Rural Health Care Coordination Program

GRANTEE DIRECTORY 2020

JANUARY 2021

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

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Introduction

Care coordination is defined as "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services".[1] Care coordination should create smooth transitions and continuity of care for patients who interact with various providers and services and allows for holistic patient care and patient engagement in the management of their health and health care. [2] Rural Americans have generally poorer health outcomes compared to their urban counterparts and have higher rates of avoidable or excess mortality from some of the leading causes of death (cancer, heart disease, injury and respiratory disease).[3] Local health care may not be available or easily accessible in geographically isolated rural community, and rates of uninsurance are often higher in rural communities.

In Fiscal Year 2020, the Federal Office of Rural Health Policy funded ten rural health awardees through the Rural Health Care Coordination Program. This program is authorized by Section 330A(e) of the Public Health Service (PHS) Act (42 U.S.C. 254c(e)), as amended. The purpose of this program is to support rural health consortiums/networks aiming to achieving the overall goals of improving access, delivery, and quality of care through the application of care coordination strategies in rural communities. Awardees will focus on four key strategies:

- Collaboration: Utilizing a collaborative approach to coordinate and deliver health care services through a consortium, in which member organizations actively engage in integrated, coordinated, patient-centered delivery of health care services.
- Leadership and Workforce: Developing and strengthening a highly skilled care coordination workforce to respond to vulnerable populations' unmet needs within the rural communities.
- Improved Outcomes: Expanding access and improving care quality and delivery, and health outcomes through evidence-based model and/or promising practices tailored to meet the local populations' needs.
- Sustainability: Developing and strengthening care coordination program's financial sustainability by establishing effective revenue sources such as expanded service reimbursement, resource sharing, and/or contributions from partners at the community, county, regional, and state levels.

This Directory provides contact information and an overview of the rural health care coordination initiatives funded through Rural Health Care Coordination Program in the 2020-2023 funding cycle. Awardee profiles include information on the project partners, the focus area and targeted populations for care coordination initiatives and, if relevant, the health information technology (e.g., Electronic Medical Records, Health Information Exchanges, Care coordination platforms) leveraged to support the project. Each profile details strategies to improve the quality and coordination of care, including training and integrating care coordination professionals onto care teams, reorganizing and integrating service (e.g., co-locating primary care and mental health services), and expanding access to and quality of care through adaptation of service delivery models like telehealth.

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[1] Agency for Healthcare Research and Quality. (2014). Chapter 2. What is Care Coordination? Available at: https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/chapter2.html.

[2] Stanek M, Hanlon C, Shiras T. (2014). Realizing Rural Care Coordination: Considerations and Action Steps for State Policy-Makers. Robert Wood Johnson Foundation. Available at: https://www.shvs.org/wpcontent/uploads/2014/04/RWJF_SHVS_Realizing-Rural-Care-Coordination.pdf

[3] 4 Moy E, Garcia MC, Bastian B, et al. Leading Causes of Death in Nonmetropolitan and Metropolitan Areas — United States, 1999–2014. MMWR Surveill Summ 2017. Available at: https://www.cdc.gov/mmwr/volumes/66/ss/ss6601a1.htm

Grantees by State

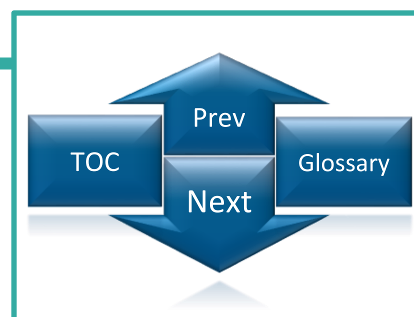
State	Grant Organization Name
Arkansas	Arkansas Behavioral Health Integration Network
Arkansas	Arkansas Rural Health Partnership
Indiana	Indiana Rural Health Association
Michigan	Upper Peninsula Health Care Solutions Inc.
Montana	Rural Health Development Inc.
New Mexico	El Centro Family Health
New York	Champlain Valley Physicians Hospital Medical Center
New York & Vermont	Finger Lakes Migrant Health Care
Washington	Kittitas County Health Network
Washington	San Juan County Public Hospital District 1

Grantees by Grant Organization Name

Grant Organization Name	State
Arkansas Behavioral Health Integration Network	Arkansas
Arkansas Rural Health Partnership	Arkansas
Champlain Valley Physicians Hospital Medical Center	New York
El Centro Family Health	New Mexico
Finger Lakes Migrant Health Care	New York & Vermont
Indiana Rural Health Association	Indiana
Kittitas County Health Network	Washington
Rural Health Development Inc.	Montana
San Juan County Public Hospital District 1	Washington
Upper Peninsula Health Care Solutions Inc.	Michigan

Grantee Profiles

Arkansas



Arkansas Behavioral Health Integration Network

Grant No.:	D78RH39346				
Organization type:	Nonprofit network				
Grantee Organization Information:	**Name:**	Arkansas Behavioral Health Integration Network (ABHIN)			
	Address:	8455 Edgemont Road			
	City:	Greers Ferry	**State:** Arkansas	**Zip Code:**	72067
	Tel No.:	479-871-3611			
	Website:	www.abhinetwork.org			
Primary Contact Information:	**Name:**	Kim Shuler			
	Title:	CEO			
	Tel No.:	479-871-3611			
	Email:	kim.shuler@abhinetwork.org			

Expected Funding Level for Each Budget Period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Sep 2020 to Aug 2021	$250,000
	Sep 2021 to Aug 2022	$250,000
	Sep 2022 to Aug 2023	$250,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organization Type**
	Boston Mountain Rural Health Center	Searcy	AR	FQHC
	PrimeCare	White	AR	Private
	North Hills Primary Care	Pulaski	AR	Private
	Arkansas Primary Care Clinic	Pulaski	AR	Private
	Cornerstone Whole Healthcare Organization	Payette	ID	Rural nonprofit

Counties the Project Serves:		
	Boone	Ouachita
	Carroll	Searcy
	Madison	Stone
	Marion	VanBuren
	Newton	White

Target Population Served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pacific Islanders	☒
	African Americans	☒	Preschool children	☐
	Caucasians	☒	Pregnant women	☒
	Elderly	☒	School-age children (elementary)	☒
	Infants	☐	School-age children (teens)	☒
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐

Focus Areas of Grant Program:	Focus Area	Yes	Focus Area	Yes
	Access: Primary care	☒	Health information technology	☐
	Access: Specialty care	☐	Health professions recruitment and retention/workforce development	☐
	Aging	☐	Integrated systems of care	☒
	Behavioral/mental health	☒	Maternal/women's health	☐
	Children's health	☐	Migrant farm worker health	☐
	Chronic disease: Cardiovascular	☐	Oral health	☐
	Chronic disease: Diabetes	☐	Pharmacy assistance	☐
	Chronic disease: Asthma/COPD	☐	Physical fitness and nutrition	☐
	Community health workers/promotores	☐	School health	☐
	Coordination of care services	☐	Substance abuse	☐
	Emergency medical services	☐	Telehealth	☐
	Health education and promotion	☐	Transportation to health services	☐

Health Information Technology System(s):	N/A

Project Goals and Objectives:	Goal/Objective	Description
	Goal	Collaboration: Convene the Arkansas Lives Network of Care (ALiNC) consortium and add membership based on care coordination and referral needs for ALiNC clinic patients.
	Goal	Leadership and Workforce: Develop capacity to assist staff at participating clinics and partner agencies in better identifying and responding to suicide risk.
	Goal	Improved Outcomes: Enhance appropriate access to care for patients with identified suicide risk, reduce suicide completion, improve provider skill and confidence in managing suicide, risk and reduce cost of care.
	Goal	Sustainability: Sustain ALiNC and replicate model across rural sites in Arkansas.

Project Description:

The Arkansas Lives Network of Care is dedicated to reducing the burden of suicidal ideation and completion through increasing the capacity of primary care to respond and connect patients to resources in rural communities across the state. The ALiNC consortium will include the Arkansas Behavioral Health Integration Network (ABHIN), Cornerstone Whole Healthcare Organization (C-WHO), Alleviant, Boston Mountain Regional Health, Arkansas Primary Care Clinic, North Hill Family Clinic, and PrimeCare Medical Clinic. These agencies will work together to enhance the ability of primary care practices to identify and manage suicide risk through a linked network of care. Primary care is often at the front lines of preventing suicide but lacks the training and resources to consistently and confidently respond to moderate to high-risk patients. As a result, the consortium, anchored by ABHIN, will collaboratively develop and implement strategies to empower and resource practices in management of these patients and thereby prevent deaths by suicide.

Evidence-Based/Promising Practice Model Being Used or Adapted:

The following models were referenced in the development of the ALiNC project: FirstLink Suicide Follow-Up Program, Regional Behavioral Health Network, and the Healthy Outcomes Integration Team. These approaches have been tailored to the ALiNC proposal by targeting initiation of encounters through primary care instead of through the suicide hotline, identifying opportunities for 24/7 support instead of creating a new resource and focusing specifically on care coordination resources related to suicide.

Expected Outcomes:

<table>
<tr><td colspan="7">The expected outcomes from our care coordination activities include reduced suicide completion rate among rural Arkansas residents, improved access to care related to suicide risk management, improved provider satisfaction and confidence in high-risk behavioral health patient management, increased quality of care (utilization of screeners, shared standard of care among various providers and organizations, patient referral communication), enhanced access to timely and appropriate triage and treatment information for providers, enhanced utilization of nonclinical community resources, enhanced safety of care, and increased collaboration among ALiNC clinics and partners in other domains.</td></tr>
<tr><td rowspan="5">Project Officer (PO) Contact Information:</td><td>Name:</td><td colspan="5">Mew Pongsiri</td></tr>
<tr><td>Tel No.:</td><td colspan="5">301-443-2752</td></tr>
<tr><td>Email:</td><td colspan="5">kpongsiri@hrsa.gov</td></tr>
<tr><td>Organization:</td><td colspan="5">Federal Office of Rural Health Policy</td></tr>
<tr><td>City:</td><td>Rockville</td><td>State:</td><td>Maryland</td><td>Zip Code:</td><td>20857</td></tr>
<tr><td rowspan="5">Technical Assistance (TA) Consultant Contact Information:</td><td>Name:</td><td colspan="5">Aliza Petiwala</td></tr>
<tr><td>Tel No.:</td><td colspan="5">404-413-0314</td></tr>
<tr><td>Email:</td><td colspan="5">apetiwala@gsu.edu</td></tr>
<tr><td>Organization:</td><td colspan="5">Georgia Health Policy Center</td></tr>
<tr><td>City:</td><td>Atlanta</td><td>State:</td><td>Georgia</td><td>Zip Code:</td><td>30303</td></tr>
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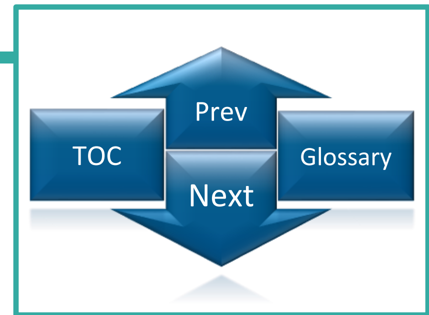

Arkansas

Arkansas Rural Health Partnership

<table>
<tr><td>Grant No.:</td><td colspan="6">D78RH39347</td></tr>
<tr><td>Organization type:</td><td colspan="6">Nonprofit regional collaborative</td></tr>
<tr><td rowspan="5">Grantee Organization Information:</td><td>Name:</td><td colspan="5">Arkansas Rural Health Partnership</td></tr>
<tr><td>Address:</td><td colspan="5">1969 Lakehall Road</td></tr>
<tr><td>City:</td><td>Lake Village</td><td>State:</td><td>Arkansas</td><td>Zip Code:</td><td>71653</td></tr>
<tr><td>Tel No.:</td><td colspan="5">870-265-6553</td></tr>
<tr><td>Website:</td><td colspan="5">ARruralhealth.org</td></tr>
<tr><td rowspan="4">Primary Contact Information:</td><td>Name:</td><td colspan="5">Ashley Anthony</td></tr>
<tr><td>Title:</td><td colspan="5">Project Director</td></tr>
<tr><td>Tel No.:</td><td colspan="5">870-723-3023</td></tr>
<tr><td>Email:</td><td colspan="5">Ashleyanthony@arruralhealth.org</td></tr>
<tr><td rowspan="4">Expected Funding Level for Each Budget Period:</td><td colspan="2">Month/Year to Month/Year</td><td colspan="4">Amount Funded Per Year</td></tr>
<tr><td colspan="2">Sep 2020 to Aug 2021</td><td colspan="4">$250,000</td></tr>
<tr><td colspan="2">Sep 2021 to Aug 2022</td><td colspan="4">$250,000</td></tr>
<tr><td colspan="2">Sep 2022 to Aug 2023</td><td colspan="4">$250,000</td></tr>
<tr><td rowspan="17">Consortium Partners:</td><td colspan="2">Partner Organization</td><td>County</td><td>State</td><td colspan="2">Organization Type</td></tr>
<tr><td colspan="2">Ashley County Medical Center</td><td>Ashley</td><td>AR</td><td colspan="2">Critical access hospital (CAH)</td></tr>
<tr><td colspan="2">Bradley County Medical Center</td><td>Bradley</td><td>AR</td><td colspan="2">CAH</td></tr>
<tr><td colspan="2">Chicot Memorial Medical Center</td><td>Chicot</td><td>AR</td><td colspan="2">CAH</td></tr>
<tr><td colspan="2">Delta Memorial Hospital</td><td>Desha</td><td>AR</td><td colspan="2">CAH</td></tr>
<tr><td colspan="2">DeWitt Hospital and Nursing Home</td><td>Arkansas</td><td>AR</td><td colspan="2">CAH</td></tr>
<tr><td colspan="2">Dallas County Medical Center</td><td>Dallas</td><td>AR</td><td colspan="2">CAH</td></tr>
<tr><td colspan="2">McGehee Hospital</td><td>Desha</td><td>AR</td><td colspan="2">CAH</td></tr>
<tr><td colspan="2">Baptist Health-Stuttgart</td><td>Arkansas</td><td>AR</td><td colspan="2">CAH</td></tr>
<tr><td colspan="2">Magnolia Regional Medical Center</td><td>Columbia</td><td>AR</td><td colspan="2">Prospective Payment System (PPS) hospital</td></tr>
<tr><td colspan="2">Drew Memorial Health Systems</td><td>Drew</td><td>AR</td><td colspan="2">PPS hospital</td></tr>
<tr><td colspan="2">Jefferson Regional</td><td>Jefferson</td><td>AR</td><td colspan="2">PPS hospital</td></tr>
<tr><td colspan="2">Ouachita County Medical Center</td><td>Ouachita</td><td>AR</td><td colspan="2">PPS hospital</td></tr>
<tr><td colspan="2">Medical Center of South Arkansas</td><td>Union</td><td>AR</td><td colspan="2">For-profit hospital</td></tr>
<tr><td colspan="2">Alleviant Solutions, LLC</td><td>Cumberland</td><td>PA</td><td colspan="2">For-profit partner</td></tr>
<tr><td colspan="2">University of Arkansas for Medical Sciences</td><td>Pulaski</td><td>AR</td><td colspan="2">University/state</td></tr>
<tr><td colspan="2">Helena Regional Medical Center</td><td>Phillips</td><td>AR</td><td colspan="2">PPS</td></tr>
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<table>
<tr><td rowspan="5">Counties the Project Serves:</td><td colspan="2">Ashley</td><td colspan="2">Cleveland</td></tr>
<tr><td colspan="2">Arkansas</td><td colspan="2">Dallas</td></tr>
<tr><td colspan="2">Bradley</td><td colspan="2">Desha</td></tr>
<tr><td colspan="2">Calhoun</td><td colspan="2">Lincoln</td></tr>
<tr><td colspan="2">Chicot</td><td colspan="2">Monroe</td></tr>
<tr><td rowspan="8">Target Population Served:</td><th>Population</th><th>Yes</th><th>Population</th><th>Yes</th></tr>
<tr><td>Adults</td><td>☒</td><td>Pacific Islanders</td><td>☒</td></tr>
<tr><td>African Americans</td><td>☒</td><td>Preschool children</td><td>☐</td></tr>
<tr><td>Caucasians</td><td>☒</td><td>Pregnant women</td><td>☐</td></tr>
<tr><td>Elderly</td><td>☒</td><td>School-age children (elementary)</td><td>☐</td></tr>
<tr><td>Infants</td><td>☐</td><td>School-age children (teens)</td><td>☐</td></tr>
<tr><td>Latinos</td><td>☒</td><td>Uninsured</td><td>☐</td></tr>
<tr><td>Native Americans</td><td>☒</td><td>Other:</td><td>☐</td></tr>
<tr><td rowspan="15">Focus Areas of Grant Program:</td><th>Focus Area</th><th>Yes</th><th>Focus Area</th><th>Yes</th></tr>
<tr><td>Access: Primary care</td><td>☐</td><td>Health professions recruitment and retention/workforce development</td><td>☐</td></tr>
<tr><td>Access: Specialty care</td><td>☐</td><td>Integrated systems of care</td><td>☐</td></tr>
<tr><td>Aging</td><td>☐</td><td>Maternal/women’s health</td><td>☐</td></tr>
<tr><td>Behavioral/mental health</td><td>☐</td><td>Migrant farm worker health</td><td>☐</td></tr>
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<tr><td>Chronic disease: Asthma/COPD</td><td>☐</td><td>School health</td><td>☐</td></tr>
<tr><td>Community health workers/promotores</td><td>☐</td><td>Substance abuse</td><td>☐</td></tr>
<tr><td>Coordination of care services</td><td>☒</td><td>Telehealth</td><td>☐</td></tr>
<tr><td>Emergency medical services</td><td>☐</td><td>Transportation to health services</td><td>☐</td></tr>
<tr><td>Health education and promotion</td><td>☐</td><td>Other: Hospital-based transitional care</td><td>☒</td></tr>
<tr><td>Health information technology</td><td>☐</td><td>Other:</td><td>☐</td></tr>
<tr><td>Health Information Technology System(s):</td><td colspan="4">State of Arkansas Health Information Exchange (SHARE)</td></tr>
<tr><td rowspan="4">Project Goals and Objectives:</td><th>Goal/Objective</th><th colspan="3">Description</th></tr>
<tr><td>Goal</td><td colspan="3">Strengthen the organizational and infrastructural capacity of 14 rural hospital partners across South Arkansas to address the post-acute care gaps and needs of Medicare beneficiaries (age 65 and above), their families, and caregivers by 2023.</td></tr>
<tr><td>Objective</td><td colspan="3">Throughout the three-year grant, Arkansas Rural Health Partnership (ARHP) consortium members will share the responsibility of planning, achievement, dissemination, and sustainability of hospital-based transitional care program activities.</td></tr>
<tr><td>Objective</td><td colspan="3">Throughout the period of performance, equip, educate, and support hospital leaders, providers, and staff in providing high-quality, post-acute transitional care within the critical access hospital setting.</td></tr>
</table>

	Objective	Beginning in year 1, enhance collaboration between critical access and acute care rural hospital partners to increase awareness of locally available, critical access hospital–based, post-acute care destinations throughout the service area.
	Objective	By the end of year one, launch hospital-based transitional post-acute care services within seven critical access hospital partners in order to improve the health outcomes and quality of life of rural Medicare beneficiaries (age 65 and above) in the service area.

Project Description:

Collaboration: Consortium members will work together in the following ways to accomplish program goals, objectives, and activities: (1) all members were active in the development of the application, each lending experience and relevant data; (2) all members have contributed resources, including chief executive officer (CEO) oversight and participation, and signing of a memorandum of understanding (MOU), committing themselves to project oversight, activities/services, and sustainability; and (3) every hospital represented (15 of out 17 signing the MOU) will actively engage in the proposed project. All seven critical access hospitals (CAHs) commit to preparing for and launching transitional care services within their swing bed units. The other eight Prospective Payment System (PPS) acute care hospitals represented commit to serve as initial referral centers to the newly established transitional care service. In this way, collaboration is essential and necessary for program success. New consortium members were added to bring a broader scope and level of expertise. Allevant plays a key role in establishing the program model and ensuring fidelity, while also providing one-on-one and group training, technical assistance, and support to CAHs.

Leadership and Workforce: The proposed project will build and strengthen care coordination teams at critical access hospitals through targeted training efforts. This includes, but is not limited to the following:

- Allevant online clinical education modules covering over 26 topics. Examples include cardiac assessment, managing patient family relations, pain management — nonpharmacologic solutions, transitional care admission and discharge, and more. Additional training offered to staff increases confidence and comfort level while they care for more challenging or complex patients. This may lead to new disciplines being added to the CAH as the scope of patients changes. (For example, as staff become more comfortable caring for respiratory patients, there may be an influx of respiratory patients so that the hospital could engage the services of a respiratory therapist. This increases service delivery options for the community.)
- Access to the Allevant team for coaching, technical assistance, and shared learning opportunities.
- Training in the Hospital-Based Transitional Care Model, including core competencies, key processes, etc.
- Implementation of the Allevant MENDS™ principles in year 3. This will engage providers and staff to recognize and prevent provider burnout and assist members of the workforce to become more mindful and team-oriented (rather than physician-centric). Principles in action assist providers to reduce their workload (and related stress) by sharing duties more evenly across the care team. In turn, providers and staff are more satisfied.

Improved Outcomes: The project will implement Critical Access Hospital-Based Transitional Care, a proven post-acute model that optimizes use of rural resources, created and implemented by Allevant Solutions, LLC. developed by Mayo Clinic and Select Medical. There will be no modifications made to the model. In addition, Allevant will work closely with hospital partners to fully implement the model successfully within each swing bed unit.

Evidence-Based/Promising Practice Model Being Used or Adapted:

Critical Access Hospital-Based Transitional Care Model: Critical Access Hospital-Based Transitional Care provides a high-quality post-acute option for patients by using existing available rural hospital capacity and staff. A focus on culture, safety, process, data, and clinical education allows rural hospitals to provide a valuable expansion in regional post-acute capacity, especially for patients with more challenging or complex post-acute needs. Patients and families benefit from shorter stays, reduced likelihood of discharge back to acute care, and fewer travel-related barriers to family participation in post-acute care plan. Larger acute care hospitals benefit from having an expanded post-acute option that can help shorten acute length of stay, open acute beds for new admissions sooner, and reduce the likelihood of acute readmissions. Over the long run, incorporation of wellness concepts influences overall health care outcomes and spending. The Transitional Care Model was initially established at Mayo Clinic Health System in 11 critical access

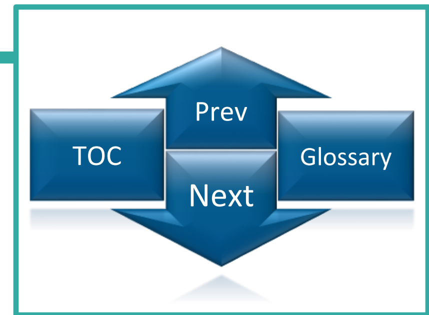
hospitals in Minnesota, Wisconsin, and Iowa. Allevant has implemented programs in over 50 critical access hospitals in 18 states, accounting for over 110,000 swing bed days.

Expected Outcomes:

The expected outcomes include:

- CAH staff become experts at providing high-quality, best practice care.
- Improved care delivery within this one area of the hospital bleeds into other areas of the hospital, naturally encouraging other departments and staff to improve processes and practice delivery.
- Local CAHs become a destination center for post-acute care.
- CAHs are well prepared and equipped to provide high-quality care to patients needing care within the post-acute care setting.
- CAHs see an increase in challenging and medically complex patients as providers become more skilled and comfortable with providing care to this patient demographic.
- CAHs become known for quality care — both within their communities, as well as with acute care hospitals across the region and state.
- There is an increase in CAH-Accountable Communities for Health (ACH) collaboration in the region and state. Rather than being seen as competitors, hospitals (regardless of type) value each other to help meet the needs of their patients and the fiscal needs to keep the doors of rural hospitals open.
- Hospitals will see an increase in patient census over time as both ACH and CAH hospitals are able to provide quality care. In turn, providers will be able to take better care of the needs of the patients depending on the treatment or services needed.
- Swing bed units within CAHs will be fully utilized, both meeting the needs of patients and providing valuable revenue for hospitals at risk of closure.
- CAHs become recognized in their communities, region, and state as destination centers — a place where people want to go for care — which has a lasting impact on provider recruitment and retention, outward migration, and the economic stability of the region.

Project Officer (PO) Contact Information:	**Name:**	Mew Pongsiri				
	Tel No.:	301-443-2752				
	Email:	kpongsiri@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip Code:**	20857
Technical Assistance (TA) Consultant Contact Information:	**Name:**	Ann Abdella				
	Tel No.:	404-413-0314				
	Email:	abdella@a2rh.net				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip Code:**	30303



New York

Champlain Valley Physicians Hospital Medical Center

Grant No.:	D78RH39348					
Organization type:	Hospital					
Grantee Organization Information:	**Name:**	Champlain Valley Physicians Hospital Medical Center				
	Address:	75 Beekman St.				
	City:	Plattsburgh	**State:**	New York	**Zip Code:**	12901
	Tel No.:	518-561-2000				
	Website:	https://www.cvph.org/				
Primary Contact Information:	**Name:**	Mary McLaughlin				
	Title:	Project Director				
	Tel No.:	518-480-0111 Ext. 413				
	Email:	mmclaughlin@ahihealth.org				

Expected Funding Level for Each Budget Period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Sep 2020 to Aug 2021	$250,000
	Sep 2021 to Aug 2022	$250,000
	Sep 2022 to Aug 2023	$250,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organization Type**
	Glens Falls Hospital	Multiple	NY	Hospital
	Alice Hyde Medical Center	Multiple	NY	Hospital
	Adirondack Health	Multiple	NY	Hospital
	Adirondacks Accountable Care Organization (ACO)	Multiple	NY	ACO
	Elizabethtown Community Hospital	Multiple	NY	Hospital
	Champlain Valley Physicians Hospital	Multiple	NY	Hospital
	HIXNY	Multiple	NY	Regional health information exchange
	Northwinds Independent Practice Association (IPA)	Multiple	NY	Behavioral health IPA
	Behavioral Health Services North	Multiple	NY	Behavioral health
	HCR	Multiple	NY	Home care and care management
	Hudson Headwaters Health Network	Multiple	NY	Federally Quality Health Center (FQHC)
	Adirondack Health Institute	Multiple	NY	Community-based organization

	Organization	County	State	Type
	Fort Hudson Health System	Multiple	NY	Skilled nursing facility, long-term care, care management and home care
	St. Joseph's Addiction Treatment and Recovery Centers	Multiple	NY	Addiction treatment

Counties the Project Serves:	Clinton	Hamilton
	Essex	Warren (rural census tract)
	Franklin	Washington (rural census tract)

	Population	Yes	Population	Yes
Target Population Served:	Adults	☒	Preschool children	☒
	African Americans	☒	Pregnant women	☐
	Caucasians	☒	School-age children (elementary)	☒
	Elderly	☒	School-age children (teens)	☒
	Infants	☒	Uninsured	☒
	Latinos	☒	Other: Rural	☒
	Native Americans	☒	Other: Low income	☒
	Pacific Islanders	☒	Other: HPSA-Special Population-Medicaid	☒

	Focus Area	Yes	Focus Area	Yes
Focus Areas of Grant Program:	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/promotores	☐	Substance abuse	☒
	Coordination of care services	☒	Telehealth	☒
	Emergency medical services	☐	Transportation to health services	☐
	Health education and promotion	☐	Other: Inpatient	☒
	Health information technology	☒	Other:	☐

Health Information Technology System(s):	Cerner	HIXNY (Regional Health Information Organization — RHIO)
	EPIC	Health Catalyst
	Netsmart	EClinical Works
	Athena	PointClick
	Medent	Other smaller IT systems

	Goal/Objective	Description
Project Goals and Objectives:	**Goal**	Build a transitions care coordination collaborative.

	Objective	The North Country Care Coordination Collaborative (NCCCC) will create a solid foundation for regional care coordination beginning with persons being discharged from hospitals in the region.
	Goal	Create and implement regional, multisector care coordination protocols that ensure alignment and coordination for people transitioning from the hospital to community supports.
	Objective	A key component of achieving optimal outcomes is improved integration, reduced fragmentation, and efficiency within and across health care sectors.
	Goal	Optimize current regional, multisector care coordination workforce and implement alternative models to ensure all levels of care coordination.
	Objective	Every person discharged from the hospital has the right level of care coordination at the right time in the setting in which they have a trusted relationship.
	Goal	Ongoing evaluation and dissemination plan.
	Objective	An internal and external communication strategy will be developed to ensure and promote transparency and communications through multiple mediums to ensure all who are impacted — providers, payers, individuals, employers, etc. — in parts of this rural region receive information in a timely and accessible manner.

Project Description:

This project will focus on persons being discharged from five area hospitals with COPD, heart disease, diabetes, and mental health conditions to ensure prompt and effective care at community-based providers that improves health and well-being and reduces potentially preventable emergency department (ED) visits and hospitalizations. Future work will focus on all individuals with the goal of promoting health for all and reducing illness and disability where possible.

The six-county NCCCC region is vast, covering 8,000 square miles in upstate New York. The communities are rural, have limited job opportunities and low median incomes, have limited access to broadband, have little access to public transportation, and experience long, cold winters.

NCCCC members will collaborate to achieve the following goals:

- Enhance collaboration and communication: Improve communication between and among care coordinators especially during care transitions to ensure an integrated and coordinated system best suited to optimize health outcome.
- Improve outcomes: Through alignment of tools used to identify patient level of risk, assign care coordination supports and promote timely communications among and between care coordinators. Tools already in use by some members of the NCCCC (the American Academy of Family Physician's Risk Stratified Care Management and Coordination model, LACE, or other evidence-based tool) will be deployed to multiple partners in the region to test the impact of using a single tool to improve timeliness and effectiveness of communications and ultimately on health status as measured by hospital admission, discharges, and ED visits for persons with specific diagnoses most likely to be amenable to improvement through care coordination.
- Promote and support leadership and workforce: Ensure institutional leadership and support of the initiative including dedication of in-kind resources to implement and test this new model throughout the region and across multiple provider types.
- Maximize health information exchange: Through electronic health records and other communication platforms between providers across the continuum of care.
- Promote sustainability: Develop tools and practices that can be easily adopted by individual providers along with a common information platform that together will ensure long-term sustainability of care coordination services through establishment of working relationships, development a value proposition, and identification of models and revenue sources to sustain this essential service.

Evidence-Based/Promising Practice Model Being Used or Adapted:

The North Country Care Coordination Collaborative (NCCCC) will use the American Academy of Family Physicians (AAFP) Risk Stratified Care Management Rubric, LACE, or other evidence-based risk-stratification tools. Based on partners' current use of evidence-based tools, the gaps will be evaluated and addressed to ensure that the collaborative is able to communicate risk across the region and identify effective protocols. The AAFP Risk-Stratified Care Management Rubric is a framework designed to guide the provider and the care team through the process of stratifying patients into six risk levels based on health severity, social determinants, and utilization of services. Created by AAFP subject matter experts, this rubric provides a framework for how to identify and assign patients' health risk level, provides care plan suggestions, and includes a diabetes example case illustrating different risk levels and associated care plan suggestions. The LACE index uses four variables to predict the risk of death or non-elective 30-day readmission after hospital discharge among both medical and surgical patients: length of stay (L), acuity of the admission (A), comorbidity of the patient (C) and emergency department use in the duration of six months before admission (E). There are other evidenced-based tools that may prove more useful as well. The collaborative will be focusing on tools that identify high, medium, or low risk and share that information via the RHIO.

Expected Outcomes:

The expected outcomes of the care coordination initiatives are:

- Decrease in potentially preventable emergency department visits.
- Decrease in potentially preventable readmission/admissions for inpatient hospital stays.
- Improved timeliness of communication among and between care coordinators based on the adoption of a common tool to stratify patient risk for success in the community.
- Creation of a common language and communication system between care coordinators focusing on a clear understanding of the severity of illness.
- Creation of shared, patient-centric care plans that establish points of accountability between care coordinators, identify barriers and the supports required to overcome those barriers to provide the right level of care at the right time.
- More appropriate referrals that best support patient level of need.
- Improved patient satisfaction and ability to access supportive services.
- Increased access to health care and community-based services including primary care.
- Improved chronic disease status with appropriate identified and allocated resources.
- Improved availability and standardization of skill sets of care coordination staff.

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Technical Assistance (TA) Consultant Contact Information:	**Name:**	Aliza Petiwala				
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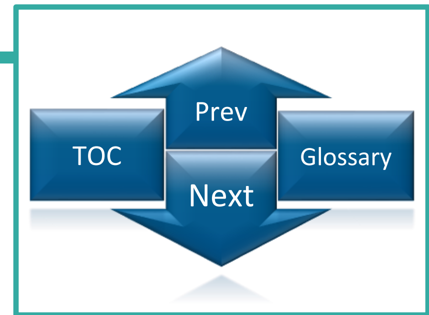
	City:	Atlanta	**State:**	Georgia	**Zip Code:**	30303



New Mexico

El Centro Family Health

Grant No.:	D78RH39349					
Organization type:	Federally Qualified Health Center (FQHC)					
Grantee Organization Information:	**Name:**	El Centro Family Health				
	Address:	538 N. Paseo de Onate				
	City:	Espanola	**State:**	New Mexico	**Zip Code:**	87532
	Tel No.:	505-753-7218				
	Website:	www.ecfh.org				
Primary Contact Information:	**Name:**	Delmiria Sanchez				
	Title:	Health Programs Manager				
	Tel No.:	505-747-5922				
	Email:	Delmiria.sanchez@ecfh.org				

Expected Funding Level for Each Budget Period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Sep 2020 to Aug 2021	$250,000
	Sep 2021 to Aug 2022	$250,000
	Sep 2022 to Aug 2023	$250,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organization Type**
	Alta Vista Regional Hospital	San Miguel	NM	Hospital
	Holy Cross Hospital	Taos	NM	Hospital
	Presbyterian Espanola Hospital	Rio Arriba	NM	Hospital

Counties the Project Serves:		
	Colfax	Rio Arriba
	Guadalupe	San Miguel
	Harding	Taos
	Mora	

Target Population Served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☐	Pacific Islanders	☐
	African Americans	☐	Preschool children	☐
	Caucasians	☐	Pregnant women	☐
	Elderly	☐	School-age children (elementary)	☐
	Infants	☐	School-age children (teens)	☐
	Latinos	☐	Uninsured	☐
	Native Americans	☐	Other: Anyone being discharged from any of the three partner hospitals.	☒

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/promotores	☐	Substance abuse	☐
	Coordination of care services	☒	Telehealth	☐
	Emergency medical services	☐	Transportation to health services	☐
	Health education and promotion	☐	Other:	☐
	Health information technology	☐	Other:	☐
Health Information Technology System(s):	eClinical Works			

Project Goals and Objectives:	**Goal/Objective**	**Description**
	Goal	Improve rural health care coordination service delivery and quality of care among El Centro Family Health (ECFH) primary care clinics and regional hospitals through the establishment of a system-wide care coordination network to ultimately support reductions in emergency department and 30-day hospital readmission rates.
	Goal	Provide trainings and skills enhancement to FQHC care coordinators and regional hospital discharge planners to support effective health care coordination leaders and a skilled workforce.
	Goal	Enhance integrated informational technology systems to improve care coordination data collection, tracking, and sharing among FQHCs and local hospitals that will improve patient health outcomes in the long term.
	Goal	In order to support ongoing financial sustainability, care coordination efforts will include staff to support billing, accessing quality improvement-based incentives, and preparing for the overall health care system transition to value-based health care and shared cost-savings payment models.
	Goal	Ensure the consortium is regularly engaged to strengthen partnerships, project planning, and to meet grant activity and reporting requirements to ensure a successful and well-executed project.

Project Description:

The Semillas de Esperanza Consortium is an existing consortium of health care, academic institutions, nonprofits, hospitals, and local government entities throughout northern New Mexico that have come together to enhance the network of rural health care delivery systems through several initiatives. The consortium's proposed Enhancing Rural Health Care Coordination in Northern New Mexico initiative builds on the existing efforts to achieve better patient care, improved overall health outcomes, and lower health care costs in the rural communities that constitute the vast service area of northern New Mexico. Semillas de Esperanza consortium members have identified El Centro as the lead applicant to implement enhanced care coordination strategies for the most vulnerable patients in northern New Mexico. The three regional hospital systems that each serve a defined region of northern New Mexico (Holy Cross Hospital — North Region; Presbyterian Espanola Hospital — West Region; Alta Vista Regional Medical Center — East Region) have also committed to be core partners in enhancing a rural health care coordination system that helps to increase access, delivery, and quality of care; improve collaborative efforts toward value-based care, Patient-Centered Medical Home

(PCMH) recognition, and Accountable Care Organization (ACO) incentive payments; and increase program financial sustainability through achieved results.

Semillas de Esperanza's core partners will implement evidence-based care coordination strategies that will be embedded into an FQHC primary care setting (26 clinics) in rural northern New Mexico to support patients who have visited the emergency department or have been admitted to the hospital through strengthened care coordination workforce, the development of a dedicated care coordination 1-800 number for regional hospitals to reach care coordinators at El Centro, and enhanced data sharing and health information technology (HIT) reporting to maximize valued-based incentive payments and shared cost-savings among the FQHCs and hospitals. The evidence base includes elements of the Bridge Model, Care Transitions Intervention (CTI), and care coordination.

Evidence-Based/Promising Practice Model Being Used or Adapted:

The evidence-based care coordination model has elements of the Bridge Model — an evidence-based care coordination model for seniors to reduce preventable hospital readmissions and emergency department visits, improve satisfaction, and improve quality of life. In addition, the model will include elements of the Care Transitions Intervention (CTI), which is an evidence-based, person-centered intervention designed for patients with complex care needs as they transition across care settings and are being discharged from the hospital with a diagnosis of stroke, heart failure, chronic obstructive pulmonary disease, diabetes, hip fracture, or coronary artery disease.

Expected Outcomes:

The expected outcomes of our program are:

- Improved population health as measured by Performance Improvement Measurement System (PIMS) clinical measures.
- A reduction in emergency department and 30-day hospital readmission rates at the three partner regional hospitals serving Northern New Mexico.

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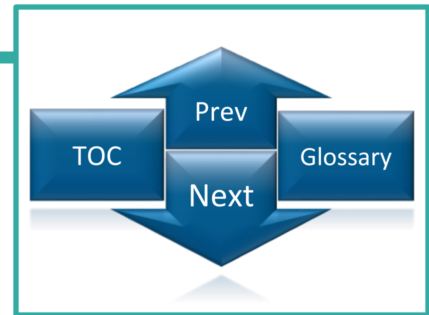
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip Code:**	30303



New York

Finger Lakes Migrant Health Care

Grant No.:	D78RH39350					
Organization type:	Federally Qualified Health Center					
Grantee Organization Information:	**Name:**	Finger Lakes Community Health				
	Address:	14 Maiden Lane				
	City:	Penn Yan	**State:**	New York	**Zip Code:**	14527
	Tel No.:	315-531-9102				
	Website:	https://localcommunityhealth.com/				
Primary Contact Information:	**Name:**	Naomi Wolcott-MacCausland				
	Title:	Migrant Health Coordinator				
	Tel No.:	802-503-2078				
	Email:	nwolcott@uvm.edu				

Expected Funding Level for Each Budget Period:	Month/Year to Month/Year	Amount Funded Per Year
	Sep 2020 to Aug 2021	$248,148
	Sep 2021 to Aug 2022	$245,504
	Sep 2022 to Aug 2023	$249,934

Consortium Partners:	Partner Organization	County	State	Organization Type
	University of Vermont Extension	Chittenden	VT	Extension service
	Open Door Clinic	Addison	VT	Free clinic
	Rutland County Free Clinic	Rutland	VT	Free clinic

Counties the Project Serves:		
	Addison County, Vermont	Orange County, Vermont
	Bennington County, Vermont	Orleans County, Vermont
	Caledonia County, Vermont	Rutland County, Vermont
	Essex County, Vermont	Washington County, Vermont
	Franklin County, Vermont	Windham County, Vermont
	Lamoille County, Vermont	Windsor County, Vermont

Target Population Served:	Population	Yes	Population	Yes
	Adults	☐	Pacific Islanders	☐
	African Americans	☐	Preschool children	☐
	Caucasians	☐	Pregnant women	☐
	Elderly	☐	School-age children (elementary)	☐
	Infants	☐	School-age children (teens)	☐
	Latinos	☐	Uninsured	☐
	Native Americans	☐	Other: Immigrant farmworkers and family members	☒

	Focus Area	Yes	Focus Area	Yes

Focus Areas of Grant Program:

Focus Area		Focus Area	
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/promotores	☐	Substance abuse	☐
Coordination of care services	☒	Telehealth	☐
Emergency medical services	☐	Transportation to health services	☐
Health education and promotion	☐	Other:	☐
Health information technology	☐	Other:	☐

Health Information Technology System(s): N/A

Project Goals and Objectives:

Goal/Objective	Description
Goal	Leverage consortium member expertise, relationships, and resources as well as community, state, and federal resources to create an integrated, collaborative, and patient-centered care coordination model that results in more equitable access to health and health care for immigrant farmworkers across Vermont.
Objective	Leverage Finger Lake Community Health’s (FLCH) decades of experience serving the New York rural immigrant farmworker population and successful implementation of a care coordination model to create a model adapted to Vermont context and needs.
Objective	Establish and build capacity within the Puentes a la Salud (PALS) Care Coordination Team to effectively and efficiently coordinate culturally and linguistically appropriate care to immigrant farmworkers and their family members.
Objective	Raise awareness about the PALS Care Coordination Team across health care and community-based organizations to facilitate ongoing and as-needed collaborations that result in timely, culturally, and linguistically appropriate coordination and delivery of services to immigrant farmworkers and their family members.
Objective	Develop ongoing collaborations at a local, statewide, and regional level and implement effective communication strategies to ensure coordination, project success, and sustainability planning.
Goal	Utilizing a whole-health approach, provide resources, referrals, and coordination of care to connect immigrant farmworkers to appropriate and desired health and community services in a timely, culturally, and linguistically appropriate manner.
Objective	The Care Coordination Team will identify and address health and social needs of immigrant farmworkers and their family members utilizing care coordination strategies and activities.

Project Description:

The Puentes a la Salud (PALS) Care Coordination team leverages consortium member expertise, relationships, and resources as well as community and state partners to create an integrated, collaborative, and patient-centered care coordination model that results in more equitable access to health care and health-related services for immigrant farmworkers in Vermont. Activities are connected to the key elements identified as contributors to a successful care coordination program: collaboration, leadership and workforce, improved outcomes, and sustainability.

Collaboration will be fostered through regular meetings, consortium site visits (virtual during COVID), and sharing of resources as well as targeted meetings with health care and community organizations. The development of a project-level community care coordinator on-boarding process/training utilizing consortium expertise will contribute to leadership and workforce development. The evidence-based Pathways model will lead to improved outcomes and include the implementation of a health and social needs screening followed by care coordination utilizing the Pathways model focused on linkages to services and resources that address identified needs. Sustainability will be achieved through project model and results dissemination at the local, state, and federal level to garner support, exploration of the FLCH Migrant Health Center Voucher Program as a fit for Vermont, and an examination of how the Rural Health Public-Private Partnership (RHPPP) model might support the project in the long term.

Evidence-Based/Promising Practice Model Being Used or Adapted:

The PALS Care Coordination project modifies the Pathways model to a Healthy Bernalillo County program, first developed by the Community Health Access Project. Community care coordinators will utilize individualized care pathways to identify, select, and guide access to health and social services across the often fragmented and siloed access points and monitor whether access to needed services was achieved. The community care coordinators will utilize a screening tool to identify needs and then assist individuals through the selected pathways, taking specific actions known to lead toward a positive (and documented) outcome.

Expected Outcomes:

The care coordination workforce will be strengthened. Effective care coordination will result in expanded access to care, a reduction in barriers, improved continuity of care, prevention of unnecessary utilization of emergency care, desired health outcomes, and enhanced satisfaction with care. Health and community-based organizations will be better equipped to respond to patient needs. Consortium efforts will lead to sustained collaboration and use of uniform processes for screenings, data collection, and outcomes monitoring. Together with community partners, the project efforts will be sustained to offer ongoing coordinated, effective access to culturally and linguistically appropriate whole-person care.

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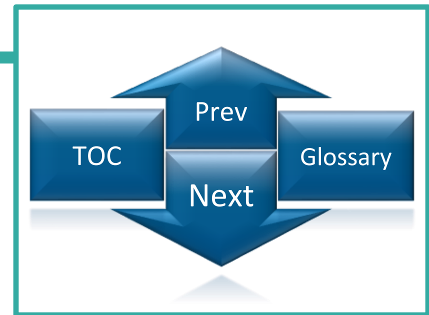
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip Code:**	30303

Indiana



Indiana Rural Health Association

Grant No.:	D78RH39351					
Organization type:	Statewide rural health association					
Grantee Organization Information:	**Name:**	Indiana Rural Health Association				
	Address:	1418 N 1000 W				
	City:	Linton	**State:**	Indiana	**Zip Code:**	47441
	Tel No.:	812-478-3919 Ext. 221				
	Website:	www.indianaruralhealth.org				
Primary Contact Information:	**Name:**	Cindy Large				
	Title:	Project Director				
	Tel No.:	812-236-3059				
	Email:	clarge@indianarha.org				

Expected Funding Level for Each Budget Period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Sep 2020 to Aug 2021	$250,000
	Sep 2021 to Aug 2022	$250,000
	Sep 2022 to Aug 2023	$250,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organization Type**
	Putnam County Hospital/ Putnam Women's Healthcare	Putnam County	IN	Critical access hospital/rural health clinic
	Greene County General Hospital/ MyLinton Clinic	Greene County	IN	Critical access hospital/rural health clinic
	Indiana Health Centers Inc. Owen County	Owen County	IN	Federally Qualified Health Center

Counties the Project Serves:		
	Greene	Putman
	Owen	

Target Population Served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Preschool children	☐
	African Americans	☒	Pregnant women	☒
	Caucasians	☒	School-age children (elementary)	☐
	Elderly	☐	School-age children (teens)	☐
	Infants	☒	Uninsured	☒
	Latinos	☒	Other: Fathers of pregnant women	☒
	Native Americans	☐	Other: Families of pregnant women	☒
	Pacific Islanders	☐	Other:	☐

Focus Areas of Grant Program:	Focus Area	Yes	Focus Area	Yes
	Access: Primary care	☒	Health information technology	☐
	Access: Specialty care	☒	Health professions recruitment and retention/workforce development	☒
	Aging	☐	Integrated systems of care	☒
	Behavioral/mental health	☒	Maternal/women's health	☒
	Children's health	☐	Migrant farm worker health	☐
	Chronic disease: Cardiovascular	☒	Oral health	☐
	Chronic disease: Diabetes	☒	Pharmacy assistance	☐
	Chronic disease: Asthma/COPD	☒	Physical fitness and nutrition	☐
	Community health workers/promotores	☒	School health	☐
	Coordination of care services	☒	Substance abuse	☒
	Emergency medical services	☐	Telehealth	☒
	Health education and promotion	☒	Transportation to health services	☐

Health Information Technology System(s):	
	The Indiana Rural Health Association (IRHA) program utilizes the REDCap online Health Insurance Portability and Accountability Act (HIPAA)-compliant data collection platform for all data collection and reporting of participant screenings
	Each clinic utilizes separate electronic medical records for documenting patient specific data

Project Goals and Objectives:	**Goal/Objective**	**Description**
	Goal	Plan and develop an enhanced, integrated maternal/perinatal health care system to collaborate and share data among member organizations.
	Objective	Providing access to enhanced perinatal care services through implementation of the Patient-Centered Medical Home model in the rural obstetrics clinic setting.
	Goal	Establish effective care coordination workforce to meet needs within the rural communities.
	Objective	Increasing workforce and educating of rural providers/clinicians perinatal navigators (PNs), and community health workers (CHWs) in the targeted service area.
	Goal	Improve access, delivery, and quality of services and overall patients' health outcomes.
	Objective	Care coordination activities for women, pre- and post-conception focusing on prenatal, post-natal, and behavioral health screenings, with an emphasis on reducing the multiple modifiable risk factors associated with behavioral health and addictions.
	Goal	Increase program financial sustainability to promote long-term effectiveness of perinatal care coordination.
	Objective	Develop and strengthen financial sustainability by establishing effective revenue sources.
	Goal	Improve access, delivery, and quality of services and overall patients' health.
	Objective	Increased access to rural maternity care referrals and resources through the deployment of telehealth services.

Project Description:

The Indiana Rural Health Association (IRHA) will facilitate partner collaboration to coordinate and deliver health care services through clinicians and participating partners actively engaged in integrated, coordinated, patient-centered delivery of health care services; identification of baseline measures and routine reporting of data collected through the REDCap HIPAA-compliant online platform; and development and strengthening of a highly skilled and coordinated workforce to respond to vulnerable populations' unmet perinatal health needs within the rural communities.

Project and health outcomes will be improved by expanding care access, quality, and delivery through the use of evidence-based models and promising practices tailored to meet the local populations' needs. These new models include the use of telehealth modalities to identify technical needs, types and deployment of equipment, and training; and implementing promising practices for care coordination of obstetrical services and maternity care and transition of care practices of patient-centered medical home, perinatal navigator, and CHW services.

Financial sustainability will be developed and strengthened by establishing effective revenue sources focusing on expanded service reimbursement, resource sharing, and/or contributions from partners at the community, county, regional, and state levels. The IRHA will facilitate town hall meetings with individual community stakeholders to identify and implement sustainability efforts. Foundation and public-private rural funding resources will be identified through discussion during strategic planning sustainability efforts through public-private collaboration in rural health, an opportunity for public and private organizations to connect with one another and discuss how combined efforts might produce better health outcomes for rural communities. The research is to include nearly 70 foundations and trusts active in the rural health public-private partnership each year and will foster discussions on building public-private partnerships into their strategic planning as part of the Rural Health Aligned Funding Initiative – Care Coordination Opportunity

Evidence-Based/Promising Practice Model Being Used or Adapted:

Patient-Centered Medical Home (PCMH)

In June 2018, the IRHA through an HRSA Federal Office of Rural Health Policy (FORHP) award grant D04RH31782 initiated the development of the IRHA Rural Maternity Medical Home (RMMH) project. The IRHA RMMH project focuses on expansion of existing early prenatal care **outreach** efforts through education and referrals for at-risk and high-risk expectant mothers, implementation of pre- and post-natal screenings, and integration of a HIPAA-compliant platform for online data collection, evaluation, and reporting. The partners are developing care coordination through a **referral workflow process** within each primary care/obstetrical practice as a "one-stop shop" for provision of referral services and access to services through integration of **telehealth** modalities specifically for maternity care, behavioral health and addictions treatment, and the diagnosis and referral process. Partners are implementing programs that incorporate elements of the evidence-based PCMH and CHW models for gathering patient clinical data through the Healthy Start evidence-based screening tool. This Tool has been adapted to include program Performance Improvement Measurement System (PIMS) and non-PIMS metrics for reporting to HRSA.

Perinatal Navigator (PN) and Community Health Worker (CHW) models

The PN model was signed into Indiana law, July 2019, by Gov. Eric Holcomb. The goal of the PN model is to provide case management for pregnant women and infants using integrated population management. The PN care coordination model seeks to align the needs of the patient with the intensity of the resource to meet the needs of the patient and align the intensity of the resource with the needs of the patient. This approach serves not only the high-risk population but all maternity patients with needs identified during screenings. It involves population risk with an emphasis on preventive care and focusing on those most at risk. The new law requires the Indiana State Department of Health (ISDH) to establish a Perinatal Navigator Program, which requires a health care provider to (1) use a validated and evidence-based verbal screening tool to assess substance use disorders in pregnancy for all pre-conception and pregnant women who are seen by the health care provider and (2) if the health care provider identifies a pregnant woman who has a substance use disorder that is not currently receiving treatment, they provide treatment or refer the patient to a treatment agency. Under this proposal, medical providers would check for signs of substance abuse in pregnant women through a consultation and refer those in need to treatment programs as early as possible. This goes hand in hand with current IRHA and ISDH efforts to combat the opioid epidemic because for pregnant mothers who use drugs or consume alcohol, there is often a higher risk of Sudden Infant Death Syndrome (SIDS). The law also requires ISDH to establish guidelines for health care providers that treat substance use disorders in pregnancy. IRHA has expanded its scope of services offered to include integration of telehealth for referrals and treatment for behavioral health, to improve access to care

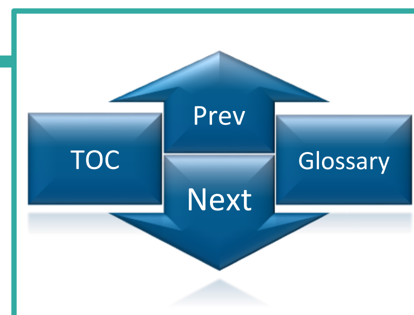
through enhanced care coordination with specialty providers, to provide education to leadership and the obstetrical (OB) workforce, and network sustainability. The partners will collect participant data through demographic and pre- and post-natal screening tools. The tools are developed through the evidence-based **Healthy Start** initiative. This will allow the partners to demonstrate improved outcomes through data pre- and post-natal screenings for reporting. The data will be obtained from the patients' screenings while at the OB practitioner's office by the contracted partners' PNs. The data will be entered into REDCap, the online HIPAA-compliant data platform for reporting and performance improvement.

Expected Outcomes:

Expand current scope of perinatal care coordination efforts to include clinical measures, and telehealth for mental/behavioral health and in rural clinic settings; enhance obstetrical workforce development through training to promote positive rural patient-provider relationships; and create sustainable rural perinatal model of the evidence-based Patient-Centered Medical Home model, Perinatal Navigator model, and Community Health Worker model.

Project Officer (PO) Contact Information:	**Name:**	Mew Pongsiri				
	Tel No.:	301-443-2752				
	Email:	kpongsiri@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip Code:**	20857
Technical Assistance (TA) Consultant Contact Information:	**Name:**	Ann Abdella				
	Tel No.:	404-413-0314				
	Email:	abdella@a2rh.net				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip Code:**	30303

Washington



Kittitas County Health Network

Grant No.:	D78RH39352					
Organization type:	Nonprofit organization/rural health network					
Grantee Organization Information:	Name:	Kittitas County Health Network				
	Address:	400 E. Mountain View Ave.				
	City:	Ellensburg	State:	Washington	Zip Code:	98926
	Tel No.:	509-607-1375				
	Website:	Healthierkittitas.org				
Primary Contact Information:	Name:	Alicia Colasurdo				
	Title:	Project Director				
	Tel No.:	208-596-9178				
	Email:	alicia@healthierkittitas.org				

Expected Funding Level for Each Budget Period:	Month/Year to Month/Year	Amount Funded Per Year
	Sep 2020 to Aug 2021	$249,643
	Sep 2021 to Aug 2022	$247,729
	Sep 2022 to Aug 2023	$250,000

Consortium Partners:	Partner Organization	County	State	Organization Type
	Southeast Washington Aging and Long Term Care	Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima	WA	Long-term care
	Community Health of Central Washington	Kittitas, Yakima	WA	Health care
	City of Ellensburg	Kittitas	WA	City government
	Kittitas County Early Learning Coalition	Kittitas	WA	Social services
	Elmview	Kittitas	WA	Disability services
	Ellensburg Police Department	Kittitas	WA	Law enforcement
	Health Commons Project	Washington State	WA	Collaborative neighborhood health system
	HopeSource	Douglas, Grant, Kittitas	WA	Social services
	Kittitas County Hospital District 2	Kittitas	WA	Health care
	Kittitas County Sheriff's Office	Kittitas	WA	Law enforcement
	Kittitas Valley Fire & Rescue	Kittitas	WA	Fire department
	Kittitas Valley Healthcare	Kittitas	WA	Public hospital
	Valley Psychological Services	Kittitas	WA	Counseling services

	Youth Services of Kittitas County	Kittitas	WA	Youth mentor program
	Molina Healthcare	National	WA	Managed care company
	Merit Resource Services	Benton, Kittitas, Yakima	WA	Outpatient substance use disorder services
	Kittitas County Public Health Department	Kittitas	WA	Public health department
	FISH	Kittitas	WA	Community food bank
	Comprehensive Healthcare	Benton, Franklin, Klickitat, Kittitas, Walla Walla, Yakima	WA	Mental health and substance use disorder services
	Greater Columbia Accountable Community of Health	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, Yakima, Yakama Nation	WA	Collaborative network

Counties the Project Serves:	Kittitas

Target Population Served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Pacific Islanders	☒
	African Americans	☒	Preschool children	☐
	Caucasians	☒	Pregnant women	☐
	Elderly	☒	School-age children (elementary)	☐
	Infants	☐	School-age children (teens)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other: Rural	☒

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/promotores	☐	Substance abuse	☒
	Coordination of care services	☒	Telehealth	☐
	Emergency medical services	☒	Transportation to health services	☐

	Health education and promotion	☒	Other: Preventative care	☒
	Health information technology	☐	Other:	☐
Health Information Technology System(s):	Strata Pathways Health Commons			

Project Goals and Objectives:	**Goal/Objective**	**Description**
	Goal	Create a care coordination program that addresses client needs upstream.
	Objective	Hire a full-time equivalent project director by Dec. 1, 2020.
	Objective	Collect feedback and input about needs for services, referrals, and care coordination from at least 15 people who are part of the target population by Feb. 1, 2021. Implement a consumer council that meets at least quarterly by Feb. 1, 2021.
	Objective	Finalize a program evaluation and data-collection plan; processes, procedures, and policies; and forms and screening/assessment tools by May 1, 2021.
	Objective	Finalize the staffing plan (roles: intake, screening, evaluation/assessment, care planning, care coordination, discharge) for the community care coordination program with subcontractors and other consortium members by May 1, 2021. Program data and progress will be reviewed quarterly to assess for quality-improvement efforts, and a report will be made to the broader consortium at least twice per year.
	Objective	Implement priority workflows to include at least referrals in, intake and screening, assessment/evaluation, care planning, referrals out, and discharge in the Health Commons technology platform by July 1, 2021.
	Goal	Build a community system for coordinating health and social service resources for clients.
	Objective	Gain the commitment of at least 15 organizations to participate in the community-based care coordination program by Sept. 1, 2021, 20 organizations by Sept. 1, 2022, and 25 organizations by Sept. 1, 2023. Train at least 10 organizations in the use of Health Commons by Sept. 1, 2021, 15 by Sept. 1, 2022, and 20 by Sept. 1, 2023.
	Goal	Raise the level of health status among priority populations in Kittitas and improve their ability to be independent and function at a level that they desire.
	Objective	Implement at least 25% of the sustainability plan activities and strategies by Sept. 1, 2021, 50% by Sept. 1, 2022, and 75% by Sept. 1, 2023.
	Objective	Enroll and provide services to at least 75 individuals in Health Commons and the community-based care coordination program by Sept. 1, 2022, and 150 by Sept. 1, 2023.

Project Description:

Kittitas County Health Network (KCHN) is an interdisciplinary consortium made up of multiple sectors: first responders, law enforcement, health care, education, public health, government, and social services. This growing collaborative seeks to build, expand, and improve community-based care coordination. The purpose of KCHN's Community-Based Care Coordination Project is to build a robust program that will address the health needs of those who are high utilizers of emergency services, experiencing crises, and/or individuals who are at risk of experiencing crises as a result of unmet health needs. Through care coordination, KCHN aims to reduce preventable utilization of emergency and health care services (i.e., 911 calls, emergency department visits, hospitalizations) and help people manage crisis situations. KCHN aims to work upstream by being proactive and providing warm handoffs through care coordination for people who are at risk of preventable utilization or crisis. Finally, KCHN aims to provide whole-person care by not only connecting with health care services, but also by identifying areas of need in social determinants of health. As the lead organization in

convening community partners as a consortium, KCHN continues to prioritize its vision by supporting all Kittitas County residents in achieving health and well-being. This is achieved by improving health through cross-sector collaboration and systems integration.

Evidence-Based/Promising Practice Model Being Used or Adapted:

Our Community Care Coordination Program is based upon the Pathways HUB model and the Ely Care Coordination Team model that was influenced by the Vermont Blueprint for Health project. Our innovative program uses the Pathways concepts to create referral and warm handoff workflows to different community-based services. It also builds upon the concept of having a HUB organization that convenes care coordinators across the community who have a special focus on social determinants of health. The Ely Care Coordination Team model was implemented in a very rural community similar to Kittitas County and also used a Rural Health Network model to create a team of community care coordinators to increase communication and partnerships, improve health outcomes, and reduce health care costs due to preventable emergency department use. Our project adapts these models with customization specific to our community through a technology platform called Health Commons through the partnership-based nonprofit organization, the Health Commons Project.

Expected Outcomes:

While "being healthy" can be defined subjectively, KCHN expects to see certain long-term outcomes for our priority populations. Examples of long-term outcomes include a decrease in clients who have uncontrolled chronic disease(s), a decrease in clients with unmet self-identified mental health concerns, a decrease in unmet social determinants of health, an increase in self-identified wellness goals met, and an increase in health support systems and social connections. Additional intermediate outcomes include increasing access to medical and dental services, decreasing preventable utilization of emergency services and hospitalizations, decreasing negative health impacts and health disparities caused by social determinants of health, and increasing access to community resources. Success for these outcomes will be measured by an increase in the number of clients who have health insurance, a decrease in preventable emergency department visits, an increase in clients who have steady and safe housing, and an increase in clients who have successful connections to needed services.

Project Officer (PO) Contact Information:	**Name:**	Mew Pongsiri				
	Tel No.:	301-443-2752				
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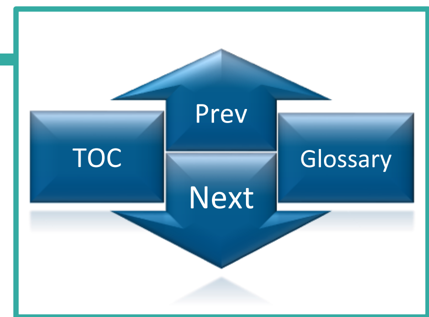
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip Code:**	20857
Technical Assistance (TA) Consultant Contact Information:	**Name:**	Aliza Petiwala				
	Tel No.:	404-413-0314				
	Email:	apetiwala@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip Code:**	30303



Montana

Rural Health Development Inc.

Grant No.:	D78RH39353					
Organization type:	Rural health network					
Grantee Organization Information:	**Name:**	Rural Health Development d/b/a Montana Health Network				
	Address:	519 Pleasant Street				
	City:	Miles City	**State:**	Montana	**Zip Code:**	59301
	Tel No.:	406-234-1420				
	Website:	www.montanahealthnetwork.com				
Primary Contact Information:	**Name:**	Nadine L. Elmore				
	Title:	Project Director				
	Tel No.:	406-939-1173				
	Email:	nelmore@montanahealthnetwork.com				

Expected Funding Level for Each Budget Period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Sep 2020 to Aug 2021	$250,000
	Sep 2021 to Aug 2022	$250,000
	Sep 2022 to Aug 2023	$250,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organization Type**
	Dahl Memorial Healthcare Association Inc.	Carter	MT	Critical access hospital/rural health clinic (CAH/RHC)
	Fallon Medical Complex	Fallon	MT	CAH/RHC
	Roosevelt Medical Center	Roosevelt	MT	CAH/RHC
	McCone County Health Center	McCone	MT	CAH/RHC
	Prairie Community Hospital	Prairie	MT	CAH/RHC
	Powder River Health	Powder River	MT	Provider-based stand-alone clinic
	Rosebud Health Care Center	Rosebud	MT	CAH/RHC
	Garfield County Health Center	Garfield	MT	CAH/RHC

Counties the Project Serves:		
	Carter	Powder River
	Fallon	Prairie
	Garfield	Roosevelt
	McCone	Rosebud

Target Population Served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Preschool children	☐
	African Americans	☒	Pregnant women	☐
	Caucasians	☒	School-age children (elementary)	☐

	Elderly	☒	School-age children (teens)	☐
	Infants	☐	Uninsured	☒
	Latinos	☒	Other: Patients with chronic conditions	☒
	Native Americans	☒	Other: Patients with behavioral health issues	☒
	Pacific Islanders	☐	Other:	☐
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/promotores	☒	Substance abuse	☒
	Coordination of care services	☒	Telehealth	☒
	Emergency medical services	☐	Transportation to health services	☐
	Health education and promotion	☒	Other:	☐
	Health information technology	☐	Other:	☐

Health Information Technology System(s):	CrossTX	eClnical Works
	Athena	MedWorxs
	CPSI, Centriq	

Project Goals and Objectives:	**Goal/Objective**	**Description**
	Goal	Expand the shared frontier care coordination model to address the needs of rural patients with two or more chronic conditions and patients with behavioral health issues.
	Objective	Expand the evidence-based regional care coordination model into additional communities, to specialty services, and to integrated behavioral health services.
	Objective	Establish and adopt National Quality Forum (NQF) clinical measures to be evaluated, monitored, and reported for network staff and local clinicians.
	Objective	Implement changes in workflow in clinics' primary care provider (PCP) practices to accommodate the care coordination model, remote patient monitoring services, integrated behavioral health services, and communications between care coordinators and PCPs. Implement workflow changes that will maximize and align with evolving payment models and reimburses for billable care coordination services.
	Goal	Establish relationships and communications with local non–health care entities to explore community involvement in the shared care coordination model.
	Objective	Continually identify concerns and issues for implementation of shared care coordination, remote monitoring, and integrated behavioral health that can be supported by local non–health care entities. This support might address

		potential problems like transportation, smoking cessation, home visitors, and access to education services.
	Goal	Expand the sustainable financial reimbursement model for care coordination services with current and evolving payment reform opportunities.
	Objective	Further develop a financial model for care coordination that maximizes reimbursement for care coordination services, remote patient monitoring, and behavioral health integrations. Expand services beyond network members to additional communities and specialty providers.
	Objective	Research additional reimbursement models to maximize financial sustainability of the shared care coordination model.
	Goal	Expand use of telehealth technology to support shared care coordination.
	Objective	Maintain and expand collaboration with the Eastern Montana Telemedicine Network (EMTN) for support in the delivery of specialty services and access to behavioral health integration, education, and other services.
	Objective	Expand the Remote Patient Monitoring (RPM) program to additional network members and additional specialty providers to monitor patients struggling to manage conditions or due to recent hospitalizations or new diagnoses.
	Objective	Evaluate and analyze the financial viability of telehealth applications in light of evolving reimbursement models.
	Goal	Advance the dissemination model for shared care coordination project to appropriately share clinical and financial results, outcomes, and evidence of improved population health in frontier communities.
	Objective	With Montana Health Network (MHN) and Eastern Montana Care Coordination Consortium (EM3C) governing boards, expand the dissemination plan and schedule for clinical and financial measures and outcomes from shared care coordination efforts.
	Objective	Expand plans for regional, statewide, and national distribution of data to allow for replication by similarly challenged rural and frontier health care providers and organizations.

Project Description:

- Recruiting and training personnel to assume care coordination responsibilities — EM3C employs a regional care coordinator to oversee care coordination among member communities. EM3C will also recruit, hire, and train community health workers (CHWs) in each member community.
- Developing new or utilizing existing behavioral health services — MHN will utilize valuable information and lessons learned from administering the Montana Health Care Foundation Integrated Behavioral Health grant to support integration of behavioral health services within primary care clinics.
- Addressing quality improvement through innovations like telehealth — EM3C utilizes best practice remote patient monitoring services to assist specialists and primary care providers in continually monitoring patient health status. MHN will also utilize implementation of telehealth for behavioral health services and implementation of care coordination software to support tracking of patient outcomes.
- Leveraging strengths and resources of different member organizations — EM3C is an established consortium of remote, frontier clinics desiring to improve population health through regional care coordination services. MHN can utilize lessons learned in establishing the network to expand services and ensure continuation of care coordination best practices while reaching additional communities and patients from all payers.

Evidence-Based/Promising Practice Model Being Used or Adapted:

EM3C will follow the Chronic Care Model outlined by the Centers for Disease Control and Prevention (CDC). The Chronic Care Model uses six components that are "hypothesized to affect functional and clinical outcomes." These components are as follows: (1) Health System Support, (2) Self-management Support, (3) Decision Support, (4) Delivery System Redesign, (5) Clinical Information Systems, and (6) Community Resources and Policies. EM3C will also utilize the evidence-based domains identified by the NQF in the 2010 report *Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report*. This report identified 25 preferred practices in care coordination to include in the implementation of a successful care coordination program. EM3C will base the further expansion of care coordination services, remote patient monitoring services, and integrated behavioral health services on the following health care practice domains: (1) Healthcare "Home" Domain, (2) Proactive Plan of Care and Follow-up Domain, (3) Communication Domain, (4) Information Systems Domain, and (5) Transitions or Handoffs Domain. These health practices domains match the Chronic Care Model adopted by EM3C to provide regional care coordination services in Montana.

EM3C will expand and upgrade as appropriate the existing remote patient monitoring (RPM) program based on well-developed best practices. EM3C determined that the program has been successful with current patients to improve outcomes by instilling the value of good daily habits to those with chronic conditions. The RPM program offers significant opportunity for MHN, providers within the region, and most of all patients who can benefit for this daily contact with clinical staff via this state-of-the-art technology. This model of RPM will be expanded beyond the initial pilot by expanding the reach of the primary communities served by the project. EM3C will also conduct dissemination and outreach projects to promote the use of RPM technology among specialty providers seeking to improve care transitions for patients at risk following hospitalizations, acute episodes of care, emergency department (ED) visits, and diagnosis of new conditions.

Efforts toward improved health outcomes for individuals with behavioral health issues will include a framework that incorporates both integration and collaboration. Integration brings together inputs, delivery, and management of services to provide diagnosis, treatment, care, rehabilitation, and health promotion. Integration is structural, organizational, and operational. Integration plays a pivotal role in how patients access care, and it influences which health care professionals will provide care. There is no one-size-fits-all model for integration; models include a patient-centered medical home and an accountable care organization. Collaboration is sharing planning, decision-making, problem-solving, goal-setting, and other responsibilities. Health care professionals must work together cooperatively, communicating and coordinating openly. Collaboration is teamwork. With more integration in the care setting, greater collaboration is required to create a successful care model. In developing and cultivating collaboration, many actions are quick and easy to implement, such as organizing regular, frequent meetings between behavioral health specialists and other health care professionals. Some actions require a high degree of energy and organization, such as consistently deploying and using care managers throughout the care continuum. Even if a lower level of integration is chosen, hospital leaders still can implement new collaboration strategies.

Expected Outcomes:

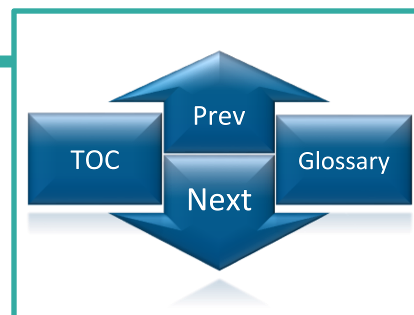
Short-term impact. (1) Best clinical practices shared across rural providers, (2) RPM expanded and integrated behavioral health available to improve all aspects of quality of life for those with chronic conditions, (3) consortium established with appropriate governance to support patients with chronic conditions, and (4) a process review that leads to increased performance and improved patient outcomes.

Long-term impact. (1) Improved patient and provider experiences, (2) reduction in ED and clinic unnecessary utilization and readmission within 30 days, (3) additional support for frontier providers in providing chronic illness care and education, (4) improved chronic care and behavioral health results in the rural population in eastern Montana, (5) increased patients with successful self-management, (6) improved patient outcomes, (7) reduced costs of care, (8) improved clinical population health management, and (9) a self-sustaining care coordination program.

Economic impact. Because the local health care organizations in these remote, frontier communities are usually the largest employers, the economic impact is typically greater than one would expect or greater than what exists in other large communities. As the Montana Department of Commerce has conducted various economic impact studies of health care organizations in frontier communities throughout Montana, the findings have been dramatically more significant with

economic impact factors greater than 1 (often between 1.2 and 1.4). In other words, the typical community with one of these small organizations received well over one dollar for each dollar spent by frontier health care providers.						
Project Officer (PO) Contact Information:	**Name:**	Mew Pongsiri				
	Tel No.:	301-443-2752				
	Email:	kpongsiri@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip Code:**	20857
Technical Assistance (TA) Consultant Contact Information:	**Name:**	Ann Abdella				
	Tel No.:	404-413-0314				
	Email:	abdella@a2rh.net				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip Code:**	30303

Washington



San Juan County Public Hospital District 1

Grant No.:	D78RH39354				
Organization type:	Public Hospital District 1, supporting critical access hospital services				
Grantee Organization Information:	**Name:**	San Juan County Public Hospital District 1			
	Address:	849 Spring Street			
	City:	Friday Harbor	**State:** Washington	**Zip Code:**	98250
	Tel No.:	360-378-2857			
	Website:	www.sjcphd.org			
Primary Contact Information:	**Name:**	Pamela Hutchins			
	Title:	SJCPHD Superintendent			
	Tel No.:	360-378-2857			
	Email:	hutchins@sjcphd1.org			

	Month/Year to Month/Year	Amount Funded Per Year
Expected Funding Level for Each Budget Period:	Sep 2020 to Aug 2021	$249,543
	Sep 2021 to Aug 2022	$249,593
	Sep 2022 to Aug 2023	$249,543

	Partner Organization	County	State	Organization Type
Consortium Partners:	Peace Health Peace Island Medical Center	San Juan County	WA	Critical access hospital
	Inter-Island Healthcare Foundation	San Juan County	WA	Foundation 501(c)(3)
	Association of Washington Public Hospital Districts (AWPHD)	King County	WA	The trade association for all of Washington state's public hospital districts

Counties the Project Serves:	San Juan County

	Population	Yes	Population	Yes
Target Population Served:	Adults	☒	Pacific Islanders	☐
	African Americans	☐	Preschool children	☐
	Caucasians	☒	Pregnant women	☐
	Elderly	☒	School-age children (elementary)	☐
	Infants	☐	School-age children (teens)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐

<table>
<tr><td rowspan="13">Focus Areas of Grant Program:</td><td>Focus Area</td><td>Yes</td><td>Focus Area</td><td>Yes</td></tr>
<tr><td>Access: Primary care</td><td>☒</td><td>Health information technology</td><td>☒</td></tr>
<tr><td>Access: Specialty care</td><td>☒</td><td>Health professions recruitment and retention/workforce development</td><td>☒</td></tr>
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<tr><td>Health education and promotion</td><td>☒</td><td>Transportation to health services</td><td>☒</td></tr>
<tr><td rowspan="3">Health Information Technology System(s):</td><td colspan="4">EPIC — electronic medical records system for critical access hospitals (CAH) and primary care</td></tr>
<tr><td colspan="4">Julota — Community Referral Platform used with San Juan County Community Paramedicine</td></tr>
<tr><td colspan="4">CrossTX — Subscription service virtual network platform for education and training</td></tr>
<tr><td rowspan="6">Project Goals and Objectives:</td><td>Goal/Objective</td><td colspan="3">Description</td></tr>
<tr><td>Goal</td><td colspan="3">Implement, evaluate, and refine a sustainable evidence-based community-based care coordination model for seniors that will meet the immediate and future needs of the high-risk elderly in our rural island communities.</td></tr>
<tr><td>Objective</td><td colspan="3">Use a collaborative approach to design, test, and operationalize a regional care coordination program that helps the growing and isolated elderly population in our multi-island county remain as independent as possible, and within their homes or on the island of their residence.</td></tr>
<tr><td>Objective</td><td colspan="3">Develop, strengthen, and train a highly skilled care coordination workforce to respond to the elderly population’s unmet needs.</td></tr>
<tr><td>Objective</td><td colspan="3">Establish effective revenue sources through braiding of various existing reimbursement streams, resource sharing, and contributions from partners at the community, county, regional, and state levels.</td></tr>
<tr><td>Objective</td><td colspan="3">Utilize grant-required and project-specific measures to assess and report on project progress and outcomes.</td></tr>
<tr><td colspan="5">Project Description:</td></tr>
<tr><td colspan="5">San Juan County’s elderly residents and their families have been greatly impacted by loss of and/or inability for the community to retain community-based long-term care services, especially after the county’s only skilled nursing home closed in 2017. This grant project will build upon the work of the San Juan County Long Term Care Coordination Network and community over the past few years. The network members will create an evidence-based sustainable care coordination system based on the Pathways Community HUB model. Modifications to this model will be made to address the unique geography and care delivery needs of the county, including small volumes, remoteness, the travel challenges of island communities, the high cost of living, lack of a caregiving workforce, and low payment/reimbursement rates. The work plan of the network will rely on a collaborative approach to design, test, and operationalize a regional care coordination program that supports the growing isolated elderly population.

There are severe limitations on county-based home care, home health, and hospice services. There are no day health respite or other supportive services, as well as virtually no public transportation options other than taxi service at a high cost. The most pressing need is for a skilled, accountable workforce to care for the most vulnerable residents of the</td></tr>
</table>

county. Workforce is in short supply due to the high cost of living and the lack of affordable housing in the county. This grant will be used to develop, train, and support a highly skilled care coordination workforce. It will be necessary to secure an effective revenue source using various existing reimbursement streams, resource sharing, and contributions from partners at the community, county, region, and state levels to support the creation of this workforce.

The network began with a community foundation willing to raise funds to pay for a feasibility study of community needs for care coordination. There is a proven track record of leveraging foundations on three of the county's main islands to undertake stabilizing primary care, securing a new critical access hospital built in 2013 and supporting EMS and its development of community paramedicine. In addition to local philanthropic support for this project, this grant supports the work of Washington's Medicaid Healthier Washington Transformation project, which calls for Accountable Communities of Health (ACHs) to create the next generation of systems of care that focus on outcomes to support families in caring for loved ones. The ACH has funding available to support infrastructure supports for providers to provide value-based outcomes. Lastly, the network includes the Association of Washington Public Hospital Districts (AWPHD) to provide technical assistance, expertise, and resources related to potential reimbursement streams and additional funding sources to ensure sustainability.

The primary strategies to operationalize the work plan are enumerated below:

- Implement a locally tailored version of the evidence-based Pathways Community HUB model called the San Juan Senior Pathways Community HUB.
- Establish a quality committee to oversee and provide support and expertise to all aspects of the grant implementation.
- Utilize a web-based platform to create "connected communities" to support care coordination, referrals, and connections to services and resources (Julota).
- Provide additional support through the addition of community care coordinators (CCCs) to develop and deliver patient-centered, evidence-based support and care to elderly, at-risk, chronic illness patients.
- Implement the promising practice of using a trained volunteer cohort (or trained EMTs, social workers, or other community health workers identified during COVID) to provide the majority of the CCCs required for this project.
- Track and quantify care coordination activities that are reimbursable.
- Pursue participation in shared savings programs
- Leverage the support of San Juan County local health care foundations and public hospital taxing districts on three of the major islands.
- Leverage state of Washington initiatives for sustainable funding — WA Medicaid Healthier WA Transformation Project — ACH North Region.
- Continue engagement with the Department of Social and Health Services— Aging and Long-Term Support Administration (ALTSA), Home and Community Services Division.
- Determine how to braid/blend existing and pending new reimbursement sources to address needs and gaps using the expertise of AWPHD advocacy.
- Utilize grant-required and project-specific measures to assess and report on project progress and outcomes, and modify the program as necessary.
- Establish quality assurance and quality improvement activities designed to identify and modify ineffective efforts.
- Periodically assess project performance to measure progress toward meeting goals and objectives.
- Directly measure impact of grant-funded activities.

Evidence-Based/Promising Practice Model Being Used or Adapted:

The evidence-based, promising practice model being adapted to achieve the goals and objectives of this grant is a locally tailored version of the evidence-based Pathways Community HUB model called the San Juan Senior Pathways Community HUB (SJSPCH). The network will adapt the Pathways Community HUB model using a guide that was initially published in 2010 by the Agency for Healthcare Research and Quality (AHRQ). The HUB model is a community care coordination approach focused on reducing modifiable risk factors for high-risk individuals and populations.

Initiation of care coordination as a team-based approach in health care began in 2011 with the implementation of the Medicare Annual Wellness visit in primary care and has continued to be an evidence-based approach toward achieving

the triple aim: better health for the population, better care for the individuals, and lower costs through improvements in care coordination. The tailored regional HUB care coordination model is a communitywide networking strategy that will help siloed health and social service programs become a quality-focused team to identify those at risk and connect them to managed care using a shared referral database. The San Juan regional HUB care coordination model will train and employ community care coordinators who can serve as community health workers, nurses, social workers, volunteer EMTs, and paramedics to reach out to at-risk, complex, chronic care individuals. Complex chronic care management services employ a team approach to complete comprehensive assessments of health, social, behavioral, economic, and other risk factors to ensure that risk is mitigated, resolved, monitored, and managed as directed by a physician or other qualified health care professional. Allowable reimbursements for these services will be tracked and used for projections and revenue to determine long-term sustainability.

Expected Outcomes:

The expectation is that the Network Care Coordination Program will result in long-term changes and specific improvements in morbidity and mortality in San Juan County by supporting seniors at home within the island communities to safely age in place, have less fall risk, fewer medication errors, and less social isolation and depression. By providing home-based community care coordination, workforce development, and maintenance of desired safety and needed supports and resources, San Juan County can serve as rural model of health care that can be replicated throughout Washington state and nationwide in other rural communities. With for-profit nursing home models failing in many rural communities, and especially as the COVID-19 pandemic has highlighted, the need to find a sustainable alternative solution to this model weighs heavily on San Juan County. The San Juan County Long Term Care Coordination Network has worked for three years and come together to form an effective network of trusted and respected community-based social and health organizations. The Network expects to be successful in implementing, supporting, and sustaining the outcomes defined in this funding opportunity.

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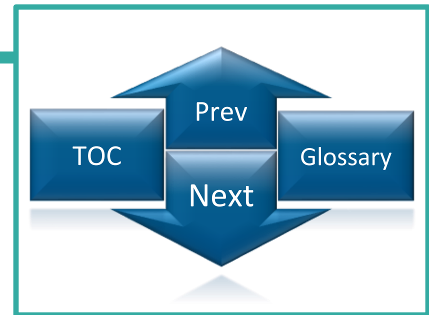
	Tel No.:	404-413-0314				
	Email:	apetiwala@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip Code:**	30303



Michigan

Upper Peninsula Health Care Solutions Inc.

Grant No.:	D7839355					
Organization type:	Nonprofit organization					
Grantee Organization Information:	**Name:**	Upper Peninsula Health Care Solutions Inc.				
	Address:	853 W. Washington St.				
	City:	Marquette	**State:**	Michigan	**Zip Code:**	49855
	Tel No.:	906-225-7843				
	Website:	www.uphcs.org				
Primary Contact Information:	**Name:**	Tyler LaPlaunt				
	Title:	UPHCS Assistant Director				
	Tel No.:	906-225-7843				
	Email:	tlaplaunt@uphcs.org				

Expected Funding Level for Each Budget Period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Sep 2020 to Aug 2021	$247,456.92
	Sep 2021 to Aug 2022	$249,986.27
	Sep 2022 to Aug 2023	$249,986.87

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organization Type**
	Marquette County Health Department	Marquette	MI	County health department
	Upper Peninsula Health Plan	15 Upper Peninsula (UP) counties	MI	MCO
	Northcare Network	15 UP counties	MI	PIHP
	Great Lakes Recovery Centers	15 UP counties	MI	NPO – BH/MH
	UP Health System – Marquette	Marquette	MI	Hospital

Counties the Project Serves:		
	Baraga	Keweenaw
	Chippewa	Marquette
	Gogebic	Ontonagon
	Houghton	

Target Population Served:	**Population**	**Yes**	**Population**	**Yes**
	Adults	☒	Preschool children	☐
	African Americans	☐	Pregnant women	☒
	Caucasians	☐	School-age children (elementary)	☐
	Elderly	☐	School-age children (teens)	☐
	Infants	☒	Uninsured	☒
	Latinos	☐	Other: Pharmacotherapy for SUD	☒

	Native Americans	☐	Other: OUD	☒
	Pacific Islanders	☐	Other: Medicaid beneficiaries	☒

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/promotores	☒	Substance abuse	☒
	Coordination of care services	☒	Telehealth	☒
	Emergency medical services	☒	Transportation to health services	☒
	Health education and promotion	☒	Other:	☐
	Health information technology	☒	Other:	☐

Health Information Technology System(s):		
	Michigan Health Information Network	eClinicalworks (EHR) with Transition of Care Management (TCM) Module
	Cotivi Provider Intelligence	Boardeffect
	Altruista GuidingCare care management	

Project Goals and Objectives:	**Goal/Objective**	**Description**
	Goal	The goal of the UP Maternal Opioid Misuse (MOM) model program is to improve the quality of care for pregnant and post-partum Medicaid beneficiaries with opioid use disorder (OUD) residing in Baraga, Chippewa, Gogebic, Houghton, Keweenaw, Marquette, and Ontonagon counties by implementing community health worker (CHW)-centered care coordination strategies that focus on cross-system collaboration and improved health outcomes over the course of the three-year performance period.
	Objective	Use the Community Health Worker Model for Care Coordination to provide services for UP MOM model program enrollees at the Marquette County Health Department
	Objective	Provide housing options for enrollees participating in the UP MOM model program in Marquette County in year 1, expand to Chippewa County Health Department service area in year 2, and further expand to the four-county service area of the Western UP Health Department.
	Objective	Train the Marquette County Community Health Worker to provider care coordination services to enrollees in year 1, expand training and/or certification for a Chippewa County CHW, and further expand training and/or certification for a Western UP service area CHW.
	Objective	Provide training to community-based organizations and care providers to reduce stigma, and improve coordination services across systems throughout all three years of the project.
	Objective	Formalize a consortium of key regional partners and stakeholders to reduce service fragmentation, improve coordination of services, and inform reimbursement strategies for program sustainability in year 1 in Marquette

		County, year 2 in Chippewa County, and year 3 in Baraga, Gogebic, Houghton, Keweenaw, and Ontonagon counties of the Western Upper Peninsula of Michigan.

Project Description:

The UP MOM model program coordinator and UP MOM model CHWs identify and enroll members through engaging with the following network of medical providers, care managers, behavioral health care providers, home visitors, and community-based organizations to coordinate program sharing and identify pregnant Medicaid beneficiaries with opioid use disorder with (1) Upper Peninsula Health Plan (UPHP), the sole Medicaid managed care and provider-service organization in the Upper Peninsula (UP) of Michigan, (2) NorthCare, the sole prepaid inpatient health plan in the UP, (3) Great Lakes Recovery Centers (GLRC), one of the largest providers of behavioral health services, (4) the Marquette Health Department, the government agency responsible for public health initiatives, and (5) the Upper Peninsula Health System–Marquette location, home to the only neonatal intensive care unit (NICU) in the UP.

The identification of a target population from all seven counties into the UP MOM Model program to make referrals to meet enrollee needs. Enrollees screened for social determinants of health (SDOH) needs receive referrals and are engaged in and compliant with in-home visiting programs, personalized plans of care, engaging in initiating breastfeeding, engaging in OUD treatment, and continuation in medication-assisted treatment through delivery. Partner and consortium collaboration will be engaged for each SDOH need identified for the enrollee. Additionally, program participants will be provided with short-term housing opportunities near proximity to the regional NICU for those women near their delivery date and those whose infant is in the NICU postpartum.

Training in care coordination services including CHW certification, safe sleep, home visiting, early childhood education, baby care and breastfeeding, caring for people with OUD, contraceptive counseling, and smoking cessation will be provided to UP MOM model CHWs. Expansion of training will continue to community-based organizations, and care providers will receive health equity training to improve coordination and reduce stigma across systems and will liaise with the UP MOM Model Consortium, UP Perinatal Collaborative, Maternal Infant Health Program, UP Home Visitor Network, and public housing agencies.

Evidence-Based/Promising Practice Model Being Used or Adapted:

An adaptation of the promising practice of the Community Health Worker Model for Care Coordination focuses on coordinating care across systems for this target vulnerable population. Additionally, the program will be guided by the Building a Community Health Worker Program: The Key to Better Care, Better Outcomes, and Lower Costs toolkit from the American Hospital Association and the Substance Abuse and Mental Health Services Administration's A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders to implement CHWs to work as care coordinators. The project will focus on maximizing the impact of CHWs as care coordinators for the target population and will provide CHW certification opportunities in addition to training on a wide array of topics that are important to program participants, including breastfeeding, smoking cessation, well care for infants, early childhood development, safe sleep practices, health coaching, contraceptive counseling, stigma reduction, and working with people who are affected by OUD.

Expected Outcomes:

The expected outcomes from program activities include an increase the number of program enrollees who participate in home visiting programming, treatment, and plan of care engagement, initiation of breastfeeding among program enrollees, and the percentage of enrollees who have been screened for SDOH needs. In addition, increase referral compliance among enrollees over the course of the three-year project period, including prenatal/OB/GYN visits, postpartum OB/GYN visits, mental health counseling, dental, Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) program, and other programs that may be developed across the project period.

For enrollees on pharmacotherapy for the treatment of OUD (medicated-assisted treatment) increase the percentage who maintain continuity of pharmacotherapy at delivery to reduce the length of stay in the regional NICU by 10% for enrollees whose infants are affected by neonatal abstinence syndrome (NAS) over the course of the three-year project period. Furthermore, reduce the proportion of emergency department utilization by pregnant Medicaid beneficiaries with OUD in the seven target counties by 5% over the course of the three-year project period.

<table>
<tr><td rowspan="5">Project Officer (PO) Contact Information:</td><td>Name:</td><td colspan="5">Mew Pongsiri</td></tr>
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</table>

Glossary of Terms

Term	Definition
Accountable Care Organization (ACO)	ACOs are networks of hospitals, physicians, specialists, and other combinations of providers that voluntarily contract with a payer to share the medical and financial responsibility for coordinating the care of an assigned population.
Community health worker	A public health worker who is a trusted member of and/or has an unusually close understanding of the community served that enables the worker to serve as a link between health/social services and the community and facilitate access to services.
Critical access hospital (CAH)	Critical access hospital is a designation given to eligible rural hospitals by the Centers for Medicare and Medicaid Services. Eligible hospitals must meet the following conditions to obtain CAH designation: Have 25 or fewer acute care inpatient beds; be located more than 35 miles from another hospital; maintain an annual average length of stay of 96 hours or less for acute care patients; and provide 24/7 emergency care services.
Electronic health record (EHR)	An EHR is an electronic version of a patient's medical history that is maintained by the provider over time, and may include all of the key administrative clinical data relevant to that persons care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory and other data and reports.
Federally Qualified Health Center (FQHC)	FQHCs are community-based health care providers that receive funds from the Health Resources and Services Administration to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients.
Health Information Exchange (HIE)	A Health Information Exchange is a system that provides the capability to electronically move clinical information among disparate healthcare information systems and maintain the meaning of the information being exchanged.
Hospital readmission rates	An episode when a patient who had been discharged from a hospital is admitted again within a specified time interval. Readmission rates have increasingly been used as a quality benchmark for health systems.
Integrated behavioral health	The blending into one setting care for medical conditions and related behavioral health factors that affect health and well-being.
National Quality Forum	Not-for-profit organization that endorses healthcare quality metrics and standards that serve as standards for many federal public reporting and pay-for-performance programs as well as in private-sector and state programs
Patient-Centered Medical Home (PCMH)	Patient-Centered Medical Home is a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand.
Prospective payment system	A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services) and the type of healthcare entity (e.g., acute inpatient hospitals, home health agencies, hospice, inpatient psychiatric facilities, etc.).
Remote patient monitoring (RPM)	The use of digital technology to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers in a different location.
Social determinants of health (SDOH)	Conditions in the environments in which people live, learn, work, play, and worship that affect a wide range of health, functioning, and quality-of-life outcomes.

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