Rural Health Care Coordination Sourcebook

September 2023

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

Table of Contents

Introduction

In fiscal year 2020, the Federal Office of Rural Health Policy (FORHP) funded 10 rural health awardees through the Rural Health Care Coordination Program for a three-year grant. This program is authorized by Section 330A(e) of the Public Health Service Act (42 USC 254c(e)), as amended. The purpose of the Rural Health Care Coordination Program is to support rural health consortiums/networks to improve access, delivery, and quality of care through the application of care coordination strategies in rural communities.

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] The goal of care coordination is to connect providers and entities (primary care, specialty care, hospitals, behavioral health providers, and other services) in a way that creates smooth transitions and continuity of care for the patient. Poorly coordinated patient care can result in a higher incidence of medical errors, lower rates of patient engagement in their health care, higher rates of hospital readmissions, and higher instances of preventable emergency department visits.[2]

Care coordination is especially essential in rural America, where health and health care have long been characterized by several competing stressors, including fragile systems of care, high rates of poverty, longer distances to health services, and provider shortages. 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] A significant shift in health care reimbursement is underway as payers and providers move away from volume to value-based care and the integration of behavioral and social care needs. Organizations working on care coordination are at the forefront of these changes. Rural providers are challenged by factors such as low volume, making it difficult for them to assume risk-sharing arrangements. FORHP created the Rural Health Care Coordination Program to provide initial seed funding to rural providers implementing creative local health solutions to expand coordination of care and to better position rural health entities for success in the current health care financing landscape.

This *Sourcebook* provides a summary of the 10 Rural Health Care Coordination grantees funded during the 2020-2023 grant period. Following the cohort snapshot below, each grantee is profiled. The grantee profiles include key program contact information, care coordination consortium partners, population served, evidence-based care coordination model utilized, program goals, key outcomes and impacts, and lessons learned.

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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

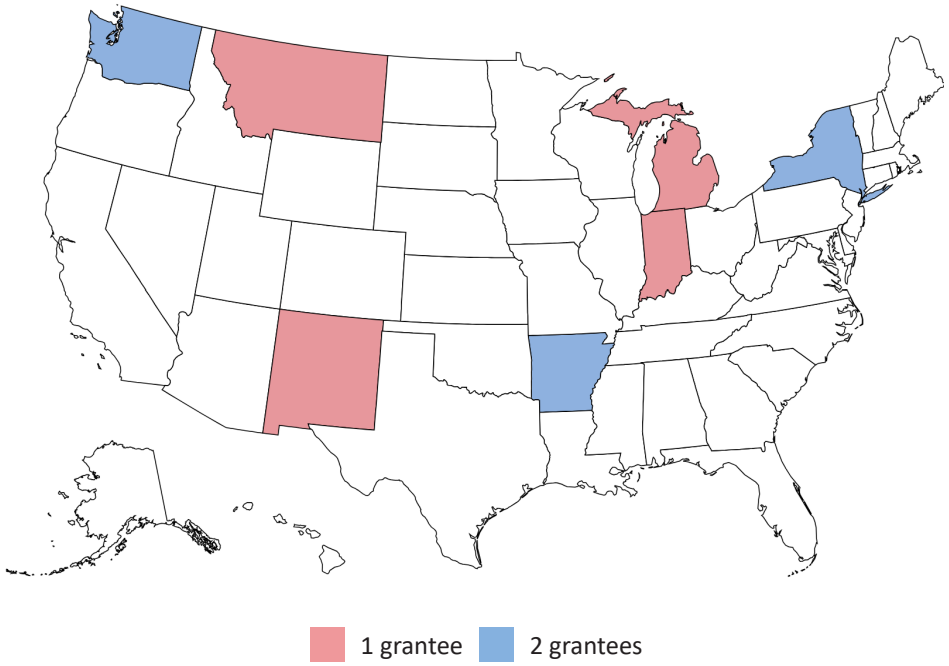
[2] Stanek, M., Hanlon, C., & Shiras, T. (2014). Realizing rural care coordination: Considerations and action steps for state policy-makers. Robert Wood Johnson Foundation. Available at https://www.shvs.org/wpcontent/uploads/2014/04/RWJF_SHVS_Realizing-Rural-CareCoordination.pdf

[3] Moy, E., Garcia, M. C., Bastian, B., et al. (2017). Leading causes of death in nonmetropolitan and metropolitan areas — United States, 1999–2014. *MMWR Surveillance Summaries*. Available at https://www.cdc.gov/mmwr/volumes/66/ss/ss6601a1.htm

Cohort Snapshot

Reach of the Program

During the 2020-2023 funding period, FORHP funded 10 rural health entities across seven states. Grantees were funded up to $250,000 a year for three years to implement rural-based care coordination initiatives.



Grantee Profiles by Primary Focus Area

Focus Area	Care Coordination	Care Transitions	Community Health Workers	Maternal/ women's Health	Migrant Farmworker Health	Suicide
Arkansas Behavioral Health Integration Network						•
Arkansas Rural Health Partnership	•					
Champlain Valley Physicians Hospital Medical Center		•				
El Centro Family Health	•					
Finger Lakes Migrant Health Care					•	
Indiana Rural Health Association				•		
Kittitas County Health Network	•					
Rural Health Development, Inc.	•					
San Juan County Public Hospital District 1	•					
Upper Peninsula Health Care Solutions, Inc.			•			

Funded Activities and Accomplishments

Collaboration. Grantees were funded to utilize 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:

- Creation of data sharing agreements and ability to effectively track patient health care utilization across entities (e.g., primary care, emergency departments, among others) allowed consortium members to better understand patient care needs and provide appropriate clinical and other supports.
- Formalization of referral agreements and workflows resulted in increased utilization of available resources within rural communities and better outcomes as a result.
- Creation of new partnerships with local organizations across the spectrum of health, behavioral health, and social services aided grantees in meeting the coordinated health and social determinants of health needs of their patients.
- Collaboration within the consortium illuminated gaps in service delivery and areas for improvement in care coordination.

Leadership and Workforce. Grantees were charged with developing and strengthening a highly skilled care coordination workforce to respond to vulnerable populations' unmet needs within the rural communities. Accomplishments included:

- Standardized trainings developed and implemented for care teams and consortium staff.
- Training and integration of newly hired care coordinators into care teams and workflows.
- Increased organizational and staff engagement in integrated care workflows as a direct result of provider training on new screening and referral processes.
- Increased usage of best practice protocols in screening and referral processes that helped standardize workflow processes.

Improved Health Outcomes. Grantees worked to expand access and improve care quality and delivery, and health outcomes through evidence-based models and promising practices tailored to meet the local populations' needs. Reported impacts included:

- Demonstrated improvement in patient screening and referrals. Grantees reported achieving near-universal patient screenings in areas including mental/behavioral health concerns, social determinants of health, and prenatal risk factors.
- Reduction in unnecessary emergency department utilization and hospital readmissions among care coordination program enrollees because of better care coordination and patient supports.

Sustainability. Grantees worked to develop long-term financial sustainability for the care coordination initiatives by establishing effective revenue sources such as expanded service reimbursement, resource sharing, and contributions from partners at the community, county, regional, and state levels. Successful sustainability strategies included:

- Increased revenue from billable services.
- New contracts with payers to provide care coordination services.
- Implementation of standard operating procedures across consortium partner organizations that embed care coordination practices in service delivery.
- Placement of community health workers within local health departments where their time is paid for by managed care organizations.

Arkansas Behavioral Health Integration Network

Rural Health Network

D78RH39346

Primary focus area:
Suicide

Other focus areas:
Behavioral/Mental Health
Care Coordination

Community Characteristics

Area
The Arkansas Lives Network of Care (ALiNC) Project serves the following counties in Arkansas: Searcy, Van Buren, Madison, Newton, Carroll, Marion, Stone, Boone, and White.

Target Population and Need
The ALiNC Project serves patients at risk of suicide by training primary care teams in screening, assessment, follow-up, and post-intervention. This includes supporting care coordination and support with specialty behavioral health, inpatient care, emergency services, and the broader community. More recently, training and support includes youth, LGBTQI+, and BIPOC patients.

Project Goals

Collaboration
Convene the ALiNC consortium and add membership based on care coordination and referral needs for ALiNC clinic patients:

- Perform an environmental scan with ALiNC clinics to identify current protocols, available services, and referral pathways related to suicide prevention.
- Invite additional organizations to participate in ALiNC consortium activities based on environmental scan.
- Finalize memoranda of understanding.
- Draft and finalize network care compact/referral management tool with ALiNC consortium members.

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:

- Increase clinic team and partnering communities' confidence in managing patients or residents who are at risk for suicide.
- Increase access to shared resources for suicide prevention and risk management.

- Based on environmental scan, establish common data metrics on access to behavioral health services, quality of care, and care coordination for patients at risk of suicide.

Leadership and Workforce
Develop capacity to assist staff at participating clinics and partner agencies in better identifying and responding to suicide risk:

- Present evidence-based practices for suicide risk and management.
- Train clinical practices and their communities in best practices in suicide prevention, intervention, and postvention.
- Identify a point person for each primary clinic or partnering agency to develop a robust peer-to-peer training and learning network.
- Develop care coordination registry and workflows with the consortium team and their community partners to manage patients as they transition through the continuum of care (identification, risk management, intervention, and follow-up).

Sustainability
Sustain ALiNC and replicate model across rural sites in Arkansas:

- Create a "road map" with key lessons learned from the project.
- Finalize evaluation report.
- Present model to Arkansas Department of Health Office of Rural Health and Primary Care.
- Present outcomes of decreased suicide and improved provider skills and confidence to Arkansas Department of Health, Department of Human Services, and multiplayer stakeholder group.

Evidence-based Model or Promising Practice

The following models were referenced in the development of the ALiNC Project: FirstLink Suicide Follow-Up Program, PROSPER, ZeroSuicide Institute, Children's Hospital CO Suicide Prevention Center of Excellence, 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 support 24 hours a day, seven days a week, instead of creating a new resource and focusing specifically on care coordination resources related to suicide.

Program Approach

ALiNC is dedicated to reducing the burden of suicidal ideation and completion through increasing the capacity of primary care to respond to and connect patients to resources in rural communities across the state. Network partners 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 respond consistently and confidently to moderate- to high-risk patients. As a result, the consortium, anchored by Arkansas Behavioral Health Integration Network, collaboratively develops and implements strategies to empower and provides resources for practices in management of these patients and thereby prevent deaths by suicide. This includes providing training, facilitating care compacts, and updating care workflows.

Outcomes

The project has achieved multiple anticipated and unanticipated key outcomes that have resulted in significant impact in various aspects of care delivery. These include impacts in the areas of health care staff attitudes and practices, documentation, engagement, and screening protocols:

Reduction of stigma among care team members.
This has fostered a more open and supportive environment for both patients and staff, facilitating better communication and understanding.

Increased staff engagement in integrated care workflows.
By promoting collaboration and communication among different health care professionals, the project has enhanced the perceived overall efficiency and effectiveness of care provision. All ALiNC clinics (100%) updated standard operating procedures to reflect evidence-based practices for managing suicide risk.

Improved screening for suicide in primary care settings.
Participating clinics have increased screening (a minimum of 25%) over the period of performance. By increasing awareness and implementing screening protocols, health care providers can identify patients at risk and provide timely interventions, potentially saving lives.

Implementation of workflows supporting suicidal ideation management.
This has resulted in the provision of appropriate and timely care to individuals experiencing suicidal thoughts. This has significantly improved the response to such cases and helped ensure the safety and well-being of patients.

Standardization of suicide-related training for all staff.
Clinics implemented standardized suicide training for staff members, ranging from front desk personnel to physicians, ensuring better recognition of warning signs and team-based crisis support. The project also expanded its impact by training community gatekeepers, enabling them to engage effectively with at-risk individuals and provide essential support. Overall, the grant team conducted 38 training sessions on a variety of topics that reached approximately 622 people over the course of the grant.

Outcomes were measured through interviews, surveys, and performance-improvement measures, confirming the project's positive impact on suicide prevention and care coordination. The multifaceted approach has significantly enhanced the quality of care and support for individuals at risk for suicide, benefiting both patients and health care providers.

Sustained Impacts

The sustained impacts of the project have been significant, leaving a lasting positive influence on various aspects of care and community engagement. Among the most notable sustained impacts are the creation of durable training on suicide and the establishment of new training requirements for all clinic staff. This ensures incoming staff members are equipped with the necessary knowledge and skills to handle suicidal ideation effectively.

Beyond training, the project has catalyzed a significant culture change related to suicide and mental health conditions, both within the clinical setting and the community at large. Stigma has been reduced, and a more

supportive and understanding environment has been fostered, promoting open discussions and destigmatizing mental health issues. Another profound and lasting impact is the increased awareness and visibility of suicide risk, symptoms, and presentation, both among health care professionals and in the wider community. This heightened awareness allows for early detection and intervention, ultimately saving lives.

The project's emphasis on coordination with specialty care providers has further enhanced the quality and continuity of care for patients at risk of suicide. By promoting collaboration and information-sharing between primary care and specialized mental health services, patients receive more comprehensive and tailored support.

Additionally, the project's commitment to universal screening and the implementation of appropriate responses in workflows has significantly improved the identification and management of individuals at risk. This systematic approach ensures that no patients fall through the cracks but instead receive the care they need promptly.

To facilitate efficient communication and care coordination, the project has successfully developed a care compact and a communication form. These tools streamline the exchange of essential information between care team members and specialty care providers, promoting better patient outcomes and reducing the risk of missed opportunities for intervention.

In conclusion, the sustained impacts of the project are evident in the transformation of care practices, the reduction of stigma, and the increased awareness of suicide risk not only among our consortium members, but also within the community. Through enhanced training, improved workflows, and better communication tools, the project has made a lasting difference in suicide prevention and mental health support, leaving a positive impact for years to come.

Lessons Learned

- Be sensitive to individual clinics and tailor assistance to them. Use a mixed-methods approach that utilizes dedicated training for primary care and behavioral health providers (combined) and real-time, individualized consults.
- Be aware of the impact of stigma, and address this directly through clinic culture and workflow change. Make suicide assessment and support everyone's job, and give them the tools to do their job (human resources training, backup, systems).
- Be responsive to and adapt to cultural differences in discussion of suicide, such as professional, community, religious, and so on.
- Utilize a "community connector" and talk to community members about their needs and leadership as you work to connect clinics and the patients and nonclinical services. You can create relationships to "borrow trust" and maximize the reach of community support. These relationships should start earlier in the process to spark connections and support for other project activities. It can be easy to be overly focused on some of the mechanics instead of the relationships, but this can be a pitfall.
- Start small and scale up (scope, service area, workflow changes, team engagement). If you gain momentum in your support, it will spark additional change.
- Engage clinic champions early. Praise them for their efforts and support them in driving changes at their clinics.

Consortium or Network Partners

Member Organization	Organizational Type
Arkansas Behavioral Health Integration Network	Nonprofit
Arkansas Primary Care	Primary Care Clinic, Multisite
Boston Mountain	Federally Qualified Health Center System
Cornerstone Whole Health Organization	Nonprofit
North Hills	Primary Care Clinic
PrimeCare	Urgent/Primary Care Center, Multisite

Grantee Contact Information

Grantee Contact: Kim Shuler
Organization: Arkansas Behavioral Health Integration Network
Address: 8455 Edgemont Drive, Suite B, Greens Ferry, AR 72067
Telephone Number: 479-871-3611
Email: kim.shuler@abhinetwork.org
Website: www.abhinetwork.org

Arkansas Rural Health Partnership

Nonprofit

D78RH39347

Primary focus area:
Care Coordination

Other focus areas:
Health Education and Promotion

Community Characteristics

Area
The project served 10 counties in the South Arkansas Delta: Arkansas, Ashley, Bradley, Calhoun, Chicot, Cleveland, Dallas, Desha, Lincoln, and Monroe.

Target Population and Need
The project addressed unmet rural post-acute needs of Medicare beneficiaries 65 years of age and older living within a 10-county service area through development of post-acute transitional care (TC) at seven Critical Access Hospitals (CAHs). Targeted support, training, and assistance equipped CAHs to care for additional, and more challenging, patients in underutilized CAH facilities and increased post-acute recovery options for rural residents.

Project Goals

Overall: Strengthen organizational and infrastructural capacity of 14 rural hospital partners to address post–acute care gaps and needs of Medicare beneficiaries (aged 65 and above), their families, and caregivers.

Collaboration
Enhance collaboration between rural CAHs and acute care hospital (ACH) partners to increase awareness and understanding of CAH post-acute TC via the Medicare swing bed option.

Improved Outcomes
Increase use of existing rural CAH resources and rural post-acute recovery.
Provide CAH post–acute care with shorter average length of stay than the national Medicare Part A nursing home average, low likelihood of discharge back to acute care from post–acute care, and a high percentage of discharge back to independence.

Leadership and Workforce
Equip, educate, and support hospital leaders, providers, and staff in provision of high-quality, CAH TC.

Sustainability
Launch TC services within seven CAHs including establishment of local processes, education, and data tracking; consortium members share responsibility for planning, achievement, dissemination, and sustainability of activities.

Evidence-based Model or Promising Practice

The project implemented CAH-based TC, a proven post-acute model with a focus on team culture and quality that optimizes use of existing rural resources, designed and supported by Allevant Solutions, LLC, developed by the Mayo Clinic and Select Medical.

Program Approach

The Arkansas Rural Health Partnership (ARHP) provided a project director and facilitated oversight via ARHP member board meetings. A consulting group, Allevant Solutions, LLC, provided project management, process and clinical staff education, reference documents, a database, just-in-time support, ACH education on TC, and access to MENDS® health and wellness content. MENDS is a wellness initiative that is offered to post-acute patients prior to discharge and focuses on mindfulness, exercise, nutrition, health habits, connection, and sleep. Local CAH project managers coordinated local implementation. Initial CAH project manager cohort concept/process topic sessions transitioned to program development and refinement touch points. Local CAH teams met monthly, as able, to review processes and outcomes. CAH staff attempted to communicate with ACHs at least weekly. ARHP and Allevant provided ACH leaders with program information and education during the effort. Increased recognition and use of CAH TC improved rural Medicare beneficiary health equity by broadening awareness of high-quality rural post-acute options and facilitating recovery closer to home with better nurse-to-patient staffing, clinical competence, and on-site medical and ancillary support than most nursing home–based facilities.

Outcomes

The TC project implemented by ARHP accomplished a range of significant outcomes related to targeted quality- and capacity-building measures around the Delta region. As a result of grant-funded efforts, ARHP was able to show increased utilization of CAH post-acute recovery services, reduce the number of days patients spent in post–acute care, and raise positive patient satisfaction reports:

- Based on inclusive CAH billing data, the seven CAHs provided 10,907 TC bed days in months 1-32 of the project, and in aggregate, experienced a 96% increase in CAH TC bed days in months 27-32 compared to months 1-6.
- CAH TCs admitted patients from 28 different ACHs during the project, including many who were not in the collaborative.
- CAHs entered data on 600 CAH TC admissions in months 1-32. Due to COVID-19, entry was intermittent at some CAHs, resulting in representative, rather than complete, data. As bed days billed were just under 11,000 and using an average length of stay of 12.5 days, 600 admissions likely represented approximately 75% of all program admissions during the project.
- The measured average CAH TC length of stay for 548 discharged patients was 12.5 days compared to the most recent Medicare Part A nursing home average length of skilled stay of 26.2 days (2021 dates of service, per 2023 MedPAC Report to the Congress). Of these patients, 70% were discharged to home,

only 7% were discharged directly back to an acute care bed from a TC stay of 30 days or less (same or different hospital, planned or unplanned), and only 0.2% (one patient) died unexpectedly during the TC stay. Of 547 patients discharged who lived at home or in assisted living prior to their CAH TC stay, 76.5% were discharged back to home or assisted living from CAH TC (returned to independence).

- The measured CAH TC average length of stay reflected consistent averages of 12-13 days for the duration of the project, so overall increases in bed days were the result of additional TC internal (CAH) and external (ACH) referrals and admissions, not due to increasing lengths of stay during the project.
- Three CAHs used a nine-question patient satisfaction survey with 130 patients, which showed average responses ranging from 4.77 to 5 on a five-point positivity scale.
- Member CAH staff received education and developed resources to support quality care transition. One hundred forty-three CAH staff completed 516 online education modules. Several TC program brochures and updated web content were developed by CAHs, and ARHP facilitated a CAH capabilities summary handout for use at ACHs. In addition, all CAH core teams received introduction to MENDS® health and wellness education and access to MENDS® health and wellness action plans.

Sustained Impacts

Through structured implementation, education, data tracking, and ongoing review, CAH participants "hard wired" key concepts and processes through local policy and practice. Sustainable impacts include a broader CAH understanding of TC under the Medicare swing bed option, and regular ARHP conversations with ACHs support ongoing ACH recognition of the benefits of CAH TC. CAH staff have gained knowledge through online education modules. Increased communication between CAHs and ACHs has established more effective, ongoing relationships and more immediate awareness of needs, capabilities, and capacities. CAH teams have gained clinical confidence by admitting new, challenging TC cases and refining teamwork-based processes. CAHs may choose to continue to measure key data collection elements to support CAH TC in the future and have incorporated regular review of data to support quality and growth. Several CAH teams have incorporated new or enhanced community communication resources (web and print) and content. CAH leadership has an enhanced awareness of the importance of staff health and wellness in relation to long-term staffing stability. Overall growth in billable TC (swing bed) days has, and will continue to, provide patient care revenue for long-term CAH financial viability. The existence of CAH TC programs will continue to provide a discharge option for ACHs to reduce under- and unreimbursed stays.

Lessons Learned

This project began in month six of the COVID-19 pandemic, yet throughout the program, CAHs incorporated new processes and completed education, and TC bed days increased. Many nurses took travel jobs, and there were high illness and quarantine absence rates, often resulting in CAH project managers having full beside patient assignments and reduced capacity for meetings, project tasks, and data entry. Allevant recorded all collaborative content/concept meetings via Zoom and shared to ensure access for any project managers unable to attend. Project leadership accepted the reality of partial data entry and encouraged collection of the most impactful elements to drive change and show key outcomes.

Patient care was the emphasis when resources were limited; the needs of the patient came first. Project leadership addressed turnover of several CAH project managers or senior leaders through local CAH timeline flexibility with a focus on high-level project vision and core concepts. ARHP and Allevant revisited concepts, processes, and resources frequently with individual CAHs, especially when a new CAH project manager was

onboarding. Short staffing, acute care surges, and post-pandemic burnout challenged CAH staff's ability to fully take advantage of online education or focus on wellness. However, recognizing the unprecedented circumstances of the pandemic, CAH leaders were able to determine who on their team would complete specific courses, and by when. This, and local timeline flexibility, greatly reduced CAH project manager/leader anxiety. ARHP leadership used their significant relationships to maintain communication with ACHs throughout the effort. This was especially valuable during COVID-19 "crisis mode" operations and when there was turnover of key ACH leadership and case management staff. ARHP also leveraged a leadership intern role to maintain support connections, a low-cost, value-added strategy.

Consortium or Network Partners

Member Organization	Organizational Type
Allevant Solutions, LLC	Consultant
Arkansas Rural Health Partnership	Rural Health Network
Ashley County Medical Center	Community Access Hospital
Baptist Health-Stuttgart	Hospital
Bradley County Medical Center	Community Access Hospital
Chicot Memorial Medical Center	Community Access Hospital
Dallas County Medical Center	Community Access Hospital
Delta Memorial Hospital	Community Access Hospital
DeWitt Hospital & Nursing Home	Community Access Hospital
Drew Memorial Hospital	Hospital
Jefferson Regional	Hospital
Magnolia Regional Medical Center	Hospital
Medical Center of South Arkansas	Hospital
McGehee Hospital	Community Access Hospital
Medical Center of South Arkansas	Hospital
Ouachita Regional Medical Center	Hospital
University of Arkansas for Medical Sciences Health	University

Grantee Contact Information

Grantee Contact: Lynn Hawkins
Organization: Arkansas Rural Health Partnership
Address: 111 N. Court Street, Lake Village, AR 71653
Telephone Number: 501-588-3938
Email: lynnhawkins@arruralhealth.org
Website: www.arruralhealth.org

Champlain Valley Physicians Hospital Medical Center

Hospital

D78RH39348

Primary focus area:
Care Transitions

Other focus areas:
Care Coordination
Health Information Technology

Community Characteristics

Area
Rural North Country in New York, six counties: Warren, Washington, Essex, Hamilton, Franklin, and Clinton.

Target Population and Need
The targeted population is high-risk discharges to community from the five hospitals in the six-county region, primarily focused on the adult population. These high-risk clients need care coordination due to complex chronic conditions, social determinants of health needs, and high hospital utilization.

Project Goals

Collaboration

- Build a transitions care coordination collaborative called the North Country Care Coordination Collaborative (NCCCC). Engaged 33 organizations from different disciplines such as hospital inpatient case management, community care coordination agencies, community-based organizations, primary care, mental health, substance use disorder providers, value-based payment contracting partners such as Adirondacks ACO and Northwinds IHN, and managed care organizations.
- Additionally, NCCCC partnered with several local county offices, including the Office for the Aging.

Improved Outcomes

- Improve communication across disparate organizations by sharing risk score and care management agencies via our New York health information exchange (HIE) (known as Hixny). Risk score is based on chronic conditions, hospital utilization, and social determinants of health.
- Adopt best practice protocols across the region with improved consistency.
- Use available aggregate data via HIE claims and care management electronic health records (EHRs) to measure outcomes and identify opportunity.

Leadership and Workforce

- Create and implement best practice protocols building on existing programs and resources by sharing best practices and then encouraging adoption consistently across the region.
- Care management workforce development by surveying front-line care managers on priority training desired, offering training to regional care managers free of charge and making them available on the New York state Health Workforce Collaborative website.

Sustainability

- Continue use of aggregate data sources through convening and contracting organizations regionally.
- HIE communication sharing via risk score and care management agency information will continue and expand through the whole region being served by Hixny.
- Expand care management workforce development offerings through collaboration with Area Health Education Centers and a New York Health Workforce Collaborative. Lead Health Home support for the continuation of front-line care management trainings and forums; the regional partner, Adirondacks Health Institute, was awarded an additional Health Resources and Services Administration (HRSA) grant for care management workforce development in the region.

Evidence-based Model or Promising Practice

The evidence-based model was based on the American Academy of Family Practice risk-stratified care management rubric and the New York state Medicaid Health Home care management model. The promising practices implemented were based on previous regional collaboration and Medicaid reform work through the Medicare Shared Savings Programs, Adirondacks ACO quality improvement work, New York state Delivery System Reform Incentive Payment Medicaid reform, and the Northwinds Integrated Health Network IPA, which includes the regions' behavioral health and substance use disorder treatment programs. The region has over three decades of experience with this level of collaboration and incorporating care management services into the region's plan for support and improving population health in high-risk clients. This collaboration has a particular focus on those patients with behavioral health and social determinants of health concerns.

Program Approach

NCCCC is built on previous collaborative relationships with partners who are engaged and eager to improve population health through the efficient use of care management services. The collaborative shared best practice protocols for transitions of care through the region and then increased adoption of those effective strategies consistently throughout the whole region. The HIE is a key partner. NCCCC leveraged the HIE to improve communication and identify clients at risk and at high risk who would benefit from care management services. NCCCC offered care management workforce-development programs based on the front-line care manager training needs assessment and ongoing program evaluations. Events were online and in person. They were offered in a way that allows networking among regional care managers from different organizations. Program outcomes were measured using existing data warehouses and regional analytics resources to ensure ongoing measurement of results and identification of future population health opportunities. A process-mapping exercise was used to identify gaps in workflow implementation. In the last months of this grant, work is being completed to address areas of opportunity identified in the process-mapping exercise.

Outcomes

- NCCCC established an effective and engaged collaborative consisting of 33 partner organizations from primary care, hospitals, community-based organizations offering care management and social determinants of health (SDOH) support, mental health substance use providers, county agencies such as Office for the Aging and an Alzheimer's association, managed care organizations, and convener and contracting organizations such as Northwind Integrated Health Network IPA and Adirondacks ACO.
- The partners shared 43 best practice protocols to increase knowledge of programs available in the region. NCCCC implemented action plans for 12 processes to spread adoption of unique successful programs.
- Thirty-one training courses were offered in the form of webinars, and an in-person conference is planned to celebrate, share insights, and offer self-care workforce support.
- Partnering with the HIE established a risk flag for high- and at-risk clients in need of care management services. This is available to all Hixny users throughout New York state.
- A free-of-charge in-person conference is being held to share resources and best practices, encourage the workforce, and celebrate success.

Sustained Impacts

The NCCCC collaborative will continue in some form to implement continued care management improvement strategies as part of the HRSA workforce development grant and the proposed New York state 1115 waiver, focusing on addressing the SDOH. As evidenced by the commitment of the collaborative partners, care management is critical to that endeavor, so the collaboration will continue. Workforce development webinars are recorded and available on the New York state Health Workforce Collaborative website identified via the care coordination tab. Access to capacity-building tools such as the Adirondack health Institute forum and New York State Health Workforce collaborative webinars will help support programming. The funding received from the HRSA Care Management Workforce Development grant will also provide continued programing support. The improved communication leveraging the HIE for risk stratification will continue and be expanded to other parts of the state using this platform. Data analytics work focused on care management and SDOH outcomes, and improved transitions will continue through the work of the Adirondacks ACO, Northwinds IPA, and AHI. The shared data warehouse and analytics team are an integral part of these organizations.

Lessons Learned

- NCCCC's best outcomes came from programs implemented based on the direct input from front-line care management staff. As a result, one of the lessons learned is to increase co-design work incorporating front-line staff at every turn. Expanding that to include the consumer would also improve strategies. The methods used to garner feedback were surveys, subgroups with direct providers, and a process-mapping exercise. The LEAN Six Sigma process-mapping exercise would have been helpful at several points during the grant, rather than just at the end focused on sustainability.
- Using existing aggregate data sources whenever possible was a key success during the grant and improved sustainability. It is not sustainable to ask provider partners to supply all the data, given the daily pressures in their organizations. Going through the data use agreement process to assure protected health information is protected sets up a system that can be sustained.
- Taking full advantage of the technical assistance and HRSA support, and networking with other grantees greatly expands knowledge, skills, and strategies.
- Partnering with the HIE is an excellent way to overcome the barriers of disparate EHR systems. The HIE is very useful in areas of data analytics, risk stratification, and SDOH identification.

Consortium or Network Partners

Member Organization	Organizational Type
820 River Street	Community-based Organization
Adirondacks ACO	Accountable Care Organizatin
Adirondack Health Institute	Community-based Organization
Adirondack Health	Hospital
Alliance for Positive Health	Community-based Organization
Alice Hyde Medical Center	Hospital
Ascend Mental Wellness (formerly known as WWAMH)	Community-based Organization
Association on Aging in New York	New York State Office for the Aging
Behavioral Health Services North	Behavioral Health
Champlain Valley Physicians Hospital	Hospital
Clinton County Office for the Aging	Office for the Aging
Community Connections of Franklin County	Community-based Organization
Elizabethtown Community Hospital	Hospital
Families First	Community-based Organization
Fort Hudson Health System	Skilled Nursing Facility, Long-term Care, Care Management, and Home Care
Fidelis Care	Managed Care Organization
Franklin County Community Services	Community-based Organization
HCR Home Care	Home Care and Care Management
Hixny	Regional Health Information Exchange
Hudson Headwaters Health Network	Federally Qualified Health Center
Irongate Family Practice	Primary Care Practice
MVP HealthCare	Insurance Payer
Nascentia	Home- and Community-based Care Agency
Northwinds IHN	Behavioral Health Integrated Network
North Country Health Heart Network	Community-based Organization
St. Joseph's Addiction Treatment and Recovery Centers	Addiction Treatment Center
The University of Vermont Health Network	Population Health Service Organization

Grantee Contact Information

Grantee Contact: Mary McLaughlin
Organization: Champlain Valley Physicians Hospital Medical Center
Address: 175 Beekman Street, Plattsburgh, NY 12901
Telephone Number: 518-376-0483
Email: Mmclaughlin@ahihealth.org
Website: www.cvph.org ahihealth.org www.adirondacksaco.com

El Centro Family Health

Federally Qualified Health Center

D78RH39349

Primary focus area:
Care Coordination

Other focus areas:
Care Transitions

Community Characteristics

Area
Seven counties in the northeast region of New Mexico: Rio Arriba, San Miguel, Colfax, Harding, Guadalupe, Mora, and Taos.

Target Population and Need
New Mexico is one of the most diverse states in the nation, with this diversity mirrored in the service area's target population, which comprises 121,044 residents who are predominantly Hispanic (64.8%), followed by non-Hispanic White (29.3%) and American Indian (4.1%). Spanish is spoken in almost half of all homes (45.4%) in the service area, which is nearly double the New Mexico percentage (27.7%) and four times the national percentage (13.2%). Within the service area, almost one out of every four residents (22.2%) lives below 100% of the federal poverty level. The Semillas de Esperanza (Seeds of Hope) Care Coordination project specifically addresses the needs of the consortium partners to improve the flow of care coordination information so that patients who are discharged from the local hospitals receive timely and comprehensive follow-up care that will not only lead to improved health outcomes for patients, but will also reduce emergency department (ED) and 30-day readmissions rates.

Project Goals

Collaboration
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 systemwide care coordination network to ultimately support reductions in ED and 30-day hospital readmission rates.

Improved Outcomes
Enhance integrated information technology systems to improve care coordination data collection, tracking, and data sharing among Federally Qualified Health Centers (FQHCs) and local hospitals that will improve patient health outcomes in the long term.

Leadership and Workforce
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.

Sustainability
In order to support ongoing financial sustainability, care coordination efforts will include bringing on 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.

Evidence-based Model or Promising Practice

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 ED visits, improve satisfaction, and improve quality of life. In addition, the model will include elements of the Care Transitions Intervention, 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.

Program Approach

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 Enhancing Rural Health Care Coordination in Northern New Mexico initiative builds on the existing efforts to achieve better patient care, improve overall health outcomes, and lower health care costs in the rural communities that constitute the vast service area of northern New Mexico. The three regional hospital systems that each serve a defined region of northern New Mexico are 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 recognition, and accountable care organization incentive payments; and increase program financial sustainability through achieved results. Semillas de Esperanza's core partners implemented evidence-based care coordination strategies that were embedded into an FQHC primary care setting (26 clinics) in rural northern New Mexico to support patients who have visited the ED or were 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 reporting to maximize value-based incentive payments and shared cost savings among the FQHCs and hospitals.

Outcomes

The Semilla de Esperanza program achieved outcomes across a range of areas.

Care coordination infrastructure and staffing:

- The dedicated Care Coordination 1-800 number has been successfully developed and implemented. Community hospitals have been able to reach different clinics to schedule patients for follow-up appointments with primary care physicians along with our after-hours nurse hotline that helps connect patients with their primary care physician before they go to the ED.

- ECFH hired and trained full-time care coordinators and integrated them into the care team and workflows; however, staff turnover has been an issue over the course of the grant period.
- Through the redesign of ECFH workflows, ECFH was able to create and execute clinic visit–type reports to capture hospital and ED follow-up visits.
- ECFH electronic medical record systems added Collective Medical and health information exchange systems to help identify patients who have been seen in the ED or hospital in the last 30 days.

Collaboration for better coordinated care:

- Engagement of El Centro's consortium members was partially successful. One out of the three hospital partners was engaged in grant projects and invested in the outcomes. Consortium quarterly meetings started off well but slowed down during the pandemic due to staff being pulled to other duties.
- Communication and follow-up care for patients with primary care physicians was greatly improved due to this program.

Capacity-building of ECFH staff:

- Medical providers were trained in the billing code for care coordination Current Procedural Terminology (CPT) codes 99495 and 99496.
- Health Insurance Portability and Accountability Act training was completed by care coordination staff along with ECFH community health worker training module through the Department of Health. Staff were also trained in motivational interviewing and opioid response

Sustained Impacts

El Centro's certified community health workers became billable as of July 2023 through their work with coordination of care. This certificate will ensure their positions are sustainable through the work they are doing. El Centro has focused on capturing visits through creating new visit types and has trained medical providers in using accurate CPT codes in order to maximize payments for follow-up care and coordinating care services.

Lessons Learned

A major lesson learned through this program was the amount of training and workflow planning it takes to get an internal central call center up and running. El Centro has an unusually large service area that spans over 22,000 miles across rural-northern New Mexico, which creates many challenges in hiring. Other challenges to the establishment of a more centralized model are the variation among providers in how patients are scheduled and the variation in clinic structures across the 26 clinics in the system. This made it challenging to keep the call center staffed, and the resulting turnover made it difficult to establish relationships with the different hospitals and different clinics within ECFH.

Recruitment and retention of staff were challenging due to the COVID pandemic with limited to no applicants for open positions during a majority of this program. Launching a new grant program during a pandemic was challenging for both the organization and partners, as staff were pulled to assist with the pandemic in their local areas and were needed most to keep the normal scope of work going and didn't leave much time for launching new programs or relationships. That made it challenging to coordinate patient care and be present at partner meetings.

Consortium or Network Partners

Member Organization	Organizational Type
Alta Vista Regional	Hospital
El Centro Family Health	Federally Qualified Health Center
Holy Cross	Hospital
Presbyterian Espanola	Hospital

Grantee Contact Information

Grantee Contact: Delmiria Sanchez
Organization: El Centro Family Health
Address: 538 N. Paseo de Onate, Espanola, NM 87532
Telephone Number: 800-284-7284
Email: delmiria.sanchez@ecfh.org
Website: www.ecfh.org

Finger Lakes Migrant Health Center

Federally Qualified Health Center

D78RH39350

Primary focus area:
Migrant Farm Worker Health

Other focus areas:
Access: Primary Care
Care Coordination

Community Characteristics

Area
Franklin, Grand Isle, Lamoille, Caledonia, Orleans, Essex, Orange, Washington, Windsor, Windham, Bennington, Rutland, and Addison counties of Vermont.

Target Population and Need
This project serves immigrant and migrant farmworkers and their family members across rural Vermont. Immigrant and migrant farmworkers face a myriad of challenges to health care access related to significant individual and systemic barriers including but not limited to knowledge of services, complexities of the health care system, ineligibility for many government programs, time cost and monetary cost of care, transportation, and language access. Care coordinators and community health workers use a person-centered whole person approach to identify and address needs and barriers for each person to provide more equitable and consistent access to needed services while working toward desired health outcomes.

Project Goals

Collaboration
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 and migrant farmworkers across Vermont.

Improved Outcomes
Implement a uniform approach to planning, tracking, and measuring care coordination activities and outcomes for patients.

Leadership and Workforce
Establish a care coordination team comprising highly trained and skilled care coordinators and community health workers who work across health and social service organizations to meet the needs of the immigrant and migrant farmworker population.

Sustainability
Collect data and disseminate information about the project, project results, and the impact of the work with community, state-level, and national partners as well as philanthropists to engage long-term support for our model.

Evidence-based Model or Promising Practice

The Puente a la Salud (PALS) Care Coordination project modifies the Pathways Model to a Healthy Bernalillo County program, first developed by the Community Health Access Project. The Pathways model creates a centralized system to identify and track the progress of enrolled individuals, monitor and reimburse for services by outreach staff, improve the health of priority underserved and vulnerable populations, and create a mechanism for evaluating organizational performance. In our modified model, there are no reimbursement avenues, but instead work is supported through grants and philanthropy. Community care coordinators and community health workers 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. Example care pathways include health insurance enrollment, immunization, prenatal care, social services, mental health, and becoming established in a medical or dental home. Staff work with each person to identify needs at any given point in time and then assist them through the selected pathways that clients prioritize, taking specific actions known to lead toward positive (and documented) outcomes.

Program Approach

At the commencement of the project, Finger Lakes provided guidance and expertise on the development of the data collection tools developed for community care coordinators and community health workers to track care coordination activities and outcomes consistently across the service delivery consortium members: Open Door Clinic and University of Vermont Extension (UVM Extension). Care coordination staff participated in the Bridging the Gap medical interpreter training offered by Finger Lakes. The care coordination team utilized care pathways to identify and address health and social needs of immigrant and migrant farmworkers and their family members. Surveys of participating farmworkers and their family members provided feedback about satisfaction and trust levels with staff coordinating services.

Consortium team members met at regularly scheduled times to keep lines of communication open and ensure project success. The PALS program was designed to be a multilevel approach to expanding access to care. Care coordinators and community health workers sought to build understanding of the health system by immigrant and migrant farmworkers, improve health system capacity to provide quality health care to immigrant and migrant farmworkers, and highlight the policy and systems challenges that impede access to care for the population. The team participated in local, state, and national conversations about access to care for the immigrant and migrant farmworker population. Care coordination activities that are tailored to each individual's needs and proactive participation in health equity conversations at a local, state, and national level have helped ensure immigrant and migrant farmworkers and their family members have a more equal opportunity to attain their highest level of health and well-being today and into the future.

Outcomes

Primary outcomes achieved through the care coordination grant project include:

- Farmworkers and their family members (1,549 of them) received support navigating health and social services.
- Ten care coordinators and community health workers improved knowledge and skills through successful completion of the Bridging the Gap medical interpreter training.
- Twenty-seven individuals accessed Spanish-speaking mental health counselors 100 times via telehealth, eliminating the barriers of transportation, language, and time cost of travel to a brick-and-mortar site.
- Eighty-nine percent of initiated pathways were completed successfully.
- Ninety-five percent of surveyed patients reported positive experiences with care coordination supports.
- Additional funding was secured to expand care coordination capacity, resulting in the hiring of six full-time regional community health workers to serve immigrant and migrant farmworkers and their families.

Sustained Impacts

El Centro's certified community health workers became billable as of July 2023 through their work with coordination of care. This certificate will ensure their positions are sustainable through the work they are doing. El Centro has focused on capturing visits through creating new visit types and has trained medical providers in using accurate CPT codes in order to maximize payments for follow-up care and coordinating care services.

Lessons Learned

A major lesson learned through this program was the amount of training and workflow planning it takes to get an internal central call center up and running. El Centro has an unusually large service area that spans over 22,000 miles across rural-northern New Mexico, which creates many challenges in hiring. Other challenges to the establishment of a more centralized model are the variation among providers in how patients are scheduled and the variation in clinic structures across the 26 clinics in the system. This made it challenging to keep the call center staffed, and the resulting turnover made it difficult to establish relationships with the different hospitals and different clinics within ECFH.

Recruitment and retention of staff were challenging due to the COVID pandemic with limited to no applicants for open positions during a majority of this program. Launching a new grant program during a pandemic was challenging for both the organization and partners, as staff were pulled to assist with the pandemic in their local areas and were needed most to keep the normal scope of work going and didn't leave much time for launching new programs or relationships. That made it challenging to coordinate patient care and be present at partner meetings.

Consortium or Network Partners

Member Organization	Organizational Type
Open Door Clinic	Free Clinic
Rutland County Free Clinic	Free Clinic
University of Vermont Extension	Extension Service

Grantee Contact Information

Grantee Contact: Naomi Wolcott-MacCausland
Organization: Finger Lakes Migrant Health Center
Address: 14 Maiden Lane, Penn Yan, NY 14527
Telephone Number: 802-656-7626
Email: nwolcott@uvm.edu
Website: www.localcommunityhealth.com

Indiana Rural Health Association

State Rural Health Association

D78RH39351

Primary focus area:
Maternal/Women's Health

Other focus areas:
Care Coordination
Population Health/Social Determinants of Health

Community Characteristics

Area
The Indiana Rural Health Association (IRHA) Rural Health Care Coordination program predominantly served new and expectant mothers in the Indiana counties of Greene, Owen, Putnam, and Sullivan, as well as surrounding counties.

Target Population and Need
The IRHA Rural Health Care Coordination program specifically targeted pregnant women, women who may become pregnant, and family structures of all types in and around the counties of Greene, Owen, Putnam, and Sullivan. The primary needs addressed by this program include improving access to enhanced perinatal care services and coordinating care to improve access to mental and behavioral health and addiction treatment either in person or via telehealth.

Project Goals

Collaboration
Plan and develop an enhanced integrated maternal/perinatal health care system to collaborate and share data among member organizations.

Improved Outcomes
Improve access to, delivery of, and quality of services and overall patient health outcomes.

Leadership and Workforce
Establish effective care coordination workforce to meet needs within the rural communities.

Sustainability
Increase program financial sustainability to promote long-term effectiveness of perinatal care coordination.

Evidence-based Model or Promising Practice

Elements of the evidence-based patient-centered medical home (PCMH), perinatal navigator (PN), and community health worker (CHW) models were applied to encourage implementation of and to provide increased access to services for maternal and infant health in communities lacking adequate community resources. The IRHA Rural Health Care Coordination program utilized PCMHs through delivering care by a team-based approach. The PN and CHW models were used in addition to PCMH to provide case management services for pregnant women and infants using integrated population management modalities. The combination of the three models within the IRHA Rural Health Care Coordination program was successful in aligning the needs of the participant with appropriate resources while using a team-based approach. This allowed for seamless referrals to health care providers and physicians and connected participants to community agencies to meet social determinants of health needs.

Program Approach

To accomplish the holistic goals of the Rural Health Care Coordination program, IRHA Rural Health Care Coordination partners understand the need for a multidisciplinary approach. Four main objectives were executed in an effort to meet the identified goals:

1. Plan and develop an integrated maternal/perinatal health care system by providing access to enhanced perinatal care services through implementation of the PCMH model in rural obstetrics clinics;
2. Establish an effective care coordination workforce to respond to rural communities' unmet needs by improving care coordination activities for women, pre- and post-conception, focusing on prenatal, postnatal, and behavioral health screenings, with an emphasis on reducing the multiple modifiable risk factors associated with behavioral health and addictions;
3. Improve access, delivery, and overall patient health outcomes by increasing access to rural maternity care referrals and resources through the deployment of telehealth services; and
4. Increase workforce and educate rural providers and clinicians.
5. The overall approach of this program ensures strong collaboration among health care providers and fosters community partnerships that strive to build capacity and program resources. Through the combined PCMH, PN, and CHW models, PNs connected participants to appropriate resources and providers, including addressing social determinants of health factors to ensure health equity.

Outcomes

Each partner identified numerous instances of women experiencing improved access to care, reducing transportation barriers, preventing disastrous medical issues, and having an increase in ongoing support for necessary health care needs.

Outcomes for the women participants throughout the grant cycle of the IRHA Rural Health Care Coordination program include:

Collaboration
Plan and develop an enhanced integrated maternal/perinatal health care system to collaborate and share data among member organizations.

- PNs received 358 total referrals coming from OB-GYNs, other health care clinics, and family members and friends who were enrolled in the Rural Health Care Coordination program and Women, Infants, Children.

Seventy-five percent of enrolled women participants would not have received care coordination services without collaboration with community health care facilities and agencies.

Leadership and Workforce
Establish effective care coordination workforce to meet needs within the rural communities.

- Eleven trained PNs, community health workers, and hospital leadership on care coordination service delivery, models, and data collection effort. An additional certification from care coordination funding included a certified lactation counselor, which allowed the PN to provide lactation support both in-person and virtually to 39 women who would have otherwise had to travel more than 30 miles to receive lactation support.

Improved Outcomes
Improve access, delivery, and quality of services and overall patient health outcomes.

- Four hundred seventy-eight Care Coordination program participants served throughout the grant funding cycle.
- Participants received 917 referrals, and 3,582 resources/education from PNs to improve access to necessary perinatal and postpartum care, as well as educate women and mothers on health care services necessary for improved outcomes for their health and their infants' health.

Sustainability
Increase program financial sustainability to promote long-term effectiveness of perinatal care coordination.

- PNs established methods to sustain their programs at their hospitals. One of the PNs implemented an automatic referral through their electronic health records system for an OB-GYN to directly refer them to care coordination services.

Each of these successes and accomplishments directly correlates with Rural Health Care Coordination program goals and objectives including responding to rural communities' unmet needs related to workforce to respond to perinatal health needs; improving access, delivery, and quality of services and overall patient health; and establishing a collaborative relationship among obstetrical health providers.

Sustained Impacts

The primary sustained impact of the Rural Health Care Coordination program has been to increase access to maternal health services available to rural residents in Indiana by (1) increasing knowledge of community resources available to the patient and her family, including the deployment and expansion of telehealth services, and (2) providing referrals for improvement of overall health of participating mothers and infants including improvement of and expanded access to physical health, mental health, and substance use intervention.

Lessons Learned

Through implementing a rural maternal care coordination program, our program staff learned the importance of engaging hospital leadership and administration. This engagement allowed for increased buy-in and further interest in sustaining the program long term. The PNs initiated successful methods for care coordination within their daily workflows, as well as provided data that supported their efforts. In addition, consistent training and retraining of data standards to partners is necessary to understand health outcomes that were impacted by program implementation.

Consortium or Network Partners

Member Organization	Organizational Type
Greene County General Hospital	Critical Access Hospital
Indiana Health Centers	Federally Qualified Health Center
Putnam County Hospital	Critical Access Hospital
Sullivan County Community Hospital	Critical Access Hospital

Grantee Contact Information

Grantee Contact: Cara Veale
Organization: Indiana Rural Health Association
Address: 2901 Ohio Boulevard, Suite 240, Terre Haute, IN 47803
Telephone Number: 812-698-7288
Email: cveale@indianarha.org
Website: www.indianarha.org

Kittitas County Health Network

Rural Health Network

D78RH39352

Primary focus area:
Care Coordination

Other focus areas:
Community Health Workers
Integrated Systems of Care

Community Characteristics

Area
Kittitas County, Washington

Target Population and Need
The target population of the Kittitas County Health Network (KCHN) Care Coordination program is adults residing in Kittitas County with complex health and social needs. KCHN Care Coordination and the A-Team (the consortium supporting the Care Coordination program) work collaboratively to identify members of the target population who are experiencing any number of unmet needs including but not limited to frequent use of emergency services, unmet health needs, dementia, housing insecurity, unsafe living environment, food insecurity, isolation, frequent falls, behavioral health issues, substance use disorder, inability to perform activities of daily living, chronic illness, and issues related to poverty.

Project Goals

Collaboration
Improve population health through cross-sector collaboration and system integration.

Improved Outcomes
Enrich the quality of life for our vulnerable population by providing expert guidance (A-Team), resources, referrals, education, and community paramedic assessments, based on individual needs and client-driven goals.

Leadership and Workforce
Facilitate conversations and increase the participation of community service organizations within the county to work together to respond to the unmet needs within our rural community.

Sustainability
Ongoing research seeking new funding opportunities. Secure contracts with payers to provide care coordination services.

Evidence-based Model or Promising Practice

Community Paramedic Program
The Community Paramedic (CP) program has been an integral part of our care coordination work. CPs assess clients upon entry to the Care Coordination program. CPs check and record vitals, provide medical checks, assess living conditions for safety, and provide mental health evaluations. The CP then works together with the care coordinator to identify needs and potential resources. The care coordinator works with the client to create a care plan with measurable objectives.

Program Approach

The Care Coordination program is a collaborative effort involving 19 community organizations with representatives who are dedicated to improving population health in Kittitas County. Over the past three years, the Care Coordination team has worked diligently on developing activities that improve services and educate members of the community on the health and safety challenges in a rural community.

Outcomes

- Care coordination increased active community partner membership (A-Team) from seven professionals in 2020 to 19 in 2023.
- The Care Coordination program assisted more than 250 vulnerable community members in the target population by providing resources, referrals, and warm hand-offs to appropriate agencies.
- KCHN facilitated more than 20 training opportunities for community-based organizations, including law enforcement, hospital and clinic staff, library staff, and more.
- Due to client successes, the KCHN Care Coordination program was able to secure contracts with the local hospital and affiliated home health and hospice programs. For example, a partnership with Molina Healthcare has been established that reimburses KCHN Care Coordination for costs related to enrolling their members who access Kittitas Valley Healthcare (KVH) services as well as a contract with KVH where KCHN is reimbursed for all KVH home health and hospice patients referred into the program. KCHN is also seeking funding for a jail-based Care Coordination component that will serve jail inmates during and after incarceration.

Sustained Impacts

This grant has enabled the KCHN Care Coordination program to greatly increase treatment and service provider partnerships within the county to meet the needs of the community. Over the past three years, the Care Coordination program has improved and evolved into a successful service model through collaborative efforts. Through the utilization of an effective data management platform (RedCap) the program has been able to record client interactions and track progress on individualized care plans. Recent access to Collective Medical (CM) has allowed the program to track if a client has visited the emergency department, was admitted, or was discharged, increasing the ability to anticipate client needs.

The Care Coordination program has been able to increase capacity by streamlining the referral and response process as policies and procedures have evolved over the past few years.

Lessons Learned

The KCHN Care Coordination program has encountered challenges throughout the creation and development processes. Through collaborative efforts, the challenges enabled the health network and partner organizations to create a more adaptive and resilient program. Weaknesses were identified, policies were developed, and outcomes for clients were improved.

KCHN has been contacted by several out-of-county organizations over the course of this Health Resources and Services Administration (HRSA) grant that have heard about the program's successes and were seeking advice on how to follow the model. Network staff are always happy to share experiences and encourage organizations to reach out as they develop or improve their care coordination programs. One of the key components to the KCHN Care Coordination program success is the A-Team. This team meets weekly to discuss complex client issues and comprises expert representatives of each of our community partnering agencies.

Consortium or Network Partners

Member Organization	Organizational Type
Adult Protective Services	State Agency
Aging & Long-Term Care of Southeast Washington	State Agency
Central Washington Disability Resources	Nonprofit Service Organization
Community Health Central Washington	Federally Qualified Health Center
Comprehensive Healthcare	Mental and Behavioral Health Organization
Department of Social and Health Services	State Agency
Ellensburg Police Department	Criminal Justice Entity, Law Enforcement
FISH Food Bank	Community-based Nonprofit
HopeSource	Community-based Nonprofit, Housing
Kaleidoscope Community Services	Nonprofit Service Organization
Kittitas County Public Health	Harm Reduction, Local Health Department
Kittitas County Fire District 6	Emergency Medical Services Entity
Kittitas County Recovery Community Organization	Recovery Community Organization
Kittitas Valley Fire and Rescue	Emergency Medical Services Entity
Kittitas Valley Healthcare	Critical Access Hospital
Meadows Place	Assisted Living Oganization
Recovery Navigator Program	Substance Abuse Treatment Provider
Upper Kittitas County Medic One	Emergency Medical Services Entity
Valley Psychological Services	Mental and Behavioral Health Organization

Grantee Contact Information

Grantee Contact: Sue Logsdon
Organization: Kittitas County Health Network
Address: 110 W. 6th Avenue PMB No. 393, Ellensburg, WA 98926
Telephone Number: 509-388-2854
Email: Sue@healthierkittitas.org
Website: www.indianarha.org

Rural Health Development Inc.

Rural Health Network

D78RH39352

Primary focus area:
Care Coordination

Other focus areas:
Access: Primary Care
Aging Services

Community Characteristics

Area
Fallon, Roosevelt, Prairie, Powder River, Rosebud, Garfield, and Sheridan counties of Montana.

Target Population and Need
The project served those with multiple chronic conditions or behavioral health conditions who received primary care in the following counties: Fallon, Garfield, Powder River, Prairie, Roosevelt, Rosebud, and Sheridan. Roosevelt County has the Fort Peck Indian Reservation, and Rosebud County has the Northern Cheyenne Indian Reservation. The total service area is approximately 24,686 square miles and a population of 29,988, or 1.4 people per square mile. Based on the Chronic Conditions chartbook, it is estimated that there are over 2,200 people (two-thirds of Medicare beneficiaries) eligible for services under the program. A dearth of resources, disparate information systems, and lack of appropriate staffing for care coordination and integrated behavioral health presented deep challenges for rural and frontier health care systems as they tried to manage the move over the "shaky bridge" from fee-for-service payment to value-based payment.

Project Goals

Collaboration

- Establish relationships and communications with local non–health care entities to explore community involvement in the shared care coordination model.
- Expand use of telehealth technology to support shared care coordination.

Improved Outcomes
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.

Leadership and Workforce
Advance the collaborative model for shared care coordination to appropriately disseminate clinical and financial results, outcomes, and evidence of improved population health in frontier communities.

Sustainability
Expand the sustainable financial reimbursement model for care coordination services with current and evolving payment reform opportunities.

Evidence-based Model or Promising Practice

The network used the evidence-based Chronic Care Model to provide regional care coordination and integrated behavioral health services. The Chronic Care Model is a multifaceted, evidence-based framework for enhancing care delivery by identifying essential components of the health care system that can be modified to support high-quality, patient-centered chronic disease management. The network provided a systematic approach to practice transformation that aligned with the project goals. The network adopted this model based on the essential ingredients for successful chronic care programs as outlined by the Center for Disease Control and Prevention. It uses six components to effect financial and clinical outcomes: health system support, self-management support, decision support, delivery system redesign, clinical information systems, and community resources and policies.

Program Approach

The network conducted the following activities to establish the regional care coordination model:

- Established collaborative organization for regional care coordination to serve patients.
- Implemented communication and care coordination protocols across the consortium.
- Compiled and analyzed data for patients in the consortium.
- Provided care coordination and behavioral health integration to identified populations.
- Continually reviewed processes and adapted where necessary to ensure progress and support to communities.
- Reviewed community and patient enrollment demographics to ensure widespread access to services among all patient groups.
- Reviewed opportunities for available access to care to ensure patient social determinant of health needs are met in the region.
- Partnered with community-based organizations where appropriate and utilized community health workers when possible to address social and economic needs of patients.
- Developed a sustainability plan considering new payment models and value-based care methods.
- Self-assessed model and shared results with local, state, and national partners.

Outcomes

The following patient outcomes resulted from the regional care coordination network development:

- Increased number of direct patient care from 68 patients in three facilities to 138 in six facilities throughout the network.
- Improved depression screening across the network from 1.5% of enrolled patients being screened to over 59% of patients being screened.
- Increased monitoring of 10 clinical measures resulting in all 138 (100%) enrolled patients monitored for outcomes, compared to fewer than 50% of baseline enrolled patients being monitored for over half (five) of the clinical measures.

- Increased awareness among clinic staff about the need to collect quality measurement data resulting in body mass index being recorded on 100% of patients by Year 2 compared to less than 65% at baseline.
- Reduced the time frame to access specialty services by having positive regional relationships with providers, leading to faster scheduling for patients in multiple communities. It is estimated that time to scheduling was reduced by one week to 10 days because of program staff efforts.
- Demonstrated fewer unnecessary clinic and emergency visits with multiple enrolled patients. For example, one patient reduced emergency visits from three to one and clinic visits from 13 to three in the first year of enrollment.

Sustained Impacts

The network has experienced the following sustained impacts:

- Network operates a robust regional care coordination program supporting multiple facilities and conducting ongoing training on value-based care and payment models.
- Small facilities are comfortable with population health management and value-based care.
- Individuals possess improved knowledge and self-management skills from referral to the program, resulting in a better quality of life for patients with chronic conditions throughout the region.
- Small facilities have implemented and sustained internal programs and access technical assistance from the regional care coordination network.
- Facilities experience cost savings because of reduced hospital readmissions and unnecessary visits to the emergency department and clinics.

Lessons Learned

As a pioneer in the establishment of a frontier regional care coordination model, Rural Health Development Inc. learned the following lessons:

- Buy-in from medical professionals is paramount in the success of a care coordination program.
- Network leaders must identify all the steps necessary to implement regional care coordination within each site. This will lead to consistent and streamlined workflows in serving those local clinics.
- It is best to learn each unique electronic health record program within each individual site and complete as much chronic care management documentation as possible within each unique system. Medical professionals will more effectively supervise team-based care if they can work solely within one computer system.
- Regional staff need to appear to patients to be direct members of the local clinic staff. This will help instill trust in the patients being contacted by regional care coordinators.
- Effective, consistent, and open two-way communication between regional staff and local clinic staffs will improve the likelihood of program success.
- Individual facilities should be encouraged to view regional staff similarly to staffing agency personnel who deliver care based on each clinic's established policies and procedures. While the network conducts a regional care coordination program, it is there to provide the staff and the knowledge but not to direct the individual clinic program.
- There is a difference between developing a network of independent clinics for regional care coordination and establishing a regional program within a system. System organizations are more likely to have the same processes and access to technology and support, while independent organizations rely on internal systems and local resources.

Consortium or Network Partners

Member Organization	Organizational Type
Fallon Medical Complex	Critical Access Hospital and Rural Health Clinic
Garfield County Health Center	Critical Access Hospital and Rural Health Clinic
Powder River Medical Clinic	Provider-based Stand-alone Clinic
Prairie Community Hospital	Critical Access Hospital and Rural Health Clinic
Roosevelt Medical Center	Critical Access Hospital and Rural Health Clinic
Rosebud Health Care Center	Critical Access Hospital and Rural Health Clinic
Sheridan Memorial Hospital Association	Critical Access Hospital and Rural Health Clinic

Grantee Contact Information

Grantee Contact: Nadine Elmore
Organization: Rural Health Development Inc
Address: 519 Pleasant Street, Miles City, MT 59301
Telephone Number: 406-234-1420
Email: nelmore@montanahealthnetwork.com
Website: www.montanahealthnetwork.com

San Juan County Public Hospital District 1

Public Hospital District

D78RH39354

Primary focus area:
Care Coordination

Other focus areas:
Access: Primary Care
Aging Services

Community Characteristics

Area
San Juan County, Washington state

Target Population and Need
San Juan County is an archipelago of more than 170 islands in the northwestern-most part of Washington state, located between the United States and Vancouver Island in British Columbia, Canada. Thirty-three percent of the county's population of 17,000 is over the age of 65, making it one of the oldest counties in the state. At the same time the population has grown and aged, San Juan County's health and social service delivery system has been hugely impacted by the loss of and the inability to retain community-based long-term care services for the elderly, and particularly the frail elderly with multiple chronic conditions. There is also fragmented care due to multiple but not connected systems of care coordination, both for the elderly and also for residents with no or limited insurance. This dearth of services is having an impact on the quality of life for the underserved and seniors and their caregivers.

Project Goals

Collaboration
Engage in integrated, coordinated, patient-centered delivery of health care services with the specific purpose of providing medical, social, and other supports for as many of the underserved in our communities as possible, including the polychronic elderly so they can safely age in place.

Improved Outcomes
Stop unnecessary travel/relocation off island for the traditionally underserved populations and the frail elderly failing in their homes through evidence-based services tailored to the resources, capacity, and needs of San Juan County residents.

Leadership and Workforce
Recruit, develop, and train a highly skilled care coordination workforce to respond to unmet needs. Additionally, and through the network's existing public-private partnership, mitigate the challenges to retaining workforce, especially housing affordability.

Sustainability
Achieve financial sustainability by establishing effective revenue sources through braiding and blending of various existing reimbursements, resource sharing, and contributions from partners at the community, county, regional, and state levels.

Evidence-based Model or Promising Practice

Evidence-based sustainable care coordination system based on the Pathways Community Hub (PCH) model — with modifications 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, workforce, and payment. Integration of the PCH with the promising practices of mobile integrated health and senior peer community health workers.

Program Approach

Based on the impacts of COVID and the differences in primary care provision on each of the islands, the program approach "morphed" over time from the network's planned approach of embedding care coordination in the primary care setting to a model primary focused on recipients utilizing the resource centers on Orcas, Lopez, and San Juan islands. The resource centers provide public and private safety nets for the most vulnerable residents. Assistance is focused on helping people solve their problems, get the resources needed for their well-being, and attain self-sufficiency. Volunteer and paid workers help clients apply for health, disability, and veteran's benefits; obtain rent, energy, transportation assistance, and food and household essentials; achieve housing stability; exit homelessness; and access special programs such as dental and vision care and job training.

With this transition, a contract was initiated with Lyn Health, based in Seattle. Lyn Health exists to support people with polychronic conditions, delivering clinical, advocacy, and care coordination services via a single point of contact, 24 hours a day, seven days a week. Lyn Health provided virtual primary care and urgent care, care coordination, navigation and advocacy, medication management, and behavioral health care for a census of 50 enrolled residents from the service area.

Outcomes

Through the care coordination initiative, San Juan County has increased participation in home visits, attendance at behavioral health visits, primary care and oral care visits, fall-prevention activities, and medication adherence. From May 2022 to June 2023:

- Four hundred seven patient visits have been completed, with 8.7 average visits between the core patient group.
- There has been a 16% reduction in hospital visits.
- Behavioral health visits between the core patient group have increased by over 22%.
- Lyn Health patients have received at least one in-person visit by a health care provider.
- Forty-eight patients are being served through the Mobile Integrated Care Program, with an average of 16 home visits per week.

The overall health of those patients served has improved through better self-management of disease, enhanced home safety, increased availability of supportive services, increased quality of life, enhanced ability to age in place, and a reduction in underserved seniors "falling through the cracks" and remaining unnoticed without needed supports.

Sustained Impacts

The grant-funded care coordination initiative is in the early stages of realizing the benefits and improved outcomes that result from coordinated care and resources provided to traditionally underserved populations, including fragile seniors.

The consortium worked to develop a more in-depth collaboration for our multiple-island county. Through the consortium, stakeholders have been identified and hold a more comprehensive understanding of island-specific gaps, progress, and remaining needs. A more structured understanding of the priorities of each island and the organizations serving the traditionally underserved, including fragile seniors on each island, has been established.

Through this care coordination effort, countywide priorities and potential opportunities to coordinate have been identified. Through stakeholder meetings, the initial framework has been established and includes a more in-depth consensus on needs and potential opportunities to coordinate. This includes:

- Telehealth/remote patient monitoring — Remote monitoring equipment has been provided to each family resource center for disbursement, providing real-time patient data on A1c levels for patients that has proven invaluable for program care coordination staff.
- Home care — There is a process in place for building a comprehensive training and home care agency that will include mobile integrated health for San Juan Island and expand to additional islands in the future.
- Home visiting — As part of the home care program, community health workers will be deployed to augment the telehealth services and will include additional in-depth assessments like medication reviews, fall prevention, smoking cessation, PHQ-9 (depression screening), home repairs and alterations, and access to additional resources locally.
- Workforce — Through the training entity a comprehensive in-person training to better build a cross-pollinated workforce that will be able to serve in multiple places has been established. Several facets of the training program provide for home care aide training, certified nursing assistant training, and community health worker training. In addition to building a more efficient training mechanism for future development, there are evolving plans for health worker housing.
- Facility-based long-term care — In 2022, voters of San Juan Island voted to approve a levy for the San Juan County Public Hospital District No. 1 to purchase the local assisted living facility. The purchase of a local assisted living facility will provide additional resources to grow staff and expand Medicaid beds and services. Expansion plans include more Medicaid housing and the potential to add nursing and memory care.
- Throughout this grant period there have been consistent adaptations to sharpen the focus. A telehealth network for the target population has been established, and there has also been significant progress in overall communication and strategic planning. This is no small feat, as the county has historically been fractured and operated independently.

Lessons Learned

The network learned early on that there are multiple barriers to implementing a countywide delivery model that the network would operate and so has instead moved to developing shared objectives and resources, including these:

- Remove silos between providers and between islands, while recognizing some solutions may still be island-specific, rather than countywide.
- Focus on advocacy. Develop a collective voice for vulnerable populations and workforce that addresses reimbursement, access, and social determinants.
- Leverage existing resources.
- Emphasize communications and information sharing among members.
- Become strong thought partners.
- Use strategic planning to define gaps and conduct business planning to evaluate need, demand, and potential shared strategies.

Consortium or Network Partners

Member Organization	Organizational Type
Lopez Resource Center	Nonprofit Organization
Lyn Health	Primary Care Provider
PeaceHealth, Nonprofit Critical Access Hospital	Nonprofit Organization
San Juan County Public Health	Government Organization
San Juan County Public Hospital District No. 1	Public Hospital District
San Juan County Public Hospital District No 2	Public Hospital District
San Juan County Public Hospital District No. 3	Public Hospital District
San Juan Island Resource Center	Nonprofit Organization

Grantee Contact Information

Grantee Contact: Evan Perrollaz
Organization: San Juan County Public Hospital District 1
Address: P.O. Box 370; 849 Spring Street; Unit B5, Friday Harbor, WA 98250
Telephone Number: 425-941-0193
Email: evan@cornerstonehcc.com
Website: ww.sjcphd.org

Upper Peninsula Health Care Solutions Inc

Non-profit Organization

D78RH39355

Primary focus area:
Community Health Workers

Other focus areas:
Care Coordination
Neonatal Abstinence Syndrome/
Neonatal Opioid Withdrawal Syndrome

Community Characteristics

Area
Upper Peninsula of Michigan: Marquette County, Chippewa County, and Delta County.

Target Population and Need
The target population for the Upper Peninsula Maternal Opioid Misuse (UP MOM) program was pregnant or postpartum (up to 12 months) Medicaid beneficiaries with a history of opioid use disorder living in or receiving care in Marquette, Chippewa, or Delta counties. The program addressed the social determinants of health (SDOH) needs that impose barriers to perinatal care and substance use disorder treatment, primarily housing and transportation, but including nutrition, communication, education, employment, and child care.

Project Goals

The primary project goal of the UP MOM program is to improve the quality of care and health outcomes of the target population by implementing community health worker (CHW)–centered care coordination strategies that focus on cross-system collaboration and meeting social determinant of health needs.

Collaboration
The UP MOM Consortium is a statewide body that meets quarterly and includes three county-specific workgroups that meet monthly to establish relationships, policies, and procedures that improve interagency communication, care transitions, and sustainability. Members include the regional Medicaid managed care organization, regional health departments, hospitals, substance use disorder treatment providers, and social service community-based organizations that provide services for enrollees.

Improved Outcomes
The UP MOM program is focused on metrics that either represent improved health outcomes (e.g., reduced emergency department utilization) or for which there is evidence indicating they lead to improved health outcomes for enrollees and their babies (e.g., increased home visiting programming, increased breastfeeding initiation and maintenance etc.).

Leadership and Workforce
The UP MOM Consortium participates in learning opportunities to improve treatment and quality of care for the target population, including implicit bias, harm reduction, neonatal abstinence syndrome, medication-assisted treatment, lactation consultation, infant safe sleep, transportation safety, and more. UPHCS acts as the facilitator of the consortium. UPHCS provides consultation and oversight to the CHWs located at partner facilities.

Sustainability
There are two distinct sources of sustainability for the UP MOM program: service reimbursement and the contributions of partners at the regional level. Services provided by CHWs are undergoing the process of incorporation into Michigan Medicaid for fee-for-service reimbursement. UPHCS aids health department partners in preparing to bill for some UP MOM CHW services. In addition, the UP MOM program improves health outcomes and reduces service utilization to such a degree that the local Medicaid managed care organization is in the process of taking over the UP MOM CHW health department contracts to continue their work beyond the project period.

Evidence-based Model or Promising Practice

The UP MOM program utilizes elements of the promising practice Community Health Worker Model for Care Coordination, in addition to 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 — Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorder.

Program Approach

The UP MOM program supports the needs of the whole person, allowing birthing persons to focus on their recovery, a healthy pregnancy, and their well-being after birth to improve outcomes for mom and infant.

The UP MOM program utilizes the CHW model of care coordination to provide support for Medicaid beneficiaries who are pregnant and up to 12 months postpartum and who have had a history of, or are currently experiencing, opioid use disorder (OUD). By virtue of their status as members of the community they serve, CHWs are uniquely positioned to attain deep engagement with program enrollees and to act as advocates, health coaches, and advisers. Each birthing person is screened for SDOH needs by their CHW to identify the details of their circumstances. The CHW then refers enrollees to community-based organizations to meet their SDOH needs, and the organizations maintain a relationship with the enrollees, continuously working with them to remove any barriers to accessing the care and services that they need. They use flexible communication methods and allow enrollees to determine the nature of the relationship to improve engagement. The CHWs are provided with access to funding and other resources to meet the unique needs of each individual. The interventions that CHWs implement are tailored to each enrollee and guided by screening tools, the CHWs' training, and the enrollees themselves.

Outcomes

By the end of the second year (Aug. 31, 2022), UPHCS had implemented the UP MOM program in Marquette and Chippewa counties. The target for enrollment was 25. Fifty-seven people were enrolled (25 were enrolled prenatally). Some key outcomes were:

- Eighty-nine percent (49 out of 57) enrollees participated in one or more evidence-based home visiting programs.
- Sixty-six percent (35 out of 53) initiated breastfeeding (about 20% improvement over Year 1) and 43% (23 out of 53) maintained breast-feeding for at least four months postpartum (about 35% improvement over Year 1).
- One hundred percent (57 out of 57) of enrollees were screened at least once for SDOH needs.
- Eighty-four percent (38 out of 45) maintained or initiated appropriate engagement in substance use disorder treatment.
- Eighty-four percent (21 out of 25) complied with their recommended prenatal ob-gyn appointments.
- Sixty-four percent (34 out of 53) complied with their recommended postnatal ob-gyn appointments.
- None of the 17 prenatal enrollees had babies with neonatal abstinence syndrome symptoms severe enough to require a neonatal intensive care unit stay.
- Thirty-five percent (20 out of 57) of enrollees visited the emergency department (ED) during their enrollment (about 37% fewer than Year 1). They had a total of 79 ED visits (about 1.4 visits per enrollee, down from about 6.1 visits per enrollee in Year 1).
- The "avoidable" (nonemergent, preventable, or treatable in the primary care setting) ED visits rate was 57% (45 out of 79), with a few individuals who enrolled late in the reporting period accounting for the majority. The "avoidable" ED visit rate among all pregnant UPHP members over the same period was 47% (548 out of 1,171).

Sustained Impacts

The implementation of the UP MOM program led to the development and testing of a CHW model of care coordination that is effective in the region and includes a training regimen, policies, and procedures for implementation. Coordination between health care providers, substance user disorder treatment providers, home visitors, and community-based organizations was improved. The program aided in the development of an ongoing relationship between the local Medicaid managed care organization and health departments by employing CHWs for care coordination.

Lessons Learned

- Access to flexible direct assistance to overcome barriers to care and service (e.g., birth documentation, auto repairs, short-term housing solutions, devices for communication, etc.) is cost-effective and dramatically improves engagement.
- Programs must be flexible in terms of the means that CHWs use to communicate with enrollees and based on enrollee preference. Access to texting capability is a must.
- Lack of communication devices is a key barrier to successful care coordination.
- Nonmedical transportation is a key barrier to utilization of services.
- A shelter-first model is imperative. Very little can be accomplished until enrollees have safe housing.
- Perinatal care plans and home visiting services benefit greatly, in terms of patient satisfaction, when they integrate trauma-informed practices.
- Stigma results in new trauma, reduces motivation to utilize services, and can result in relapse and poor health outcomes.

- The court and jail systems must provide for basic rights of pregnant and postpartum people, including access to medical care, prenatal care, medications for OUD and medication-assisted treatment care, and mental health services. Pregnant people need advocates to access these rights.
- Expanded application of CHW model of care coordination would be beneficial to all perinatal persons.
- CHWs serving this population should receive higher than average wages with the specialization of this position.
- CHWs with peer recovery support training and/or lived experience are particularly adept at engaging populations with a history of substance use disorder.
- CHWs are effective at increasing success of care plans, reducing fragmentation of services, reducing family separation, reducing burden on family support systems, reducing ED utilization, and ensuring equity of all resources available to the target population.

Consortium or Network Partners

Member Organization	Organizational Type
Chippewa County Health Department	Regional Health Department
Great Lakes Recovery Centers	Nonprofit Substance Use Disorder Treatment Provider
Luce Mackinac Alger Schoolcraft District Health Department	Regional Health Department
MyMichigan Medical Center Sault	Nonprofit Hospital System
NorthCare Network	Prepaid Inpatient Health Plan
OSF St. Francis Hospital	Nonprofit Hospital System
Public Health Delta Menominee	Regional Health Department
Upper Peninsula Health Care Solutions (UPHCS)	Nonprofit Organization
Upper Peninsula Health Plan (UPHP)	Medicaid Managed Care Organization
Upper Peninsula Health System Marquette	For-profit Hospital System

Grantee Contact Information

Grantee Contact: Katrina Keough
Organization: Upper Peninsula Health Care Solutions Inc.
Address: 853 W. Washington Street, Marquette, MI 49855
Telephone Number: 906-227-5698
Email: kkeough@uphcs.org
Website: www.uphcs.org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