Health Agency
	Visiting Nurse Association of Indiana County	Indiana	PA	Home Health Agency
	Clarion Forest, Visiting Nurses Association	Clarion	PA	Home Health Agency

	Punxsutawney Home Health		Punxsutawney	PA	Home Health Agency
The communities/counties the project serves:	Butler County Clarion County		Indiana County Jefferson County		

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☒	Pregnant Women	☐
	Caucasians	☒	School-age children (elementary)	☐
	Elderly	☒	School-age children (teens)	☐
	Infants	☐	Uninsured	☒
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☒	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☒	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☒	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☐
	Coordination of Care Services	☒	Telehealth	☒
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The goal of the Regional Alliance Chronic Disease Coordination and Management program is to improve the health and well-being of rural patients' living with two or more chronic diseases by maximizing the coordination and adherence of appropriate health care resources. The primary objectives of this program are the following: 1) Improve coordination, communication and adherence of patient-centered care plans by providing a comprehensive care management program which incorporates a care management tracking software and an easy to use telehealth interface for home use; 2)Improve patient health outcomes related to chronic disease through linkages to chronic disease self-management education and lifestyle coaching services; and 3)Reduce inappropriate utilization of healthcare resources associated with chronic disease. These objectives will be achieved through the implantation of an evidence based care management program that follows patients from inpatient care through care transitions until they have reached a level of self-sufficiency in their home settings.

Expected Outcomes:

The expected outcomes include improved adherence with patient care plans as a function of care management support; reduced readmission rates and hospital/emergency room utilization rates; improved visits with PCP and or specialty care within 7 days post discharge; best practice manual medication reconciliation during care transitions to reduce medication errors; and improved patient safety.

Evidence Based/ Promising Practice Model Being Used or Adapted:						
The program is implementing the following evidence based/promising practice models: chronic disease self-management education (CDSME), motivational interviewing, and an adaptation of the Intensive Outpatient Care Program (IOCP) from the California Quality Collaborative.						
Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Sara Afayee				
	Tel #:	301-945-4169				
	Email:	SAfayee@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	John Butts				
	Tel #:	404-413-0314				
	Email:	jbutts@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

South Dakota

University of South Dakota

Grant Number:	D04RH31802					
Organization Type:	University					
Grantee Organization Information:	**Name:**	University of South Dakota				
	Address:	414 East Clark East Hall 120				
	City:	Vermillion	**State:**	South Dakota	**Zip code:**	57069
	Tel #:	605-658-5959				
	Website:	www.usd.edu/dh				
Primary Contact Information:	**Name:**	Ann Brunick				
	Title:	Project Director/Chair of The Department of Dental Hygiene				
	Tel #:	605-658-5964				
	Email:	Ann.Brunick@usd.edu				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	The Center	Yankton	SD	Senior Center
	Centerville Senior Center	Turner	SD	Senior Center
	Beresford Senior Center	Lincoln	SD	Senior Center
	Avera Sister James Majestic Bluffs	Yankton	SD	Nursing Home
	Alcester Care and Rehab	Union	SD	Nursing Home
	Centerville Care and Rehab	Turner	SD	Nursing Home
	Alcester-Hudson School	Union	SD	School
	Elk Point-Jefferson School	Union	SD	School
	Avon School	Bon Homme	SD	School
	Emery-Bridgewater School	Hanson/McCook	SD	School
	Marty Indian School	Charles Mix	SD	School
	Tripp-Delmont School	Hutchinson	SD	School
	Avera Sister James Hospital	Yankton	SD	Hospital

The communities/counties the project serves:		
	Bon Homme	Charles Mix
	Hanson	Hutchinson
	Lincoln	McCook
	Turner	Union
	Yankton	

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☒
	African Americans	☒	Pregnant Women	☐
	Caucasians	☒	School-age children (elementary)	☒
	Elderly	☒	School-age children (teens)	☒
	Infants	☐	Uninsured	☒
	Latinos	☒	Other: Veterans	☒
	Native Americans	☒	Other: Patients in the ICU	☒

	Pacific Islanders	☒	Other: Click here to enter text.	☐

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☒
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☐
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The University of South Dakota Rural Dental Health Service Program will provide evidence-based oral health services to rural low-income, Medicaid-eligible, uninsured or immobile high-risk children, senior citizens, Veterans and to ventilated and non-ventilated patients in the hospital ICU. The Rural Health Service Program will provide dental services through use of portable dental equipment. These services include dental screenings, dental exams, fluoride varnish, dental cleanings, x-rays, dental sealants, oral cancer screenings, oral prosthesis adjustments/relines, limited restorative procedures, as well as oral health, tobacco, and nutritional education. In the hospital, oral debridement, disinfection and screening will be provided to ventilated and non-ventilated patients in the ICU. All individuals will be referred to dental providers within their communities if they do not have a dental home.

Expected Outcomes:

The primary objectives of the Rural Dental Health Service Program are to: 1) provide dental services to high-risk children, senior citizens, and Veterans who are low-income, Medicaid-eligible, uninsured or immobile living in the targeted rural communities who have limited or no access to dental care with no dental home; 2) provide evidence-based oral care to ventilated and non-ventilated patients in the ICU with the hopes of improving the patients overall health and promoting shorter hospital stays.

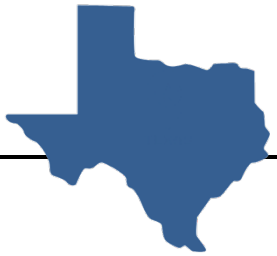
Evidence Based/ Promising Practice Model Being Used or Adapted:

The school-based portion of this grant uses the following evidence-based models: School-based Dental Sealant Program, Preventing Dental Caries: School-Based Dental Sealant Delivery Program, and the Comprehensive School-Based Program Innovation Model. The evidence-based models used for the senior citizens and Veterans are Elder Smiles (to be modified when used in the senior centers) and Patient Aligned Care Team. The evidence-based models used for patients in the ICU are the Bedside Oral Exam and the Barrow Oral Care Protocol.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Meriam Mikre				
	Tel #:	301-945-3110				
	Email:	MMikre@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Tamanna Patel				
	Tel #:	404-413-0314				
	Email:	tpatel25@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Texas

Plainview Foundation For Rural Health Advancement, Inc.



Grant Number:	D04RH31793					
Organization Type:	Community Based 501©3 Organization					
Grantee Organization Information:	**Name:**	Plainview Foundation For Rural Health Advancement, Inc.				
	Address:	P.O. Box 727, 705 Second Street				
	City:	Hart	**State:**	Texas	**Zip code:**	79043
	Tel #:	806-937-0014				
	Website:	www.plainviewfoundation.org				
Primary Contact Information:	**Name:**	Retta Knox				
	Title:	Executive Director				
	Tel #:	806-937-0014				
	Email:	rettaknox@gmail.com				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Plainview Foundation for Rural Health Advancement		TX	Community nonprofit organization
	Texas Tech Health Science Center Department of Pediatrics		TX	Medical school
	Dr. Kevin Pope, DDS		TX	Dental practice
	Nelson Counseling		TX	Community mental health provider
	Hart Independent School District		TX	School district

The communities/counties the project serves:	Briscoe, Castro, Hall, Lamb, Parmer, and Swisher Counties in the Texas Panhandle

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☒
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☒
	Elderly	☐	School-age children (teens)	☒
	Infants	☐	Uninsured	☒
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐

	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☒
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☐
	Coordination of Care Services	☒	Telehealth	☒
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The focus area of this project is the integration and coordination of care including oral health delivery, mental health services, and primary/preventive medical care. This includes several disease specific modules including weight management (focus on childhood obesity), diabetes management, asthma management and cardiovascular risk factor evaluation and intervention. The education and coordination are enhanced with the utilization of Community Health Workers working with the clinic professional staff to address the needs of the targeted clients.

Expected Outcomes:

The expected outcomes are the stability and enhancement of existing services and increased access to total comprehensive medical/dental /mental health services to an underserved area and rural/low-socioeconomic population. The coordination of services and implementation of Community Health Workers are expected to impact the effectiveness of health services to change health-related lifestyle choices.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The evidence-based/promising practice models being adapted to deliver services are: Donabedian's Quality Framework utilizing the Rural Care Coordination toolkit adapting the model type in the Community Health Workers Model for Care Coordination – A Promising Practice for Frontier Communities; the Service Integration toolkit with the Technology and Telehealth Model; a School Based Health Center Model for delivery of dental services with a modification to accept clients of all ages while located on a school campus and serving children as first propriety; and Primary Care – Behavioral Health Integration Model Reverse Co-location with an adaptation for school-based and telemedicine services.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Michele Pray Gibson				
	Tel #:	301- 443-7320				
	Email:	mgibson@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	John Shoemaker				
	Tel #:	404-413-0314				
	Email:	TA@jasmph.com				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Vermont

Bi-State Primary Care Association, Inc.

Grant Number:	D04RH31631					
Organization Type:	Primary Care Association					
Grantee Organization Information:	**Name:**	Bi-State Primary Care Association, Inc.				
	Address:	61 Elm Street				
	City:	Montpelier	**State:**	Vermont	**Zip code:**	05602
	Tel #:	802-229-0002				
	Website:	https://bistatepca.org/				
Primary Contact Information:	**Name:**	Kate Simmons				
	Title:	Director, Operations				
	Tel #:	802-229-0002 ext. 217				
	Email:	Kate Simmons <ksimmons@bistatepca.org>				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$199,997
	May 2019 to Apr 2020	$199,979
	May 2020 to Apr 2021	$199,999

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	University of Vermont Extension*	Chittenden	VT	Extension Service
	Open Door Clinic*	Addison	VT	Free Clinic
	Vermont Care Partners*	Washington	VT	Provider Network

The communities/counties the project serves:		
	Addison	Bennington
	Caledonia	Chittenden
	Essex	Franklin
	Grand Isle	Lamoille
	Orange	Orleans
	Rutland	Washington
	Windham	Winsor

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☐
	Elderly	☐	School-age children (teens)	☐
	Infants	☐	Uninsured	☒
	Latinos	☐	Other: Immigrant farmworkers and their families	☒
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☒
	Children's Health	☐	Oral Health	☐

	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☐
	Coordination of Care Services	☒	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

Bridges to Health is a statewide care coordination program for immigrant farmworkers and their families. Through consortium collaboration, the program will work strategically to ensure appropriate and accessible health care and mental health services for immigrant dairy workers. Open Door Clinic (ODC) and UVM Extension will enhance existing outreach services to include a focus on mental/behavioral health. Outreach staff will screen immigrant farmworkers to identify mental health care needs. Non-clinical needs will be addressed using motivational interviewing techniques that engage farmworkers around stress and anxiety reduction. A partnership with consortium member Vermont Care Network will improve access to clinical care through cultural awareness and sensitivity training of mental health care providers and collaborations to reduce barriers to care. Outreach staff will offer referrals and care coordination to farmworkers with physical, mental and emotional health care needs.

Expected Outcomes:

Increasing care coordination while decreasing barriers will result in more immigrant farmworkers accessing critical primary and mental/behavioral health care services, improving health outcomes and mental health status among clients with such needs, and avoiding unnecessary emergency room usage. The project will measure knowledge changes for outreach staff, providers, and farmworkers, and will collect objective data on accessibility. Changes in the target population's access to care will be evaluated through farmworker health access surveys and tracking quality improvement measures taken by health care access points as a result of project technical assistance.

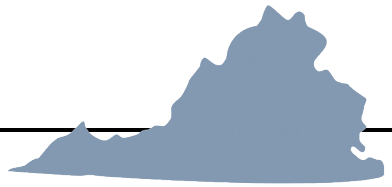
Evidence Based/ Promising Practice Model Being Used or Adapted:

Bridges to Health utilizes a modified "Promotora" or "Community Health Worker" model to reach the immigrant farmworker target population. This is a promising practice for Vermont, in which bilingual staff of local organizations incorporate health outreach into their existing employment positions. Recruiter/ Promoter positions created within UVM Extension and an Outreach Nurse position created at ODC enabled the consortium to utilize staff that is already respected and trusted within the target population, while at the same time maximizing outreach effectiveness and leveraging resources for both projects. This has been key in effectively reaching the hidden, isolated, and fearful population that is spread out over 175 farms statewide. On-farm health clinics and outreach visits liaised by UVM Extension Recruiter/Promoters and the ODC Outreach Nurse have been very successful in bridging the gap to primary health care services for the farmworker population. This promising practice is being enhanced by integrating a mental health component. The five regional Recruiter/Promoters in addition to the Outreach Nurse will be trained on mental health within the Latino community, mental health education topics, identifying and appropriately responding to mental health needs, motivational interviewing techniques, and strategies to address non-clinical (stress and anxiety) mental health needs. Outreach staff will apply the care coordination model they have used to successfully increase access to primary care services to increase access to mental health services for this highly vulnerable population.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Meriam Mikre				
	Tel #:	301-945-3110				
	Email:	MMikre@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Amanda Phillips Martinez				
	Tel #:	404-413-0314				
	Email:	aphillipsmartinez@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Virginia

Bay Rivers Telehealth Alliance



Grant Number:	D04RH31770					
Organization Type:	Non-Profit Telehealth Consortium					
Grantee Organization Information:	**Name:**	Bay Rivers Telehealth Alliance				
	Address:	618 Hospital Road				
	City:	Tappahannock	**State:**	Virginia	**Zip code:**	22560
	Tel #:	804-443-6286				
	Website:	www.bayriverstelehealth.org				
Primary Contact Information:	**Name:**	Donna Dittman Hale				
	Title:	Executive Director				
	Tel #:	804-443-6286				
	Email:	execdirector@bayriverstelehealth.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Bay Aging	Middlesex	VA	Agency on Aging
	Riverside Health System	Newport News	VA	Hospital System
	Middle Peninsula-Northern Neck Community Services Board (CSB)	Middlesex	VA	Behavioral Health
	Riverside Center for Excellence in Aging and Lifelong Health	Williamsburg	VA	Non-Profit

The communities/counties the project serves:		
	Essex	Middlesex
	King and Queen	Northumberland
	Lancaster	Westmoreland

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☒	Pregnant Women	☐
	Caucasians	☒	School-age children (elementary)	☐
	Elderly	☒	School-age children (teens)	☐
	Infants	☐	Uninsured	☐
	Latinos	☒	Other: Click here to enter text.	☐
	Native Americans	☒	Other: Click here to enter text.	☐
	Pacific Islanders	☒	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☒
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐

	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☒	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☒	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☐
	Coordination of Care Services	☐	Telehealth	☒
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Sustainability	☒
	Health Information Technology	☒	Other: Evaluation & Planning	☒

Description of the Project:

Bay Rivers Telehealth Alliance (BRTA) is implementing a rural health care services outreach project, *Bridges to Cardiovascular Population Health,* to address the health-related challenges of its service area, by deploying strategies to overcome the geographic and economic barriers faced by patients in these rural communities. *Bridges to Cardiovascular Population Health* addresses the goals of the Federal Office of Rural Health Policy's (FORHP) Outreach Program to expand the delivery of health care services in rural communities through a strong consortium using evidence-based models to improve population health and demonstrate health outcomes and sustainability. This program integrates remote patient monitoring, behavioral health and chronic disease self-management training in primary care physicians' offices, in a rural area that encompasses 1,447 square miles and serves a population of 78,653 individuals. The project's target service area is seven HRSA designated rural counties of the Middle Peninsula and Northern Neck, each of which is designated as a Medically Underserved Area (MUA) and a Health Professional Shortage Area (HPSA) for primary care and mental health.

Expected Outcomes:

Anticipated outcomes include: improved health status, reduced hospital admissions and ED usage, improved access to health services, reduced cost of care delivery, improved integration and oversight of services with regional providers, as well as improved patient management of chronic conditions. The project will achieve sustainability as a result of the strenuous evaluation protocols measuring and evaluating the triple aim of cost, quality, and access to services; implementation of sustainability planning; working with managed care organizations; and patient awareness.

Evidence Based/ Promising Practice Model Being Used or Adapted:

BRTA, in a Consortium including three member organizations, is developing and implementing coordinated services using modified versions of the following evidence- based models of care: Essentia Health Heart and Vascular Center model of care (RPM for long-term cardiovascular care), Healthy IDEAS (behavioral health coaching for depression and anxiety), and the CDC-recognized Diabetes Education Program and the Stanford Model for chronic disease self-management training.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Michele Pray Gibson				
	Tel #:	301-443-7320				
	Email:	MPray@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	John Butts				
	Tel #:	404-413-0314				
	Email:	jbutts@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Virginia

Strength in Peers

Grant Number:	D04RH31799					
Organization Type:	Community-based, peer-run, nonprofit organization					
Grantee Organization Information:	**Name:**	Strength in Peers				
	Address:	9560 S Congress St				
	City:	New Market	**State:**	Virginia	**Zip code:**	22844
	Tel #:	540-217-0869				
	Website:	www.strengthinpeers.org				
Primary Contact Information:	**Name:**	Nicky Fadley				
	Title:	Project Director and Executive Director				
	Tel #:	540-217-0869				
	Email:	nicky@strengthinpeers.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Shenandoah County Free Clinic*	Shenandoah	VA	Free clinic
	Sinclair Health Clinic*	Frederick	VA	Free clinic
	Northwestern Community Services Board*	Warren	VA	Public behavioral health facility

The communities/counties the project serves:	
	Page County
	Shenandoah County

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☐
	Elderly	☐	School-age children (teens)	☐
	Infants	☐	Uninsured	☒
	Latinos	☐	Other: Lower income	☒
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐

	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☒
	Coordination of Care Services	☐	Telehealth	☒
	Emergency Medical Services	☐	Transportation to health services	☒
	Health Education and Promotion	☐	Other: Peer Support services	☒
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

Serving two rural counties in northwestern Virginia, the goal of the project is to increase access to substance use services and achieve positive recovery outcomes for adults with substance use challenges in Shenandoah and Page County, Virginia. The project establishes a substance use program for uninsured and underinsured individuals who have incomes under 200% of the Federal Poverty Level. The program will provide four services: peer support, counseling, psychotropic prescribing services, and help in accessing higher levels of care. Services will be provided by a consortium of organizations: Strength In Peers, Shenandoah County Free Clinic (SCFC), Sinclair Health Clinic, and Northwestern Community Services Board (NWCSB). The project will develop and scale up the program, test outreach strategies, and support implementation until sustainability can be achieved.

Expected Outcomes:

The anticipated outcomes of the project are: a) improvements in participants' self-rating of their recovery progress; b) reductions in participants' use of illicit drugs and/or alcohol to intoxication; c) reductions in participants' symptoms of depression, symptoms of anxiety, and any mental health symptoms; d) reduction in the number of participants who receive inpatient and emergency room services; and, e) reduction in recidivism among participants.

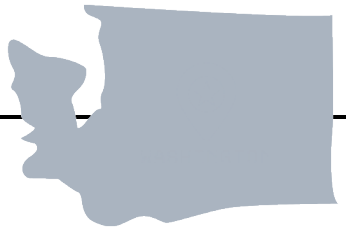
Evidence Based/ Promising Practice Model Being Used or Adapted:

Strength In Peers will provide peer support services following the evidence-based Consumer Operated Services Model. This model has a very large body of evidence showing that services facilitate recovery and reduce health care costs. These services will be provided by Peer Support Specialists (PSSs) who are in recovery from substance use disorders and are trained to help others. They provide peer mentoring, resource connecting, and recovery groups. The recovery groups provided will be evidence-based interventions. Wellness Recovery Action Plan is a group workshop to help people with mental health challenges manage their symptoms. Self-Management and Recovery Training (SMART) Recovery is a peer recovery group that is built on cognitive behavioral therapy and motivational interviewing practices. The program will complement peer support services with clinical treatment. SCFC will provide professional counseling and Sinclair Health Clinic will provide psychotropic medication management. NWCSB will collaborate with the program on referrals to its services for participants who need higher levels of care, including residential treatment and Medication Assisted Treatment for opiate dependence.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Meriam Mikre				
	Tel #:	301-945-9882				
	Email:	MMikre@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Amanda Phillips Martinez				
	Tel #:	404-413-0314				
	Email:	aphillipsmartinez@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Washington

Adams County Public Hospital District



Grant Number:	D04RH31628					
Organization Type:	Public Hospital District (PHD)/Hospital					
Grantee Organization Information:	**Name:**	Adams County Public Hospital District				
	Address:	903 South Adams Avenue				
	City:	Ritzville	**State:**	Washington	**Zip code:**	99169
	Tel #:	509-659-1200				
	Website:	http://www.earh.org				
Primary Contact Information:	**Name:**	Gary Bostrom				
	Title:	CEO/CFO				
	Tel #:	(509) 659-5402				
	Email:	gbostrom@earh.com				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$199,625
	May 2019 to Apr 2020	$199,875
	May 2020 to Apr 2021	$199,400

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Adams County Public Hospital District (PHD) No. 2 dba East Adams Rural Healthcare	Adams	WA	PHD/Hospital
	Grant County PHD No. 3 dba Columbia Basin Hospital	Grant	WA	PHD/Hospital
	Adams County PHD No. 3 dba Othello Community Hospital	Adams	WA	PHD/Hospital
	Lincoln County PHD No. 1 dba Odessa Memorial Healthcare	Lincoln	WA	PHD/Hospital
	Grant County PHD No. 1 dba Samaritan Healthcare	Grant	WA	PHD/Hospital

The communities/counties the project serves:		
	Ephrata, WA - Grant County	Othello, WA – Adams County
	Lind, WA – Adams County	Ritzville, WA – Adams County
	Marlin, WA – Grant County	Warden, WA – Grant County
	Moses Lake, WA – Grant County	Washtucna, WA – Adams County
	Odessa, WA – Lincoln County	

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☐
	Elderly	☒	School-age children (teens)	☐
	Infants	☐	Uninsured	☐
	Latinos	☒	Other: Population age 30-74 at risk for Cardiovascular Disease	☒
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☒	Integrated Systems of Care	☒
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☒	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☐
	Coordination of Care Services	☒	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the Project:

The Grand Columbia Health Alliance (GCHA) - including the five PHD consortium partners – is developing and utilizing standardized care delivery and data monitoring processes across the GCHA communities with the overarching goal of preventing cardiovascular disease and improving the quality of life for patients through prevention, detection, and treatment of risk factors for heart attack and stroke.

Because of the identified shortage of primary care providers and cardiologists in the service area, GCHA plans to modify the widely recognized evidence-based Collaborative Care Model (today used in behavioral health) to provide coaching and support to the primary care practices that will manage and support the cohort of patients age 30-74 at risk of developing cardiovascular disease (CVD). This model is combined with elements of the chronic care model and evidence-based community health worker models to ensure that the social determinants of health, health behaviors and clinical indicators that lead to CVD are identified and addressed in a comprehensive manner.

Expected Outcomes:

The expected outcomes of this program include specific improvements in health behaviors placing patients at risk for CVD health, reduction in the prevalence, incidence and severity of chronic illnesses and improvement in health status. From a larger delivery/policy perspective, expected outcomes include policy and reimbursement changes to support the project model's impact on population health, and costs of care and reduction in barriers to access.

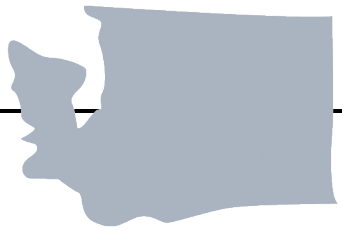
Evidence Based/ Promising Practice Model Being Used or Adapted:

Collaborative Care Model
Chronic Care Model
Community Health Worker Model

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Meriam Mikre				
	Tel #:	301-945-3110				
	Email:	MMikre@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Lisa McGarrie				
	Tel #:	404-413-0314				
	Email:	lmcgarrie@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Washington

Inspire Development Center



Grant Number:	D04RH31784					
Organization Type:	Head Start					
Grantee Organization Information:	**Name:**	Inspire Development Center				
	Address:	105 B South 6th Street				
	City:	Sunnyside	**State:**	WA	**Zip code:**	98944
	Tel #:	509-837-8909				
	Website:	www.inspirecenters.org				
Primary Contact Information:	**Name:**	Lori Charvet				
	Title:	Director of Programs				
	Tel #:	509-837-8909				
	Email:	Lori.charvet@inspire-centers.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Yakima Memorial Hospital	Yakima	WA	Hospital
	Catholic Charities Housing Services	Yakima	WA	Non Profit Housing

The communities/counties the project serves:	Yakima County:	Mabton
	Buena	Parker Heights
	Grandview	Sunnyside
	Granger	Toppenish

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☐	Pre-school children	☒
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☒
	Elderly	☐	School-age children (teens)	☒
	Infants	☐	Uninsured	☐
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☒	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐

	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☐
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the project:

The MEND program has been shown to be effective in improving consumption of healthful foods, regular physical activity, and healthy body weights in 26 peer-reviewed journal articles. The project purpose is to expand the delivery of nutrition and physical activity services in the rural Yakima County, Washington. This is done by providing the MEND 2-5 program in early care education centers. Providing the MEND 6-13 program, in housing developments. Providing other nutrition and physical activity programs in early care and education centers and housing developments. Provide nutrition and physical activity programs to families regardless of employment status, insurance status, or poverty level.

Expected Outcomes:

Improving from baseline the healthful food consumption, regular physical activity, and healthy body weights of families are expected outcomes of the project. The project goal is to improve the health of low-income, Hispanic/Latino, and/or agricultural worker families in rural Yakima County, Washington through the consumption of healthful foods, regular physical activity, and healthy body weights. The goal and objectives correlate to the health-related challenge of childhood obesity and associated contributing factors of lack of healthful food consumption and regular physical activity; and are measurable, realistic, and achievable in the specific timeframe.

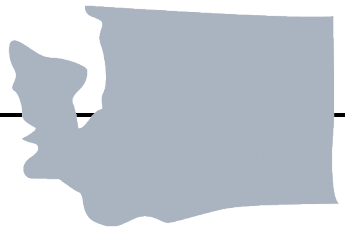
Evidence Based/ Promising Practice Model Being Used or Adapted:

MEND programs have been shown to be effective in improving consumption of healthful foods, regular physical activity, and healthy body weights in 26 peer-reviewed journal articles. In a randomized controlled trial of 201 children ages 2-4, Skouteris et al. (2016) found a significant increase in consumption of vegetables and significant decrease in consumption of simple carbohydrates in the intervention group compared to the control group. In an uncontrolled repeated measures design of 440 children ages 5-7, Smith et al. (2013) found a significant increase in consumption of fruits and vegetables, significant increase in physical activity, significant decrease in sedentary screen time, and significant improvement in healthy weight status in the intervention group. In a randomized controlled trial of 116 children ages 8-12, Sacher et al. (2010) found a significant improvement in healthy weight status in the intervention group compared to the control group; and a significant increase in physical activity and significant decrease in sedentary screen time in the intervention group.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Meriam Mikre				
	Tel #:	301-945-3110				
	Email:	MMikre@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Tamanna Patel				
	Tel #:	404-413-0314				
	Email:	tpatel25@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Washington

Spokane Tribal Network



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Grant Number:	D04RH31697					
Organization Type:	Non-Profit 501(c)(3)					
Grantee Organization Information:	**Name:**	Spokane Tribal Network				
	Address:	P O Box 390				
	City:	Wellpinit	**State:**	WA	**Zip code:**	99040
	Tel #:	509-258-4535 ext 04006				
	Website:	www.spokanetribalnetwork.org				
Primary Contact Information:	**Name:**	Penny Spencer				
	Title:	Network Director				
	Tel #:	509-258-4535 ext 04006				
	Email:	pennys@spokanetribalnetwork.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$199,473
	May 2019 to Apr 2020	$199,361
	May 2020 to Apr 2021	$199,852

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Wellpinit School District	Stevens	WA	School
	Indian Health Services-Wellpinit	Stevens	WA	Medical Clinic
	Spokane Tribal Business Council	Stevens	WA	Tribal Government
	Empire Health Foundation	Spokane	WA	Private Health Foundation
	National Native Children's Trauma Center	Missoula	MT	Training and Technical Assistance Center

The communities/counties the project serves:	Spokane Tribal Reservation (Stevens County, WA)	Wellpinit School District (Stevens County, WA)

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☒
	African Americans	☐	Pregnant Women	☐
	Caucasians	☒	School-age children (elementary)	☒
	Elderly	☒	School-age children (teens)	☒
	Infants	☐	Uninsured	☒
	Latinos	☐	Other: Families of K-12 students	☒
	Native Americans	☒	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐

	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☐
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Trauma Informed Training	☒
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the project:

Spokane Tribal Network (STN), and its consortium partners will develop the capacity to train, and then train individuals within the Wellpinit Schools, and health care providers with the Indian Health Service's David Wynecoop Clinic annually, to provide trauma-informed care. In addition, STN and the consortium will provide training to behavioral health providers with the Spokane Tribe of Indians Department of Health and Human Services in the provision of trauma-informed therapy.

Expected Outcomes:

Create a trauma informed community on tribal lands by training a minimum of 20 individuals within the Wellpinit School District as well as health care providers with the Indian Health Services' David Wynecoop Clinic with the expectation that services are provided to reduce trauma related disorders. Provide trauma informed therapy to 30 children in year 2 and 50 children in year 3, with the expectation of decreasing truancy and increasing self-reported health for youth and their caregivers. Provide a trauma training center servicing eight community partners with the expectation that service recipients incorporate and deliver trauma informed care within their job duties. The center will provide culturally appropriate training services and a trauma informed certificate to public health and education service providers and staff.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The evidence-based model(s)/promising practice(s) the project is using, which will be tailored for local Tribal culture in consultation with the National Native Children's Trauma Center (NNCTC) at the University of Montana (UM) draw upon the ideas and interventions of:

- Multi-Tiered Systems of Support (MTSS)
- Positive Behavior Instructional Support (PBIS)
- Adverse Childhood Experiences (ACE)
- Gathering of Native Americans (GONA)
- Medicine Wheel

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Michele Gibson				
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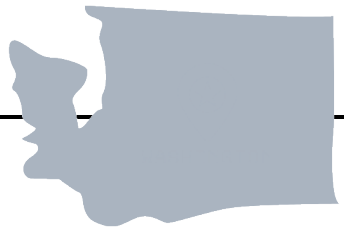
	Email:	mgibson@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	John Butts				
	Tel #:	404-413-0283				
	Email:	jbutts@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Washington

Yakima Valley Farmworkers Clinic



Grant Number:	DO4RH31803					
Organization Type:	Federally Qualified Health Center					
Grantee Organization Information:	**Name:**	Yakima Valley Farmworkers Clinic				
	Address:	510 West First Avenue				
	City:	Toppenish	**State:**	Washington	**Zip code:**	98948
	Tel #:	509-865-5898				
	Website:	www.yvfwc.org				
Primary Contact Information:	**Name:**	Linda Sellsted				
	Title:	Project Director				
	Tel #:	509-574-3207				
	Email:	lindas@yvfwc.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Yakima Valley Farm Workers Clinic	Yakima	WA	FQHC
	Virginia Mason Memorial Hospital	Yakima	WA	Non-profit Hospital
	Memorial Foundation	Yakima	WA	Nonprofit Community Foundation
	Comprehensive Healthcare	Yakima	WA	Nonprofit Community-based Behavioral Healthcare

The communities/counties the project serves: (list alphabetically)		
	Rural Yakima County:	Satus
	Buena	Sunnyside
	Grandview	Tampico
	Granger	Toppenish
	Mabton	White Swan
	Outlook	Zillah

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☐	Pre-school children	☒
	African Americans	☐	Pregnant Women	☐
	Caucasians	☒	School-age children (elementary)	☒
	Elderly	☐	School-age children (teens)	☒
	Infants	☒	Uninsured	☐
	Latinos	☒	Other: Click here to enter text.	☐
	Native Americans	☒	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☒	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☐
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Children with Special Health Care Needs	☒
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the project:

The project builds on the previous project by expanding Patient Navigation services (with addition of one FTE PN, for a total of two FTE PN) to serve 2,000 rural children referred to Children's Village (Regional Neurodevelopmental Center) for pediatric specialty care (cardiology, gastroenterology, neurology, orthopedics, developmental behavior evaluation), pediatric speech and language therapy, pediatric physical and occupational therapy, and mental health and nutrition counseling. In addition, a Public Health Nurse (PHN) will promote optimal child and family outcomes through care coordination and follow-up through nurse home visiting.

Expected Outcomes:

The expected outcomes are to: 1) To decrease persistent disparities in access and outcomes of rural Hispanic CSHCN and their families; 2) Overcome barriers to pediatric specialty care (cardiology, gastroenterology, neurology, orthopedics, developmental behavior evaluation), pediatric speech and language therapy, pediatric physical and occupational therapy, mental health and nutrition counseling for underserved CSHCN in rural areas; 3) Facilitate timely access to pediatric specialty care, pediatric speech and language therapy, pediatric physical and occupational therapy, mental health and nutrition counseling for underserved rural CSHCN who are referred; and 4) Improve coordination of care along the healthcare continuum including health, education, social service, and public health to provide comprehensive and coordinated care for rural CSHCN.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Dr. Harold Freeman's Patient Navigator program is a nationally recognized, evidence-based best practice designed to improve cancer outcomes in vulnerable populations by eliminating barriers to timely screening, diagnosis, and treatment. Promising Practice: **CaCoon**, a CSHCN nurse home visiting, care coordination program developed in Oregon State and operating in most Oregon counties for over 20 years.

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Meriam Mikre				
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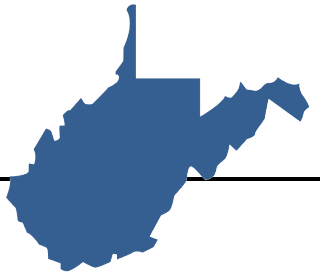
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Hailey Reid				
	Tel #:	404-413-0314				
	Email:	hreid3@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

West Virginia

Community Care of West Virginia



Grant Number:	D04RH31773					
Organization Type:	Federally Qualified Health Center					
Grantee Organization Information:	**Name:**	Community Care of West Virginia				
	Address:	PO Box 217				
	City:	Rock Cave	**State:**	West Virginia	**Zip code:**	26234
	Tel #:	304-924-6262				
	Website:	www.ccwv.org				
Primary Contact Information:	**Name:**	Christina Walker				
	Title:	Senior Project Manager				
	Tel #:	304-881-1190				
	Email:	Kristi.walker@ccwv.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Paxis Institute		AR	Private
	Upshur County Schools	Upshur	WV	School System
	Clay County Schools	Clay	WV	School System
	Lewis County Schools	Lewis	WV	School System

The communities/counties the project serves:		
	Clay County, WV	Upshur County, WV
	Lewis County, WV	

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☐	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☒
	Elderly	☐	School-age children (teens)	☐
	Infants	☐	Uninsured	☐
	Latinos	☐	Other: Teachers	☒
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☒	Health Professions Recruitment and Retention/Workforce Development	☒
	Access: Specialty Care	☐	Integrated Systems of Care	☒
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☒	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☒

	Chronic Disease: Asthma/COPD	☐	School Health	☒
	Community Health Workers /Promotoras	☐	Substance Abuse	☒
	Coordination of Care Services	☒	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☒	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the project:

This project will implement the PAX Good Behavior Game in the three target counties of Clay, Lewis and Upshur in West Virginia. By implementing this program in classrooms K-2 children will be taught coping skills that will assist them in their daily lives and also identify children that could need further assistance through behavioral health, primary care, substance abuse and home situations. Equipping classroom teachers with the single most effective classroom-based universal preventive intervention (PAX GBG) proven to decrease mental, emotional, & behavioral disorders and associated negative outcomes and training school-based clinicians to support them in a public health approach will dramatically increase access to behavioral health strategies for all children and improve the health and future for the people of West Virginia.

Expected Outcomes:

This project targets elementary students in three counties to reduce and prevent multiple proximal mental, emotional, and behavioral disorders that can have costly, lifetime consequences for the children, communities and health care. Prevalence of mental, emotional, behavioral and related physical disorders of West Virginia children are typically similar or higher than the rest of the United States, according to Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: West Virginia, 2015*. In our particular service area, the needs of children are significantly worse because of negative impact of the opiate epidemic, resulting child removals, and exceedingly sparse resources available in terms of time, distance and transportation in this mountainous, Appalachian rural setting. Transportation alone of children to treatment or transportation of clinicians to settings for effective mental-health treatment is unlikely to be effective or feasible. Thus, a cost-effective or intervention preventive strategy that can be embedded in normal school activities would meet the needs of our settings in several ways: 1) preventing these diagnoses in the first instance, 2) up-scaling the skills of existing on-site personnel (e.g. administrators, nurses, and other school staff) to support teachers' use of a powerful evidence-based prevention strategy, and 3) increasing the efficacy of scarce tiered intervention or treatment strategies or personnel (e.g. psychiatrists, psychologists, and clinical social workers).

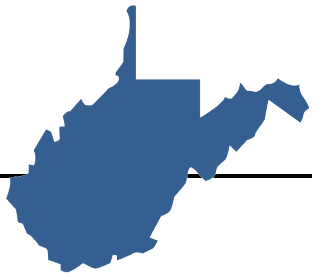
Evidence Based/ Promising Practice Model Being Used or Adapted:

Our evidence-based practice model is specifically named by the SAMSHA's National Registry of Evidence-Based Practices, hgttp://nrepp.samhsa.gov/. It is the PAX Good Behavior Game, which is presently the only scientifically proven elementary-school program explicitly documented to reduce lifetime risk of opiate addiction specifically (Furr-Holden, Ialongo et al. 2004), using the highest standards of prevention science (Flay, Biglan et al. 2005, Gottfredson, Cook et al. 2015).

Federal Office of Rural Health Policy Project Officer (PO):	**Name:**	Michele Pray Gibson				
	Tel #:	301-443-7320				
	Email:	MPray@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Hailey Reid				
	Tel #:	404-413-0314				
	Email:	hreid3@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

West Virginia

Rural Health Access Corporation



Grant Number:	D04RH31796					
Organization Type:	Rural Health Clinic					
Grantee Organization Information:	**Name:**	Rural Health Access Corporation				
	Address:	386 Airport Road				
	City:	Chapmanville	**State:**	West Virginia	**Zip code:**	25508
	Tel #:	304-855-1200				
	Website:	www.coalfieldhealth.com				
Primary Contact Information:	**Name:**	Kristin Dials				
	Title:	Executive Director				
	Tel #:	304-855-1228				
	Email:	Chambers3@marshall.edu				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000
	May 2019 to Apr 2020	$200,000
	May 2020 to Apr 2021	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	West Virginia Health Right	Kanawha	WV	Free Health Clinic
	Roane General Hospital	Roane	WV	Hospital
	Welch Community Hospital	McDowell	WV	Hospital
	Charleston Area Medical Center-Ryan White	Kanawha	WV	Hospital

The communities/counties the project serves:		
	Logan County, West Virginia	Roane County, West Virginia
	McDowell County, West Virginia	Wyoming County, West Virginia
	Mingo County, West Virginia	

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☐
	Elderly	☐	School-age children (teens)	☐
	Infants	☐	Uninsured	☐
	Latinos	☐	Other: Click here to enter text.	☐
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☒	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☐

	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☐	Substance Abuse	☒
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the project:

The project will be a collaborative effort to raise awareness and merits of Harm Reduction and to expand Harm Reduction services throughout the consortium area. Consortium members will work to provide a comprehensive harm reduction program to the rural communities in the consortium area and to provide outreach activities to educate and increase awareness of the harm reduction program.

Expected Outcomes:

The expected outcomes of the program will be to reduce the rate of opioid induced overdose deaths by 20%, reduce drug related infection rates of Hepatitis C by 20% and to increase the awareness and understanding of harm reduction programs.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The project will be based on the evidence-based practice models of: West Virginia Screening Brief Intervention and Referral to Treatment Program (WV SBIRT) and the National Harm Reduction Coalition.

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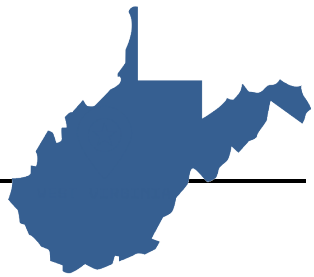
	Email:	MMikre@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Tamanna Patel				
	Tel #:	404-413-0314				
	Email:	tpatel25@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

West Virginia

Williamson Health and Wellness



Grant Number:	D04RH31652					
Organization Type:	Federally Qualified Health Center					
Grantee Organization Information:	**Name:**	Williamson Health and Wellness				
	Address:	PO Box 2080				
	City:	Williamson	**State:**	WV	**Zip code:**	25661
	Tel #:	304-235-3400				
	Website:	www.williamsonhealthwellness.com				
Primary Contact Information:	**Name:**	Jennifer Hudson				
	Title:	Development Director				
	Tel #:	304-928-1704				
	Email:	jhudson@williamsonhealthwellness.com				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2018 to Apr 2019	$200,000.00
	May 2019 to Apr 2020	$200,000.00
	May 2020 to Apr 2021	$200,000.00

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Appalachian Regional Hospital*	Pike	KY	Hospital
	American Heart Association		WV	Social Service
	My Mobile Market	Mingo	WV	Food Distribution
	Marshall University		WV	University

The communities/counties the project serves:	Mingo County, WV	Pike County, KY

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pre-school children	☐
	African Americans	☐	Pregnant Women	☐
	Caucasians	☐	School-age children (elementary)	☐
	Elderly	☐	School-age children (teens)	☐
	Infants	☐	Uninsured	☐
	Latinos	☐	Other: At risk for Cardiovascular Disease	☒
	Native Americans	☐	Other: Click here to enter text.	☐
	Pacific Islanders	☐	Other: Click here to enter text.	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Access: Specialty Care	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐
	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☒	Pharmacy Assistance	☐
	Chronic Disease: Diabetes	☐	Physical Fitness and Nutrition	☒

	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☐
	Coordination of Care Services	☒	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	Health Education and Promotion	☐	Other: Click here to enter text.	☐
	Health Information Technology	☐	Other: Click here to enter text.	☐

Description of the project:

The Healthy Lives, Healthy Hearts community health worker model aims to advance an integrated health care delivery system that focuses on cardiovascular disease prevention. The program will implement an evidence-based model for cardiovascular disease intervention by engaging community health workers. Other activities will include referrals for diverse community activities including Rx Veggies, cooking classes, and physical activity programs. WHWC will utilize the CDC's Heart Age Calculator as a key measurement tool to assess cardiovascular disease risk reduction and health outcome improvements. We will engage health insurance payers for Community Health Worker (CHW) model reimbursements.

Expected Outcomes:

A CHW care coordination model is fully integrated into the Williamson Health and Wellness service delivery model.

Establish third party pay-for-performance and reimbursement for CHW services.

Decrease the rates of cardiovascular disease in Mingo County, WV.

Evidence Based/ Promising Practice Model Being Used or Adapted:

CHW model for cardiac disease prevention

Walk With Ease: The Centers for Disease Control and Prevention promotes an evidence-based physical activity model, **Walk with Ease**, to increase physical activity as a method for reducing heart disease. CDC recommends Walk with Ease as "proven to improve the quality of life of people with arthritis. Scientific studies have shown that physical activity can reduce pain, improve function, mood, and quality of life for adults with arthritis. Physical activity also can help manage other chronic conditions that are common among adults with arthritis, such as diabetes, heart disease, and obesity and can improve overall health and wellbeing." The Walk with Ease is a community-based walking program developed by the Arthritis Foundation.

American Heart Association Cooking Classes: Cooking classes teach participants to cook heart healthy meals using fresh and easy-to-find ingredients.

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	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant's Contact Information:	**Name:**	Amanda Phillips Martinez				
	Tel #:	404-413-0314				
	Email:	aphillipsmartinez@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303