

Grantee Sourcebook

Rural Northern Border Region Health
Care Support Program FY 2023-2024
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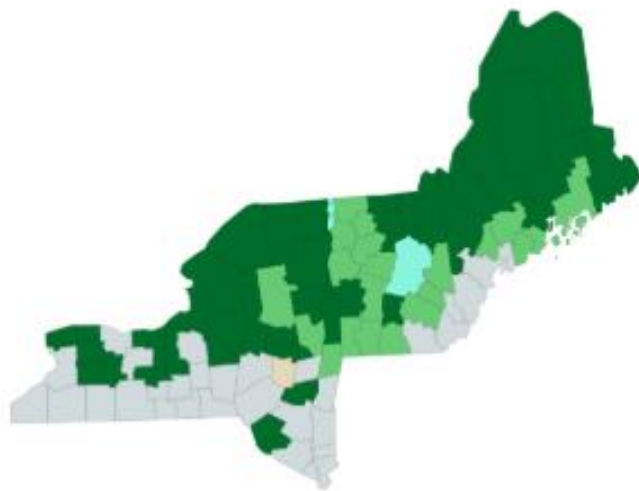
Background and Purpose

Through its Rural Northern Border Region Healthcare Support Program, the Health Resources and Services Administration (HRSA) through the Northern Border Regional Commission (NBRC) awarded the Rural Health Redesign Center Organization, Inc. (RHRC) a supplemental award in the amount of \$1,170,000 to support organizations across the Northern Border Region with focused one-year healthcare programming. The purpose of the funding was to support the development of innovative planning and/or programming in rural communities across the region of the NBRC in their efforts to enhance access to health (including behavioral health); improve recruitment and retention of health care providers; and assist rural hospitals and clinics in their efforts to enhance the delivery of community focused value-based care. In collaboration with the NBRC, funding was awarded to seven organizations in Maine, New Hampshire, New York, and Vermont to support innovative programs designed to enhance healthcare services to rural residents in all four states.

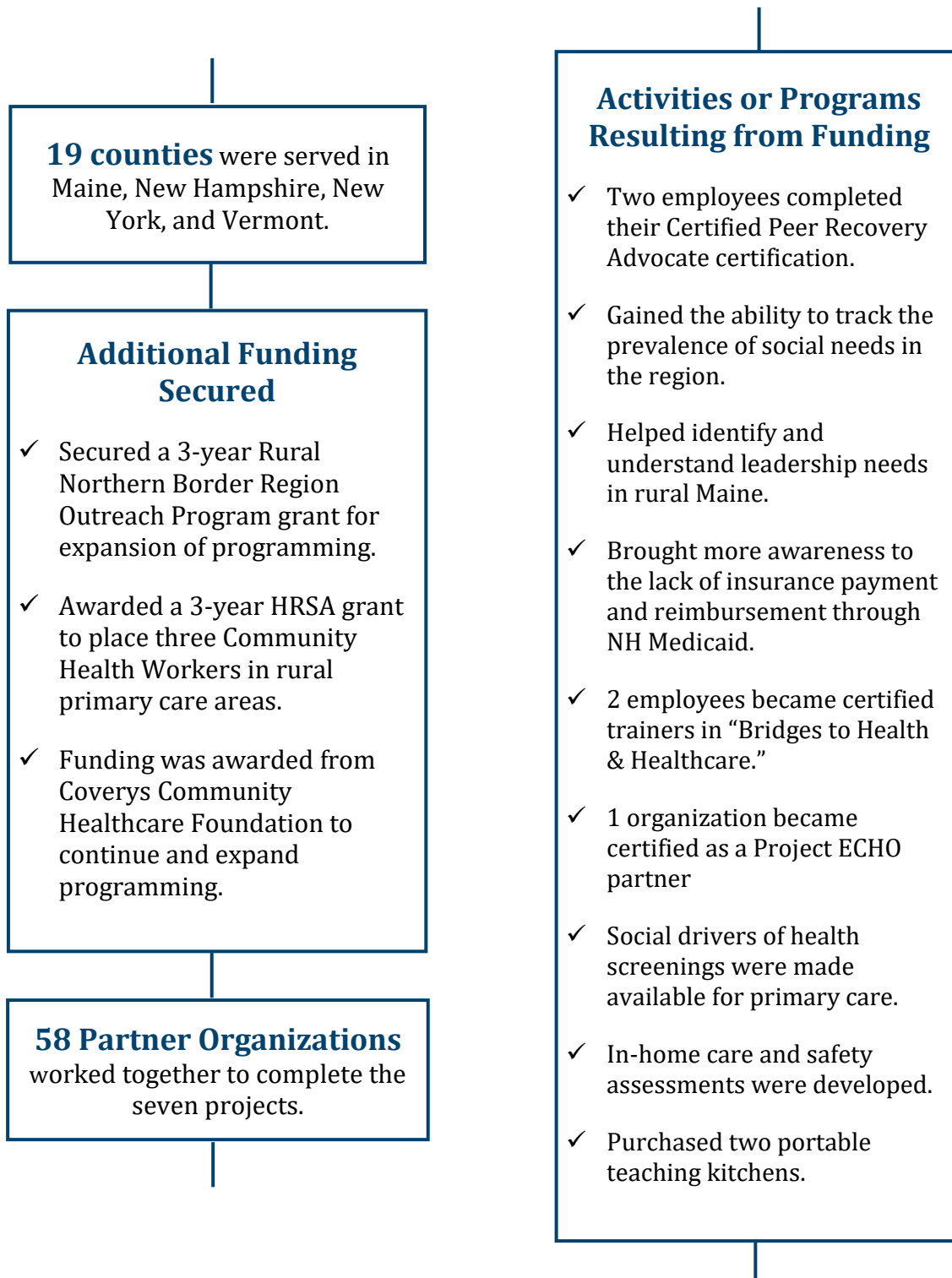
In alignment with the Rural Northern Border Region Healthcare Support Program, the Rural Health Redesign Center Organization, Inc. (RHRC) administered the funding and provided support to the awardees over a one-year period, from October 1, 2023, to September 29, 2024. The RHRC is delivering technical assistance (TA) through a three-year cooperative agreement from HRSA, to rural health care providers and organizations in the NBRC geographic area.

Program Impact

The sixty-four counties (see map) located in the NBRC region offer breathtaking natural beauty and rich cultural tapestries. Many of these counties are considered among the most distressed counties within the four northeastern border states and are home to more than 4,343,440 residents (US Census Bureau, Population and Housing Unit Estimates. 2024). Fifty-five of the counties are considered rural (non-metropolitan areas).



Over the one-year period of the funding, the grantees met with RHRC to review project status, barriers or challenges to implementation, as well as any successes they achieved. Each grantee completed quarterly reports and submitted a final report. At the completion of the funding, grantees provided presentations to approximately 172 attendees during a webinar on September 23, 2024, highlighting the outcomes of the projects.



Grantee Organization Snapshots

Grantee by State and Type of Organization

State	Type of Organization
Maine	(i.e. Area Health Education Center (AHEC), Critical Access Hospital (CAH), Rural Health Clinic (RHC), etc.)
Community Care Partnership of Maine	Accountable Care Organization
The Hanley Center for Health Leadership and Education	Non-Profit, Health Leadership
New Hampshire	
Ammonoosuc Community Health Services	Federally Qualified Health Center
Mary Hitchcock Memorial Health Services	Hospital/Academic Health System
New York	
St Lawrence Health Canton-Potsdam Hospital	Non-Profit Community Hospital
Fort Drum Regional Health Planning Organization	Non-Profit, Rural Health Network
Vermont	
Brattleboro Memorial Hospital	Non-Profit, Community Hospital

Grantee by Funding Award

Grantee Organization	Opioid Use Disorder (OUD)/Substance Use Disorder (SUD)	Access to Care	Leadership Development	Food Insecurity	Pediatric Oral Health	Mobile Integrated Health
Community Care Partnership of Maine	•					
The Hanley Center for Health Leadership and Education			•			
Ammonoosuc Community Health Services				•		
Mary Hitchcock Memorial Health Services					•	
Canton-Potsdam Hospital	•					
Fort Drum Regional Health Planning Organization		•	•			
Brattleboro Memorial Hospital						•

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Award Amount – \$182,453

Counties Covered – Aroostook County, Cumberland, Hancock, Kennebec, Oxford, Penobscot, Waldo, Washington Counties, Maine.

Partner Organizations – St. Joseph Healthcare, Penobscot Community Health, Together Place, Maine Department of Health and Human Service, and Office of Behavioral Health.

Needs Addressed – The rationale for the target population and the need addressed by the project was a gap in clinical and operational knowledge of medications for opioid use disorder (MOUD) treatment, particularly low-barrier approaches to MOUD administration and the use of extended-release buprenorphine (XRB). Project Extension for Community Health Outcomes (ECHO)'s target population were providers and patient care staff in rural health centers with need or interest in offering MOUD treatment.

Activities – Project ECHO offered monthly virtual sessions comprised of a didactic presentation by a subject matter expert faculty member, a case presentation given by a provider participant in the ECHO, and a case discussion facilitated by a member of the Community Care Partnership Team (CCPM) team. Additionally, Project ECHO developed a resource repository for providers offering MOUD comprised of sample workflows, conversation guides, policy and procedure templates, and other educational materials. Project ECHO also offered individualized training and technical assistance sessions which resulted in the initiation of XRB treatment in at least one rural practice participant.

Project ECHO promoted the evidence-based approach to MOUD treatment known as low-barrier or low-threshold. This is a model of care that prioritizes quick and easy access to MOUD while offering behavioral health support but not placing it as a prerequisite for medication. Low-barrier MOUD is characterized by accessibility, flexibility, and harm reduction

Outcomes/Accomplishments:

- One practice achieved the necessary certification for XRB administration and initiated three patients on the medication.
- Nine rural practices throughout Maine were provided with various MOUD and OUD learning topics.
- Policy and procedure documents were developed to support XRB administration in the complete form of a toolkit, administering the toolkit to participating organizations.
- Supported a rural practice in setting up XRB treatment.
- According to Whitney Jandreau, PharmD, Project ECHO, "CCPM's approach to educational programming through Project ECHO breaks down silos in healthcare and puts everyone in a more capable and ready position to save lives. CCPM is fully dedicated to the treatment and prevention of substance use disorder, and I am grateful for this collaborative learning opportunity."

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Award Amount - \$112,303

Counties Covered – Aroostook County, Maine.

Partner Organizations – Northern Maine Medical Center, NLH Gould Hospital, and the Cary Medical Center.

Needs Addressed – In response to the critical need for effective leadership among rural based physicians and advanced practice providers, the initiative aimed to equip the professionals, whether newly stepping into or already established in leadership roles, with the knowledge and skills essential for success. Recognizing the paradigm shift from a strictly clinical focus to one that encompasses system-wide perspectives, the focus was on building competencies that would enable providers to lead effectively within and across their organizations and communities.

Activities – The Provider Executive Leadership Institute (PELI) Foundational Course was delivered in person rotating at the various participating hospitals over a 10-month period. The course was comprised of six core in-person sessions and three 90-minute virtual Intersession Learning Seminars covering topics such as: Emerging Healthcare Trends and System Thinking, Intrapersonal Understanding, Emotional Intelligence & Self-Assessment, Interpersonal Skills: Communication & Working With One Another, Organizational Skills & Business Skills, Teamwork & Collaboration, and Innovation and Change Management. Core sessions consisted of six hours of interactive learning per session, roughly every other month. Sessions were built on reference materials from Harvard Business Publishing Online (“Harvard Manage Mentor”) and additional sources.

Outcomes/Accomplishments:

- Rural based providers gathered to learn about the value of leadership and to network and have a better understanding of the health and healthcare landscape within rural Maine.
- Surveys determined that 90% of participants rated the materials and presenter as “excellent” and 89% found the presentations and relevance of the topics to be “excellent.”
- Based on evaluations and in-person feedback, people are learning and appreciating their new leadership frameworks and skills and building relationships with one another across the participating hospitals.
- One participant stated, “I have used the learned skills to improve the dynamics of the office staff’s interactions with each other and patients. I have also used the skills to improve my personal interactions with my patients and colleagues. These skills have been invaluable to my professional and personal life.”
- Another participant said, “I am definitely implementing what I have learned in this course!”

Award Amount – \$45,539

Counties Covered – Northern Grafton and Southern Coos County, New Hampshire.

Partner Organizations – North Country Health Consortium, White Mountain Community College, Northern Vermont University, New Hampshire Hunger Solutions, Bi-State Primary Care Association, and Southern New Hampshire University.

Needs Addressed – For the Ammonoosuc Community Health Services, Inc. (ACHS) service area, residents and patients experience various levels of food security and insecurity. Factors affecting this population include access to food due to transportation difficulties, multi-generational loss of knowledge, and experience in developing a grocery list based on recipes, cooking foods with the recipes, and cooking foods that are lower in carbohydrates and sodium. The ACHS Food as Medicine Portable Teaching Kitchen was an experimental community-based service that engaged people where they lived and worked. It is a multisensory experience (sight, sense, and smell) that enabled participants to realize they can cook meals in fewer than thirty minutes from prep to plate that tastes good, are low in carbohydrates and sodium, and share meals that make them feel good.

Activities – Community-based educational experiences, creation, collation and curation of recipes that were accessible through high visual image/light vision text recipes, and short video demonstrations. The collection and curation of “food security” resources were developed through a collaborative relationship with Southern New Hampshire University’s Master’s in Public Health Program, the results of which are archived and curated on the ACHS’s Resilient American Community Web Portal and Dashboard. The Portable Teaching Kitchen focused on the preparation of menu plans, recipes, and the cooking of meals that made people feel good.

Outcomes/Achievements:

- Two portable teaching kitchens, utensils and a mobile trailer were purchased.
- Over twelve teaching videos, with print-based recipes, were collated and curated on the ACHS’s Resilient American Community Web Based Portal.
- A deeper and broader collaborative partnership was developed, which is critical to success and sustainability of the program.
- Engagement with academic institutions resulted in student experiences that were academically robust and memorialized through videography and visual image/text back documents for others to access.
- Secured a three-year HRSA Northern Border Regional Outreach grant for program expansion.
- Mobile kitchens were launched during National Health Center week in 2024 in partnership with White Mountain Community College and Northern Vermont University.

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Award Amount - \$126,105

Counties Covered – Windsor, Orange and Addison Counties in Vermont. Grafton County, New Hampshire.

Partner Organizations – Vermont Department of Health, Oral Health Program, Mount Ascutney Hospital and Health Clinic, Ottaquechee Health Clinic, Upper Valley Pediatrics, White River Family Pediatrics, Dartmouth Health Children's (DHMC) Pediatrics, DHMC Moms in Recovery Program, Alice Peck Day Memorial Health, Potter Medical Center, New Hampshire Department of Health, Oral Health Program, and SHMC Center for Advancing Rural Health Equity.

Needs Addressed – The Silver Diamine Fluoride (SDF) Treatment in Pediatric Practices project addressed the needs of children ages 0-7 in rural New Hampshire and Vermont counties who have untreated dental tooth decay. These children generally live in small rural towns with limited or no water fluoridation and are unlikely to have access to dental care until age 4-5 and the access issue is even more severe for children with Medicaid. SDF is an inexpensive, brush-on, minimally invasive treatment for dental caries that arrests the progression of caries and re-mineralizes treated teeth.

Activities – Regional training was provided to pediatric medical providers in the use of SDF treatment as part of routine pediatric care. The project included engaging interested practices, providing one session of didactic oral health education for pediatricians, followed by one session of hands-on practical training in the application of SDF. Along with direct training, consultation was provided to clinic teams about clinical guidelines, parent/child educational materials and practices, coding and billing information, and clinical workflows. As part of this work, a three-session Project ECHO series was hosted about child oral health and SDF practices, and an SDF 'toolkit' was created that is accessible to interested practices.

Outcomes/Achievements:

- SDF training was provided for eight clinical practices in the region, plus follow-up consultation and support for workflow and billing issues.
- A total of thirty providers from all practices were trained: Two practices, Dartmouth Hitchcock Pediatrics and Upper Valley Pediatrics, have already administered SDF for five patients.
- Fifty-one people from NH, VT, and ME, including forty-one clinical providers and clinic administrators, attended at least one of the three Project ECHO sessions.
- Trained clinicians were extremely optimistic and excited they could now treat patients while they awaited a referral for dental care.
- The ECHO webinar is sustainable and available as an enduring material that can be viewed by interested clinicians in perpetuity.
- A poster presentation is planned at Vermont Nurse Practitioner Association in 2025 and application for presentation at the Northern New England Cooperative annual meeting in January 2025.

Award Amount – \$133,600

Counties Covered – St. Lawrence County, New York.

Partner Organizations – N/A

Needs Addressed - The Peer Support Network program provided vital support to individuals with addiction or in recovery from Certified Peer Recovery Advocates (CPRAs) who truly understand what it means to experience the process, therefore improving the patient experience and overall recovery process. CPRAs are a necessary component in addressing these barriers, but because peer programs are a relatively new, salaries average \$22,500 less than the median household income of St. Lawrence County and \$37,000 less than New York State. CPRAs face many potential issues, such as managing their own recovery, dealing with difficult, unpredictable emotional and challenging situations, working irregular hours, managing caseloads, and navigating complex healthcare and social service systems to connect clients with the resources they need.

Activities – The first goal of the project was recruiting and retaining staff through staff identifying education for additional training, obtaining a membership with the Association for Addiction Professionals (NAADAC) for additional educational opportunities, offering de-escalation training, establishing a baseline staff satisfaction score at the start of the program by providing stipends at six, nine and twelve months, creating “Patient Giving” closets, homeless packages, and providing needed supplies and assistance to participants. The second goal focused on unique access problems, the healthcare and needs of the target population by implementing the Recovery Capital Index (RCI), holding ongoing training for staff on social drivers of health and motivational interviewing, and identifying key areas from the RCI that helped participants with identifying and completing goals to improve their support.

Outcomes/Achievements:

- Provided diapers and wipes to over forty families, 500 items to assist with family’s needs, created “Patient Closets” at all behavioral health locations, provided kits for residents facing homelessness, Harm Reduction supplies, and Child Safety supplies.
- Medication-assisted treatment (MAT) payment assistance was provided when a patient was uninsured or underinsured.
- Cell phones were provided with three months of service for patients who did not qualify for free phones.
- Two employees completed their Certified Peer Recovery Advocate certification.
- NAADAC membership was obtained so CRPA staff will have additional access to education and training.
- Stipends were provided throughout the grant period totaling \$2,500 per CRPA.
- CRPA job satisfaction scores improved from 2023- 3.8/5 compared to 2024- 4.2/5 during the project.

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Award Amount – \$225,000

Counties Covered – Lewis and Saint Lawrence Counties, NY, and the rural census tracts in Jefferson County, NY.

Partner Organizations - Carthage Area Hospital Carthage, Claxton-Hepburn Medical Center Ogdensburg, Child & Adolescent Health Associates Watertown, Clifton-Fine Hospital, Complete Family Care, Lowville Medical Associates, North Country Family Health Center, Ogdensburg Family Practice, Pediatric Associates of Watertown, Pediatric Wellness of Northern New York, River Hospital, Samaritan Medical Center, Watertown Internists, Children's Home of Jefferson County, THRIVE Wellness & Recovery, St. Lawrence County Community Services, Mental Health Association in Jefferson County, Northern Regional Center for Independent Living, Resolution Center & Family Counseling Services, Catholic Charities, Cornell Cooperative Extension of Jefferson County, Jefferson County Public Health, Lewis County Public Health, Maximizing Independent Living Choices, NNY YMCA, North Country Prenatal Perinatal Council, Pivot, Seaway Valley Prevention Center, Volunteer Transportation Center, Watertown Urban Mission.

Needs Addressed - The project sought to improve primary care access and experiences in the region through workforce training, the implementation of patient-centered strategies, a regional survey of adult residents, and the promotion of consistent care through social drivers of health needs. The project identified primary care as a significant access point for various types of preventative and acute physical care, as well as behavioral and social care, to promote more consistent health outcomes across communities.

Activities – Fort Drum Regional Health Planning Organization (FDRHPO) and the thirty-one project partners collaboratively conducted four primary activities: 1) FDRHPO trained the project partners in effective communication, service delivery, and bridges to health and healthcare. 2) Each partner organization identified specific actions to implement to improve patient care and experience within their organization, 3) Project partners selected a standardized social driver of health screening tool and, 4) FDRHPO conducted a Community Health Survey of adult residents in the region to gain additional insight into the healthcare perspectives and needs of the region's rural residents.

Outcomes /Achievements:

- 169 project partner staff members participated in effective communication, service delivery, and bridges to health and healthcare models.
- Three FDRHPO staff are now certified to conduct the Bridges to Health & Healthcare training.
- Project partners selected a standardized social driver of health (SDOH) screening tool and conducted at least 1,604 screenings with the target population during the grant period.
- FDRHPO conducted a Community Health Survey with 1,878 adult respondents in the region.
- Project partners have reported implementing the action items they identified as part of the training they received.

Award Amount – \$225,000

Counties Covered – All Counties in Vermont.

Project Partners – Rescue, Inc.

Needs Addressed – The primary goals of the Mobile Integrated Health (MIH) program were to improve patient health outcomes, decrease hospital re-admissions, enhance both patient and caregiver experiences, and reduce the total cost of care. Additionally, the program aimed to ensure a safe transition for patients returning home after surgery, while minimizing preventable or unnecessary office visits and emergency room trips following surgery. These goals collectively addressed the need for more efficient, effective, and supportive care throughout the patient's recovery process.

Activities – After the surgery was scheduled, the patient met with the Total Joint Nurse Navigator to discuss the program and obtained the necessary consent. MIH completed an in-home visit 10-14 days before the surgery. During this visit, a safety assessment was conducted including the need for durable medical equipment (DME). MIH also reviewed post-operative medications, confirmed ride arrangements for both pre- and post-surgery, and reviewed educational materials with the patient and their home support team. On the day of discharge from the hospital, MIH met with the patient at home to ensure a safe transition. A follow-up phone call was made one week after surgery, with a home visit scheduled for total knee patients. Additional phone calls and home visits were provided as needed to ensure a successful recovery and overall well-being of the patient.

Outcomes/Achievements:

- Served over fifty patients enrolled in the MIH program, reduced phone calls to on-call providers and clinics, prevented emergency room visits, arranged transportation for urgent needs, held weekly phone/video calls to discuss learning opportunities and trouble shoot challenges, had constant real-time feedback for any questions or concerns, and added in-home assessments as a valuable documentation tool.
- By implementing proactive, in-home care and safety assessments, the project effectively minimized post-surgical complications and the need for emergency interventions.
- Improved patient outcomes and increased savings for high readmission costs, estimated at \$15,000 per patient.
- Successfully demonstrated the cost-effectiveness of in-home care and safety assessments, with an average cost of \$1,100 per patient for MIH services.
- Patients reported higher satisfaction due to personalized care, clear education on post-operative expectations, and seamless follow-up services.
- Staff reported higher job satisfaction as a result of fewer emergency visits and after-hours calls, which made the workload easier to handle and improved work-life balance.
- BMH was awarded a \$100,000 through Coverys Community Healthcare Foundation to continue and expand the MIH program because of the work through this program.