

**NETWORK DEVELOPMENT PROJECTS
 2007 and 2008**



- | | | | | |
|-----------------------|----------------------|------------------------|---------------------|---------------------|
| 1. Anchorage, AK | 12. Sandersville, GA | 23. Augusta, ME | 34. Rolla, ND | 45. Centerville, TN |
| 2. Ketchikan, AK | 13. Harlan, IA | 24. Blue Hill, ME | 35. Beatrice, NE | 46. Centerville, TX |
| 3. Childersburg, AL | 14. Moscow, ID | 25. Lexington, MO | 36. Kearney, NE | 47. Kingsville, TX |
| 4. Roanoke, AL | 15. Monmouth, IL | 26. Macon, MO | 37. Conway, NH | 48. Lufkin, TX |
| 5. Siloam Springs, AR | 16. Quincy, IL | 27. Anaconda, MT | 38. Taos, NM | 49. Luling, TX |
| 6. Eureka, CA | 17. Bremen, IN | 28. Cut Bank, MT | 39. Cooperstown, NY | 50. Nacogdoches, TX |
| 7. Lone Pine, CA | 18. Rosedale, IN | 29. Ronan, MT | 40. Penn Yan, NY | 51. Montpelier, VT |
| 8. Ukiah, CA | 19. Hartford, KY | 30. Brevard, NC | 41. Warrensburg, NY | 52. Randolph, VT |
| 9. Avon Park, FL | 20. Morehead, KY | 31. Elizabeth City, NC | 42. Athens, OH | 53. Toppenish, WA |
| 10. Lake Butler, FL | 21. Delhi, LA | 32. Bowman, ND | 43. Hugo, OK | 54. Scarbro, WV |
| 11. La Grange, GA | 22. Easton, MD | 33. Minot, ND | 44. La Grande, OR | 55. Laramie, WY |

**Rural Health
 NETWORK DEVELOPMENT
 Grantee Directory
 FY 2009**

ALABAMA

City of Childersburg Medical Clinic Board, Inc.

Grant Number: D06RH09004

PROGRAM DIRECTOR

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 197,151.00
- Year 2- 179,880.00
- Year 3- 174,963.00

PARTNERS TO THE PROJECT

Community Health Council of Manhattan, Inc., in Manhattan, Kansas; RHNMC in Florida; and the Itasca County Health Network in Minnesota.

AREAS SERVED

Talladega County Alabama

TARGET POPULATION SERVED

The target area for these primary care and wellness focuses is also both a Health Professional Shortage Area (HPSA) and a Medically Underserved Area.

PROJECT SUMMARY

The City of Childersburg's, Alabama Medical Clinical Board Incorporated (AMCB) is the applicant and will be an advisor to the network. AMBC is seeking grant funding to strengthen and extend its existing rural healthcare network, centered in Talladega County, Alabama but also covering patients in immediately adjacent parts of surrounding counties. A total of approximately 110,000 persons reside within the AMCB's defined service area.

Seventy two percent are white, 62 percent live in rural areas, 11 percent of white residents and 28 percent of African American residents live below the federal poverty level. The AMCB will provide existing premises, staff, and administrative support as the equivalent of partially matching funds. The target area for these primary care and wellness focuses is also both a Health Professional Shortage Area (HPSA) and a Medically Underserved Area.

The primary problems and opportunities that the AMCB network will address are:

- Increase the capacity of the primary care physicians and improve access to working residents by extending open hours to include some evenings and parts of weekends,

ALABAMA

City of Childersburg Medical Clinic Board, Inc.

Grant Number: D06RH09004

- Make greater use of available computer technology to improve practice efficiency, diagnostic services, telehealth, and patient information,
- Improve the long-term viability and sustainability of the network and its partners all of whom will be involved in the design of programs. The providers will benefit by improved promotion of their availability (particularly in evenings and at weekends), more consistent use of their time, and prompt access to diagnostic results.
- Expand the existing network: a) explore the inclusion of other providers in the network: e.g., specialists from one or more Birmingham medical centers, b) expand dental and eye-care services, c) recruit a nurse practitioner to promote health education, offer health fairs, and in-school diagnosis and prevention, and, d) collaborate with the school system to address the major issue of mental health problems and disruption of the teaching process and loss of frustrated teachers,
- Build a system that will be self-sustaining and increase social dividends resulting from increased access and the range and quality of local healthcare provided to the residents of our defined service area.

Elsewhere in the United States there are three models that are similar to some of the main goals (Community Health Council of Manhattan, Inc., in Manhattan, Kansas; RHNMC in Florida; and the Itasca County Health Network in Minnesota).

Advisors to AMBC have experience in Alabama with community health support projects including health fairs and school education. The exploratory goal involving medical and behavioral causation of disruption in the school system will be racially and culturally sensitive to the needs of Alabama and may contain some original intervention work.

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ALABAMA

Roanoke Health Care Authority DBA Randolph Medical Center

Grant Number: D06RH09015

PROGRAM DIRECTOR

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TOPIC AREAS

Healthcare needs

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 234,313.00
- Year 2- 179,713.00
- Year 3- 179,963.00

AREAS SERVED

Washington, Randolph, Escambia, Franklin Counties in the State of Alabama

TARGET POPULATION SERVED

Estimated size of the target population (2005 U.S. Census) is 109,309. All are classified as highly rural and health needs are all ones similar to rural populations. Populations to be served include all ages, races and genders.

PROJECT SUMMARY

According to the United States Public Health Service, until the mid 1980s the quality of health care in rural Alabama was measurably among the lowest of any area in the United States and offered a striking lack of preventative health care services. Today, despite making many strides in the 1980s to improve the state's health care delivery system, disparities in health care needs still exist in the majority of rural Alabama. The Rural Healthcare Consortium of Alabama, Inc. has identified the following environmental situations reflective of unmet health needs in the network's hospital's service area:

- Hospitals have net losses;
- Hospitals are not stable;
- Hospitals receive poor reimbursements;
- Hospitals operate with inadequate technology;
- Residents have insufficient health status;
- Patients who suffer from chronic diseases are non-compliant with treatment; and
- High numbers of uninsured utilize emergency room for non-emergency care.

Primary service areas represented by the network members are four counties Randolph, Washington, Franklin and Escambia. Estimated size of the target population (2005 U.S. Census) is 109,309. All are

ALABAMA

Roanoke Health Care Authority DBA Randolph Medical Center

Grant Number: D06RH09015

classified as highly rural and health needs are all ones similar to rural populations. Populations to be served include all ages, races and genders.

The impact of this project will specifically increase the percentage of healthy residents in the service areas, maximize each member's resources, create economies of scale and reduce network members operating costs. The long term impacts of the Rural Healthcare Consortium of Alabama are:

- Financial stability and viability;
- Delivery of services based on best practices;
- Expanded business opportunities;
- Improved accessibility to healthcare services; and
- Healthier communities in service areas.

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ALASKA

Eastern Aleutian Tribes

Grant Number: D06RH09059

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 179,995.00
- Year 2- 179,995.00
- Year 3- 179,997.00

PARTNERS TO THE PROJECT

Eastern Aleutian Tribes Inc., Aleutian Pribilof Islands Association, Inc., Alaska Native Tribal Health Consortium

AREAS SERVED

Aleutians East Borough, Pribilof Islands and Alaska Native Tribal Health Consortium

TARGET POPULATION SERVED

The target population is the 8,288 permanent residents in the 13 rural communities of the Aleutian and Pribilof Islands, the most remote health service region in the United States.

PROJECT SUMMARY

Eastern Aleutian Tribes, Inc. (EAT) is applying for this grant project as a participating partner of the Alaska Rural Health Network that has two other members: Aleutian Pribilof Islands Association (APIA); Alaska Native Tribal Health Consortium (ANTHC).

The primary need to be addressed through this grant proposal is for the sustainability of health care services for the target population. The key goal of the Alaska Rural Health Network (ARHN) is to strengthen the economic viability of health care services in the Aleutian and Pribilof Islands through improved cost recovery. The significant barrier to be overcome in rural Alaska has to do with access to technical expertise for integration of the Indian Health Service's *Resource Patient Management System* (RPMS) with the revenue cycle of small tribal provider organizations. The ARHN partners aim to overcome this barrier by means of consolidating demand for assistance, by leveraging telecommunications connectivity to overcome cost of access, and by using a network hub located in the urban area closest to the service area.

ALASKA

Eastern Aleutian Tribes

Grant Number: D06RH09059

The target population is the 8,288 permanent residents in the 13 rural communities of the Aleutian and Pribilof Islands, the most remote health service region in the United States. APIA and EAT are the only providers of health care in the thirteen communities included in this project. Caucasians make up 36% of the population; Alaska Natives 27.6%; Asians 25%; Other 11.4%. The male population accounts for 64% of the population and females 36%. The percent of persons over age 18 is 83%¹.

Benefits to ARHN members are: that they can work towards becoming self sustaining through the effective billing and collection of patient revenue; and the production of accurate data for grant reporting and making clinical/management decisions regarding health care service delivery.

By the beginning of the third year of this proposed project ARHN plans to open up network membership opportunities to other small, rural Alaska health clinics. ARHN plans to build financial sustainability by charging current and new network partners a fee for expert medical revenue cycle services, such as medical billing and collection. Currently, these are services which cannot be found elsewhere in Alaska for organizations that use both the IHS and CHC/330 programs. The value proposition for the small tribal health care providers is a high cost recovery rate in exchange for a reasonable membership and service fee. An aggressive marketing plan will be developed in year two to promote the services available to outside entities in year three.

¹U.S. Census 2000.

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ALASKA

PeaceHealth DBA Ketchikan General Hospital

Grant Number: D06RH09055

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TOPIC AREAS

Quality of care and access

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 205,803.00
- Year 2- 179,906.00
- Year 3- 179,902.00

PARTNERS TO THE PROJECT

Ketchikan General Hospital (KGH) and the POW Island Health Network

AREAS SERVED

Prince of Wales Island

TARGET POPULATION SERVED

Uninsured Residents

PROJECT SUMMARY

A collaborative effort is needed to resolve healthcare quality issues and access barriers on Prince of Wales (POW) Island in Southeast Alaska. The POW Island Health Network was established to implement solutions to long-term and on-going quality and access issues. One of the participating members of the network, Ketchikan General Hospital (KGH), is serving as the applicant agency on behalf of the POW Island Health Network.

Prince of Wales (POW) Island is extremely remote, with the only transportation access to the island by airplane or boat. Quality of care and access are critical issues, largely due to difficulty recruiting and retaining medical practitioners and lack of a well coordinated system to support the struggling and remote medical facilities and providers on the island that are separated by distance and lack of technology. The long distances between health facilities combined with weather and transportation challenges also help create and magnify access and quality issues for rural Alaskans. Since Alaska has the highest rate of unintentional injuries in the country, the establishment of an excellent health system is critically important.

Rural POW Island residents often have to travel long distances for care at high costs, and are often without the support and help of family and friends. The island has long suffered from health care worker

ALASKA

PeaceHealth DBA Ketchikan General Hospital

Grant Number: D06RH09055

shortages, and is designated as a Health Professional Shortage Area (HPSA) and Medically Underserved Area (MUA).

The target population includes all residents of Prince of Wales (POW) Island, a remote rural island in Southeast Alaska. POW Island is approximately 2,200 square miles in area, with 990 miles of coastline. The island lies 750 miles north by air of Seattle, WA, and 750 miles south of Anchorage, AK. POW Island is sparsely populated with 4,570 residents and a population density of 2.0 persons per square mile. About 31 percent of POW Island residents live below 200 percent of the poverty level and 14 percent receive public insurance. At the medical clinic in Klawock, 64 percent of the clients are uninsured. The island has one of the lowest per capita income levels in Alaska, and a 19.2 percent unemployment rate.

The POW Island Health Network will work with medical providers, community leaders, and consumers on the island to achieve its objectives. Primary objectives are to empower the Network through creation of strong partnerships among providers and a consumer advisory group; introduction of communications technology among medical facilities; implementation of a strategic plan; and establishment of a viable and sustainable collaborative provider network. Priority areas to be addressed include: applying new solutions to recruitment and retention issues; supporting shared responsibility among providers to ensure 24/7 emergency care coverage; and addressing key healthcare concerns identified through the work of the strengthened Network. Network viability will benefit POW Island residents far into the future by working steadily to acquire an adequate number of medical providers who will stay in the community; maintaining access to critically needed 24/7 emergency services; providing access to communications technology for providers and consumers, and ensuring consumer access to new programs and services designed to meet the most prevalent healthcare needs on the island.

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ARKANSAS

Siloam Springs Memorial Hospital

Grant Number: D06RH09546

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TOPIC AREAS

Medical Care

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1 - 179,995.00
- Year 2 - 179,996.00
- Year 3 - 179,999.00

AREAS SERVED

Western Benton and Washington Counties in Arkansas, Adair and Delaware Counties in Oklahoma and parts of Cherokee County in Oklahoma.

TARGET POPULATION SERVED

Medically underserved residents

PROJECT SUMMARY

The applicant, Siloam Springs Memorial Hospital, applies for the Rural Health Network Development Grant on behalf of the Siloam Springs Regional Health Cooperative, a Rural Health Network. The project proposed by the Network addresses several serious issues in its service area, including a large number of patients who do not receive the medical care they need because of high poverty, lack of insurance, high co-pays or deductibles, high costs of prescriptions, and long distances to providers; a health care system that is not coordinated; rates of chronic disease that exceed state and national levels; and a tendency of the system to reward disease treatment or crisis management instead of rewarding a focus on lifelong wellness.

This network serves medically underserved residents of western Benton and Washington Counties, Arkansas and Adair, Cherokee and Delaware Counties in Oklahoma. The service area has a combined population of over 111,131. Of these, 23,000 (21%) lack health insurance, and over 18,000 (16.5%) have incomes less than 100% of the poverty rate.

For the purposes of the Rural Health Network Development Grant, the Siloam Springs Regional Health Cooperative will achieve the following project goals between 2008 and 2011:

- Goal #1: Increase Access to Health Care
- Goal #2: Strengthen the Viability and Quality of Rural Health Care Providers

ARKANSAS

Siloam Springs Memorial Hospital

Grant Number: D06RH09546

The long-term goals of Network Members are to increase access to health care and improve the quality of life for the poverty-stricken residents of the area served, decrease inefficiencies in the health care system, reduce inappropriate Emergency Room use, help businesses keep insurance premiums under control, and improve the system for managing patients' long-term health, especially those with conditions like diabetes and heart disease.

The federal funding requested will serve as an investment in information, plans, and formalized agreements to kick-start efforts to:

- improve the coordination of patient care among health care providers,
- improve the quality of care patients receive by investing in recruiting and training health care professionals,
- strengthen the long-term financial viability of small, rural health care providers by achieving economies of scale and improved efficiency, and
- improve access to care for medically underserved residents by enabling the indigent care clinic to get prepared to apply for increased reimbursement rates

A significant portion of the project efforts will be targeted toward strengthening the viability of health providers in the community, who will benefit from:

- planning and budgeting for coordinated health information technology,
- joint recruitment and sharing of critically-needed staff, and
- joint marketing of their services to reduce people leaving the area for medical care

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CALIFORNIA

Alliance for Rural Community Health

Grant Number: D06RH09003

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TOPIC AREAS

Health

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 179,605.00
- Year 2- 168,605.00
- Year 3- 126,105.00

PARTNERS TO THE PROJECT

Anderson Valley Health Center; Mendocino Community Health Clinics, Inc.; Long Valley Health Center; Redwood Coast Medical Services; Potter Valley Community Health Center; and Mendocino Coast Clinics.

AREAS SERVED

Mendocino County, California Lake County, California

TARGET POPULATION SERVED

For the uninsured, Medicaid, and low-income patients in our region

PROJECT SUMMARY

The purpose of the ARCH Integrated Electronic Health Records Project (IEHRP) is to improve patient care, health outcomes, and clinical efficiency through the installation and use of electronic health record software in six community health center organizations based in Mendocino County, California.

The ARCH Integrated Electronic Health Record Project will make a quantifiable difference on the business and clinical operations of our network in terms of effectiveness and efficiency. In addition, we anticipate that our EHR Project will facilitate significantly improved health outcomes as a result of increased safety and quality.

The Alliance for Rural Community Health (ARCH) is a non-profit Network of six community health center organizations in Mendocino and Lake Counties, California. Our health centers provide care to 43,000 patients in a rural and isolated region of the state, and are the primary providers of care for the uninsured, Medicaid, and low-income patients in our region. Over 40% of the total population of our region access services at one or more of our health center sites. Our Network includes four Federally Qualified Health Centers (FQHC) and two FQHC- Look Alikes.

CALIFORNIA

Alliance for Rural Community Health

Grant Number: D06RH09003

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CALIFORNIA

North Coast Clinics Network

Grant Number: D06RH09006

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TOPIC AREAS

Improve the quality of life in Rural California

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

The North Coast Clinics Network's (NCCN) fifteen member organizations include thirteen Federally Qualified Health Centers (FQHCs), a Family Planning Clinic and a county public health agency spanning an area that encompasses two counties and part of a third in the Northwest corner of California

AREAS SERVED

Northern California counties of Humboldt, Del Norte and Trinity.

TARGET POPULATION SERVED

Federally funded and low-cost providers

PROJECT SUMMARY

Breathtaking coastal bluffs, vast pristine beaches, towering mountain ranges, and lofty primordial redwoods abound on California's North Coast, attracting tourists from across the nation. Yet behind this renowned backdrop exists an economically impoverished, rural population which relies on a fragmented safety net system for their healthcare needs. North Coast Clinics Network's (NCCN) member clinics provide a safety net to care for this rural region.

Our service area extends three counties across Northern California and includes Humboldt, Del Norte, and Trinity Counties. Located 200 miles north of San Francisco and extending to the Oregon border, NCCN serves a region roughly the size of Connecticut, though with less than 5% of its population. The largest city within the region is Eureka (population 26,000). This rural area is rugged and mountainous, and has tenuous transportation and communication corridors which are often disrupted by extreme weather conditions such as fires, blizzards, and flooding. Between poverty, lack of adequate health care providers, rugged terrain, and lack of public or private transportation, residents face many barriers to care which intensify the need for federally funded and low-cost providers of quality primary and specialty care.

CALIFORNIA

North Coast Clinics Network

Grant Number: D06RH09006

The North Coast Clinics Network's (NCCN) fifteen member organizations include thirteen Federally Qualified Health Centers (FQHCs), a Family Planning Clinic and a county public health agency spanning an area that encompasses two counties and part of a third in the Northwest corner of California. Clinics provide quality primary medical, dental and mental health services for all ages and income levels regardless of ability to pay. In 2006, NCCN member clinics provided over 192,000 visits for 52,315 patients—one third of the regions population. NCCN exists to assist member clinics in their efforts to meet the needs of this community and the needs of the clinics themselves through information sharing, community education, shared administrative activities, and direct services projects. Currently, NCCN clinics face issues involving the efficiency of health care delivery and operations due to challenges with training staff on use of Information Technology, reducing waste, and meeting our staffing needs.

NCCN's proposed project under the ORHP's Network Development Grant Program hopes to:

- Appropriate Information Technology (IT) Training for Clinic Staff to allow clinics to adapt to the continual changes in legislation and Health Information Technology, thus improving operations and health care delivery.
- Implement cost-saving Green Initiatives for Community Clinics by integrating recycling into their operations, improving the efficiency of electrical systems and using 'green' cleaning supplies which will create a cleaner and healthier community.
- Recruit and Retain Medical Providers for the community to receive adequate and timely health care.
- Ensure the network's sustainability by updating and expanding its Strategic Plan to include Sustainability Planning, and by developing alternative income sources to decrease the organization's dependency on grants.

Activities associated with each of the objectives of this project will strengthen the fiscal and operational capacity of the network while fostering growth and development in each of the network's member clinics.

The most important outcome would be improved capacity to respond to patient needs and concerns - faster, more appropriately and in a way that builds confidence and trust in the community and in each other.

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CALIFORNIA

Southern Inyo Hospital

Grant Number: D06RH09007

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TOPIC AREAS

Telehealth Services

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 179,685.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

The Inyo County Telehealth Network (ICTN) in a collaborative effort with the Southern Sierra Telehealth Network (SSTN).

AREAS SERVED

Inyo County, California

TARGET POPULATION SERVED

Medically Underserved, high desert and mountainous county east of the Sierra Nevada Mountain Range in South Central California.

PROJECT SUMMARY

The Inyo County Telehealth Network (ICTN) will be established to provide telehealth services throughout Inyo County California in a collaborative effort with the Southern Sierra Telehealth Network (SSTN) rural hub in Ridgecrest, California. Inyo County is a sparsely populated, Medically Underserved, high desert and mountainous county east of the Sierra Nevada Mountain Range in South Central California. It has only 17,945 residents (1.8 per square mile) and 12.6% are Hispanic, 11.8% speak a language other than English, and 19.1% are disabled. Most residents do not have ready access to primary care providers, much less specialty providers. Southern Inyo Healthcare District (SIHD) is located in Lone Pine, a Frontier/Rural community with only 1890 residents.

SIHD has had a telemedicine program since 2001 and is connected to the SSTN and other providers for telemedicine services. The ICTN will partner with the SSTN for development of telehealth services throughout Inyo County to reach underserved residents. The ICTN will address the unusual needs of the Death Valley National Park area which has only a small resident population, but hosts approximately 1.5 million visitors a year. With no medical facilities, the only option for emergency or urgent care is transport to hospitals located in Lone Pine, Ridgecrest or Las Vegas, Nevada – all approximately two hours ambulance ride away.

CALIFORNIA

Southern Inyo Hospital

Grant Number: D06RH09007

The SSTN is a telemedicine network that includes ten rural clinics, hospitals and medical centers, as well as many individual consultant providers, and provides specialist telemedicine services for cardiology, medicine, psychiatry (adult, pediatric, geriatric), pulmonology, radiology, dermatology and developmentally disabled patients. It performs more than 100 interactive video consults a month and was established in 2000 at Ridgecrest Regional Hospital (RRH) which is located 90 miles south of Lone Pine, in Kern County, and also provides care to a Medically Underserved Population in the isolated high desert.

The SSTN was founded and other telehealth/tele-education (e-health) and health information technologies (HIT) were implemented to meet the many unmet health care needs resulting from the lack of critical medical specialists and subspecialists in the high desert regions east of the Sierras. The SSTN has unique experience and expertise in implementing innovative telemedicine, telehealth and HIT in rural communities.

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FLORIDA

Heartland Rural Health Network, Inc.

Grant Number: D06RH09002

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TOPIC AREAS

Diabetes

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 181,850.00
- Year 2- 177,530.00
- Year 3- 177,530.00

AREAS SERVED

Highlands County, Florida

TARGET POPULATION SERVED

The Network's target population are the approximately 8,900 African American and 14,300 Hispanic men and women, ages 18-64, who have diabetes or are at risk of developing diabetes.

PROJECT SUMMARY

Heartland Rural Health Network, Inc., as the grant applicant, proposes to address the problem of escalating diabetes and diabetes related complications that our local network of health care providers are experiencing in relation to unmanaged diabetes in low-income rural residents, particularly within the African American and Hispanic populations. It is the Network's intent to develop a provider network Diabetes Master Clinician Program that will "grow" a more effective, valuable, fully mature and revenue productive Network that effectively addresses an evidenced community issue at a provider level in concert with a grassroots network effort.

Highlands County is a socio-economically disadvantaged county with a population of 94,177 and an 83.7% white population, 9.5% black population, and 6.8% of various other races. The Hispanic population in Highlands County is 15.2%, which has increased 3% over the last five years. According to the Centers for Disease Control (CDC), all major racial/ethnic minority groups in the United States have a higher prevalence of diabetes than non-Hispanic whites. There are significant racial disparities regarding diabetes in Highlands County with the non-Hispanic black mortality rate being 3.8 times that of non-Hispanic whites and the Hispanic mortality rate being 1.7 times that of non-Hispanic whites.

The diabetes Age Adjusted Death Rate (AADR) in Highlands County is 30.9 compared to the state's rate of 20.8 and national rate of 28.1%. Thirteen point three percent of all non-Hispanic blacks and 9.5% of Hispanic/Latino Americans, aged 20 years or older, have diabetes. These numbers do not reflect prediabetes.

FLORIDA

Heartland Rural Health Network, Inc.

Grant Number: D06RH09002

The Network will use a two-prong approach that makes efforts at both a grass-roots level through the utilization of Community Health Navigators in conjunction with an evidence-based Diabetes Master Clinician Program (DMCP) which influences the Network members to address barriers and disparities in diabetes care. These two approaches are interdependent and create a synchronous, seamless model of care. This model has the potential to adequately address the disparities and cultural boundaries as it relates to diabetes treatment in rural areas while influencing network providers through the sharing of staff and expertise across network members and increased financial viability of both the network and its members. The Network's model strategically relies on the commitment and resources of its valued members. This model "links" them technologically through the utilization of the Diabetes Data Registry. This Diabetes Data Registry aids in the coordination of diabetes care among network providers, improves the quality of essential health care services, strengthens the local rural health care system as a whole, and strategically utilizes resources from our Network members.

The Florida Academy of Family Physicians Foundation's DMCP model has been in existence since 2003. It was initially funded through several foundation grants. Since 2003 it has been used to address diabetes care in the northern part of Florida. It started with 35 providers participating and has now grown to include over 50 participating providers. The DMCP program relies on the commitment of a network of providers within a community to make the program successful. In 2006, the cost savings for the 5,300 patients registered in the diabetes registry in the northern part of Florida was \$831,507.00. This savings means reduced uncompensated visits to the ER, physicians' offices, and reduced complications by managing diabetes and being held accountable through the diabetes data registry. This fully developed model has the potential to increase the financial viability of the Network and its members, shared staff and expertise across network members, a seamless continuum of care, and enhance the Network's value as a progressive leader in rural health care delivery.

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FLORIDA

Rural Health Partnership of North Central Florida, Inc.

Grant Number: D06RH09050

PROGRAM DIRECTOR

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

Rural Health Partnership of North Central Florida (RHP), a state certified rural health network, on behalf of its members and the residents of its nine county regions.

AREAS SERVED

Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Levy, Suwannee and Union Counties

PROJECT SUMMARY

There are two goals in the proposed project and although they are linked, they reflect two slightly different geographic regions.

Goal Number One includes a nine county rural network area which is designated by the Florida Department of Health (DOH). Goal Number One reflects activities that will be conducted by the Rural Health Partnership of North Central Florida (RHP), a state certified rural health network, on behalf of its members and the residents of its nine county region to develop and strengthen the networks infrastructure to better support the region in multiple ways including preparing them to actively participate in Florida's Medicaid Reform.

Goal Number Two includes the nine county rural network and two additional rural counties. When considering the pattern of the delivery of health care services, the nine county RHP area functions as part of an 11-county region which is included in the second goal. In Florida, this 11-county area is considered Medicaid Area Three and has been designated by the Agency for Health Care Administration (AHCA) as eligible for a Medicaid Reform Demonstration Project. Goal Number Two is specifically related to the issue of working collaboratively with our Medicaid Managed Care Partner to implement a demonstration project. The providers in the eventual 11-county area will be represented by a single newly formed non-profit corporation that will be able to contract with our Medicaid Managed Care Partner. This plan is based on a working model that has been developed and is being implemented by a rural health network in North East Florida.

FLORIDA

Rural Health Partnership of North Central Florida, Inc.

Grant Number: D06RH09050

This working model is discussed in the Impact section of this narrative.

The plan is to supplement the approximately \$67,000 received each year by the RHP to support minimal network activities with \$180,000 in federal funding for each of three years in order to create the infrastructure enhancements necessary to ensure the long-term viability and sustainability of the network. These enhancements will allow the network to grow and strengthen itself in the face of Medicaid reform and a rapidly increasing rural uninsured population, while simultaneously expanding access to critically needed health care services to the region's most vulnerable residents.

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GEORGIA

East Georgia Health Cooperative, Inc.

Grant Number: D06RH09000

PROGRAM DIRECTOR

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

Candler Community Health Centers and Medical College of Georgia

AREAS SERVED

East central Georgia. Emanuel, Glascock, Hancock, Jefferson, Jenkins, Johnson, Taliaferro, Tattnall, Treutlen, Warren and Washington.

TARGET POPULATION SERVED

The poor and elderly, has a high percentages of minorities, low educational levels, and poor health status.

PROJECT SUMMARY

- a) *Applicant Information:* East Georgia Health Cooperative, Inc. (EGHCoop), is a 501(c)(3) organization providing health care linkages and services to 14 rural counties in east central Georgia. Emanuel, Glascock, Hancock, Jefferson, Jenkins, Johnson, Taliaferro, Tattnall, Treutlen, Warren and Washington will be joined by three “top 200 neediest” counties when Wilkinson, Twiggs, and Candler Community Health Centers (CHCs) open this year. Positive aspects of this organization include its diversity – four hospitals, three CHCs serving 11 counties, four rural health clinics, physicians associated with the institutional providers, public health, and a cooperating tertiary provider – and the group’s eight-year history of collaboration. The Medical College of Georgia (MCG), Georgia’s well-respected public hospital in Augusta, Georgia, is an organizational, voting member and pays dues and offers services and expertise to the members.
- b) *Primary Problem:* The cooperative’s primary problem is the vulnerability of its provider community, which, in turn, puts continued citizen access, particularly access to minority and poor citizens, at further risk. We intend to use grant funds to improve member financial strength and, by extension, access to care. Our efforts will be targeted in four major areas:

GEORGIA

East Georgia Health Cooperative, Inc.

Grant Number: D06RH09000

1. Shared services: member cost savings and revenue to the cooperative through a major campaign to provide a wide variety of provider training, including business office, MD, and hospital services and development of a web-based system for area-wide education;
 2. Shared resources for community and patient education with special emphasis on the elderly and diabetics;
 3. Cooperative endeavors that will keep patients in their home communities, to include identification of gaps and barriers within the EGHCop community and a plan to work with area businesses for mutual benefit;
 4. Assistance to citizens who are uninsured or underinsured in accessing care, thereby reducing inappropriate Emergency Room utilization and costs and improving preventive care.
- c) *Population groups to be served:* This area of the state is poor and elderly, has a high percentages of minorities, low educational levels, and poor health status when compared with the rest of the state and the nation. One-fifth of the approximate 158,421 residents are in poverty and 35% have Medicaid.1 By improving viability of the EGHCop organizations, continued access to care will be a reality. Each county in EGHCop has been designated a medically underserved area (MUAs) d2 and 12 of the 14 counties are single county health professional shortage areas, the remaining two designated as HPSAs for low-income population or a population group.3d. *How the region will benefit:* The goals are two-fold: by keeping providers viable, patients will have access. We plan education targeted at seniors for end-of-life care and advance directives and diabetes education. We will refer indigent patients who present at hospital Emergency Rooms to the area's CHCs for preventive care. We will provide cost-effective, shared, education through a web-based teleconferencing system to providers on a variety of topics ranging from improving collections to updating regulations. We will economize by sharing services and costs and strategize to determine how we can work together more effectively to ensure access to care for the underinsured and the uninsured.

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GEORGIA

Troup Cares, Inc.

Grant Number: D06RH09027

PROGRAM DIRECTOR

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TOPIC AREAS

Healthcare Access

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 179,823.00
- Year 3- 179,895.00

PARTNERS TO THE PROJECT

In coordination with current Network Partners, *Troup Cares, Inc.* intends to link a volunteer free clinic with the services of the health district, the hospital, the FQHC in Hogansville and in West Point

AREAS SERVED

Hogansville, West Point, LaGrange, and Unincorporated Troup County, Georgia

TARGET POPULATION SERVED

The target population is the low income, uninsured Troup County residents who have no public health care coverage assistance nor employer sponsored health insurance coverage.

PROJECT SUMMARY

Troup County is a rural county in west central Georgia approximately 65 miles southwest of Atlanta's Hartsfield-Jackson airport and 45 miles northwest of Columbus, Georgia, which houses Fort Benning. The county's 61,000 residents face rapid change as the more traditional agricultural and textile mill jobs are eliminated along with job losses due to local manufacturing downsizing. As this occurs, Troup County is poised to become a "bedroom community" of the two largest cities in the state. Less than 20% of Troup County's residents attained a college degree and almost one-third of the residents do not have a high school diploma or GED. Often, the ability to obtain health insurance is linked with professional employment, which is not available to a large portion of the county's residents. For this grant initiative, the target population is the low income, uninsured Troup County residents who have no public health care coverage assistance nor employer sponsored health insurance coverage. According to U.S. Census Data Health Insurance Coverage for Georgia Counties, 2005, 15.3% of the county population is uninsured which represents approximately 6,739 individuals between 18 and 64 years of age. In coordination with current Network Partners, *Troup Cares, Inc.* intends to link a volunteer free clinic with the services of the health district, the hospital, the FQHC in Hogansville and in West Point, if one becomes operational. Additionally, the services of local United Way agencies, churches, care managers, and a medical

GEORGIA

Troup Cares, Inc.

Grant Number: D06RH09027

information and referral services will become part of the “continuum of care” provided to the medically uninsured and underserved residents. Through a coordinated intake process, these uninsured residents along with family members will be enrolled in any existing public insurance programs for which they are eligible. Consequently, all of the uninsured will be able to establish a “medical home.”

The specific goals of the grant funding activities are:

- **Goal 1:** Establish and improve healthcare access options for uninsured and underserved low income residents.
- **Goal 2:** Establish network programs which increase the efficiency of providing health care in a rural setting
- **Goal 3:** Refine organizational structure of *Troup Cares, Inc.* to meet the needs of the expanding Network
- **Goal 4:** Enhance the financial viability of the Network and secure the financial sustainability of the Network At this point in its development, *Troup Cares, Inc.* has the opportunity to create a system of health care for low income, uninsured and underserved residents of Troup County that mobilizes a volunteer effort of the medical community and leverages a better alignment of existing healthcare and related resources for the uninsured. If successful within this county, it is the intention of the Network to reach out to neighboring communities, many of which have fewer resources than Troup County.

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IDAHO

Gritman Medical Center

Grant Number: D06RH09056

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TOPIC AREAS

Mental health

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

Gritman Medical Center, Whitman Hospital and Medical Center and Pullman Regional Hospital, Area Agency on Aging and the Council on Aging & Human Services.

AREAS SERVED

Latah County, Idaho and Whitman County, Washington

TARGET POPULATION SERVED

Rural elderly are more likely to be poor, with lower lifetime incomes than their metropolitan counterparts, thus their social security benefits are subsequently less in many cases.

PROJECT SUMMARY

The primary mission of Project ACCESS/*Mental Health* is to improve the quality of life for seniors living in rural areas by 1) addressing mental illness (including dementia) by providing continuing education, professional training and efficient and effective access to resources to network partners and 2) strengthening and supporting the current mental healthcare networks in Whitman County, WA and Latah County, ID.

Project ACCESS/*Mental Health* will work collaboratively with mental health professionals, long-term care providers, social workers, faith-based organizations, the Inland Northwest Alzheimer's Association and primary care providers to eliminate disparities and discontinuity in the quality of mental healthcare in our rural area to make a difference for those we serve. Like many rural areas, Whitman and Latah counties face challenges in meeting the mental health needs of its aging rural populations. Small towns in these counties are geographically dispersed and have limited access to mental health and human service providers.

IDAHO

Gritman Medical Center

Grant Number: D06RH09056

Areas of focus and action plan:

- Project ACCESS/*Mental Health* plans to provide support to the Rural Network Partners by linking the network members with each other online and provide up-to-date resources and valuable links with information from more urban areas. The site will include a schedule of upcoming events in the area, frequently asked questions, helpful hints, links to the latest news and research, links to local mental health professionals, federal agencies, best practice programs and other rural mental health resources specific to senior's mental health issues, including dementia, in the rural Palouse region. This user-friendly tool will be of value as a hub of information for even the most inexperienced Internet users.
- Project ACCESS/*Mental Health* will address continuity of care by providing educational resources to the Palouse region. Through a variety of traditional and non-traditional programs reflective of "best practices" in continuing education, cross-training, referral strategies, and utilization of information technologies specific to the mental healthcare of seniors living in rural areas, we will be better able meet senior mental health needs.

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ILLINOIS

Access Health Adams County

Grant Number: D06RH09018

PROGRAM DIRECTOR

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 153,197.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

Consortium partners for the project include Adams County Health Department, Blessing Hospital, SIU Quincy Family Practice, Transitions, Quincy Medical Group, Tri-State Health Care Coalition, and the Salvation Army

AREAS SERVED

Adams County

TARGET POPULATION SERVED

The program targets the uninsured population in Adams County totaling 6,177 people and those enrolled in Medicaid which is 10,894 people.

PROJECT SUMMARY

The applicant agency for the proposed program is Access Health Adams County. Consortium partners for the project include Adams County Health Department, Blessing Hospital, SIU Quincy Family Practice, Transitions, Quincy Medical Group, Tri-State Health Care Coalition, and the Salvation Army.

The proposed program will serve Adams County Illinois- a rural, highly agricultural community with an increasingly older and low-income population. Adams County is located in the westernmost point of Illinois, along the Mississippi River. The program targets the uninsured population in Adams County totaling 6,177 people and those enrolled in Medicaid which is 10,894 people.

Thus, the program targets a total of 17,071 Adams County residents of all ages.

The Adams County community completed a 15-month planning process in June, 2006 to assess issues affecting access to healthcare in Adams County focusing specifically on “safety net” services (those provided to low-income, uninsured and otherwise vulnerable individuals) and the population most likely to utilize those services. The project was funded by a Network Planning grant through the Federal Office

ILLINOIS

Access Health Adams County

Grant Number: D06RH09018

of Health Policy. The proposed project will implement the strategic plan developed through this process including the following goals: 1) Develop and fully implement a comprehensive eligibility enrollment program that facilitates community linkages to eligible and appropriate health and social service providers 2) Develop and implement a care management program that supports the provider network by facilitating effective coordination and service navigation to “at risk” individuals 3) Develop a network of health care providers willing to accept an agreed-upon number of uninsured and Medicaid patients.

All of the strategies were chosen based upon their success in other communities. The technology system that we are implementing, CHASSIS, is used in several sites to help manage access to care initiatives. CHASSIS was developed by Network Sciences in Austin, Texas to support efficient and effective connection between the uninsured/needful and health/social services. It serves as the information system for the Austin, Texas indigent care collaborative, and as the information system to support similar initiatives in other Texas locations and in Palm Beach County, Florida. The care management strategy is also used in a variety of access initiatives to help improve follow-through of clients. The Network of Provider model is based on other models throughout the country that have joined together to share information and ideas under the American Project Access banner (APAN). APAN and other projects have developed program models, including information, policies, procedures and forms, which can be replicated in other communities.

Through coordination/integration of services and a more effective mechanism to navigate access to community services that are already available, the local community will have increased access and enhanced utilization of local resources. Once the system is developed, our community will benefit by having an affordable, comprehensive, quality, and coordinated system of care available for the targeted population.

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ILLINOIS

Warren Achievement Center, Inc.

Grant Number: D06RH09058

PROGRAM DIRECTOR

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 105,006.00
- Year 2- 75,500.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

Tri-County Health Care Planning Network

AREAS SERVED

Henderson, Mercer and Warren Counties, Illinois

TARGET POPULATION SERVED

The potential users of service include seniors, those seeking mental health/substance abuse treatment, the disabled, children/families and those with critical health needs such as dialysis and chemotherapy.

PROJECT SUMMARY

Warren Achievement Center, Inc. is a participating member of the Tri-County Health Care Planning Network (T-CHCPN) in implementing the Country Roads to Health project. The Tri-County Health Care Planning Network (T-CHCPN) is a group of community providers in Henderson, Mercer and Warren Counties, Illinois that recognize the lack of transportation options is leading to unmet health care needs of residents.

The T-CHCPN has developed the following output and outcome goals:

1. Develop a permanent and free-standing network of providers and support organizations to address health care needs in the three county area.
2. Make a formal evaluation of barriers to accessing healthcare in the area.
3. Complete a strategic plan focusing on community transportation to address the unmet healthcare needs of residents in Henderson, Mercer and Warren Counties.
4. Development of a sound network sustainability strategy to create meaningful long-term change in the community.

ILLINOIS

Warren Achievement Center, Inc.

Grant Number: D06RH09058

The planning process will include consistent communication with the external community, conducting an environmental scan including focus groups of potential users of services, a market analysis, an internal assessment, and a SWOT analysis. The potential users of service include seniors, those seeking mental health/substance abuse treatment, the disabled, children/families and those with critical health needs such as dialysis and chemotherapy. This information will then be used to set goals and objectives and develop an action plan to implement those goals and objectives including researching funding sources. It is believed that using a return on investment model the network will be able to show the potential for reduced trip costs for agencies, a reduction in missed appointments, improved access for consumers, less duplication of services and greater productivity in the services already being provided.

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INDIANA

Community Hospital of Bremen, Inc.

Grant Number: D06RH09054

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TOPIC AREAS

Health Records

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 179,929.00
- Year 2- 179,905.00
- Year 3- 179,182.00

PARTNERS TO THE PROJECT

Connecting Health Information for Rural Providers (CHIRP)

AREAS SERVED

Marshall, Saint Joseph, Elkhart, and Kosciusko Counties in Indiana

TARGET POPULATION SERVED

23,000 patients in four rural counties in north-central Indiana

PROJECT SUMMARY

Connecting Health Information for Rural Providers (CHIRP) will electronically capture health records of patients served by Community Hospital of Bremen (CHB) and its family practice physicians. Data from over 23,000 patients in four rural counties in north-central Indiana will be uploaded into an electronic medical record (EMR) via a secure, HIPAA compliant network. The EMR will feature a physician portal allowing primary care physicians access to their patient's data. The portal will also allow other treatment providers, such as specialists in larger cities, long term care facilities or transfer hospitals, access to a patient's health care record. The portal will also serve as a platform for tracking aggregate patient data, including compliance with care plans, numbers of patients receiving recommended screening procedures and improvement in health indicators such as obesity, smoking and diabetes management. The project will also bring EMRs to the local family practice physicians. This will improve the primary care provider's access to their patients clinical care record and give them tools for improved clinical decision support.

Data from the local hospital (CHB) and the local family practice physicians is not collected or available electronically. Paper charts and records do not provide information in a timely manner to the individuals that need it most, the family physicians and direct care providers.

INDIANA

Community Hospital of Bremen, Inc.

Grant Number: D06RH09054

CHIRP will use proven, reliable software to create an EMR, physician portal and ambulatory record (physician office EMR). A secure, wireless network will enable caregivers to capture and view patient data at the point of care, be it the bedside or the physician office. The hospital will implement bedside medication verification, a process proven to reduce medication administration errors.

The CHIRP network board comprised of hospital and physician leadership will evaluate, plan and allocate resources for the project. The board will establish performance measures to be evaluated and will serve as liaisons to the community and caregivers. Performance measures will be reported through the RPM (Rural Performance Measurement) system to identify trends and track performance.

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INDIANA

Indiana Rural Health Association

Grant Number: D06RH08997

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

The statewide organizations that have committed to participation in the Indiana Statewide Rural Health Network (InSRHN) include the Indiana Rural Health Association as the applicant organization, Indiana Hospital & Health Association, Union Hospital's Richard G. Lugar Center for Rural Health, and Health Care Excel.

AREAS SERVED

Indiana

PROJECT SUMMARY

The *Indiana Statewide Rural Health Network* is a formative health care network that brings together 29 of Indiana's rural health organizations. The statewide organizations that have committed to participation in the Indiana Statewide Rural Health Network (InSRHN) include the Indiana Rural Health Association as the applicant organization, Indiana Hospital & Health Association, Union Hospital's Richard G. Lugar Center for Rural Health, and Health Care Excel.

In addition, nine of Indiana's Critical Access Hospitals, seven additional rural hospitals, and nine Rural Health Clinics have committed to participation in network planning activities.

The primary problems addressed by the network include:

1. The need for increased financial viability and sustainability among Indiana's rural health care providers that will insure access to care by rural residents.
2. The need for increased access and use of Health Information Technology among Indiana's rural health care providers.
3. The need for increased connectivity among Indiana's rural health care providers that will enable the sharing of resources, services, implementation and participation in education programs, and others as deemed appropriate.

INDIANA

Indiana Rural Health Association

Grant Number: D06RH08997

4. The need for increases in quality improvement activities among Indiana's rural health care providers.

To meet these needs, the identified organization members will implement the following activities to insure successful network implementation: 1) Conduct network planning activities in conjunction with network members; 2) Increase connectivity and communication among rural health organizations and providers in Indiana; 3) Develop a strategic plan that will direct formal network development activities and sustainability of the InSRHN; and 4) Coordinate the availability of needed services, products, and programs as determined by the needs assessment and strategic planning process at a cost savings to network members. Once developed, the Indiana Statewide Rural Health Network will serve rural health care providers in Indiana. It is anticipated that Indiana's rural communities and residents will experience increased/more stable access to health care services as a result of the efforts of the network. These increases in access to care will occur as a result of the combined efforts of network members across diverse issues, achieving economies of scale for rural health care providers, resource sharing, and establishing shared programs. This initiative is modeled after the work of the Illinois Critical Access Hospital Network, which has been modified to include Indiana's Rural Health Clinics. These efforts would establish this network as a model for other areas in the country.

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KENTUCKY

Morehead State University

Grant Number: D06RH09051

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TOPIC AREAS

Primary care, and/or wellness and prevention strategies.

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 164,475.00
- Year 2- 168,626.00
- Year 3- 167,975.00

PARTNERS TO THE PROJECT

Morehead State University invited the Center for Excellence in Rural Health, the University of Kentucky, the University of Louisville, the Center for Rural Development, Kentucky Educational Television, the Kentucky Department for Public Health, the Roy Collier Community Center, and Martin County School System.

AREAS SERVED

Martin County, Kentucky

PROJECT SUMMARY

Bordering West Virginia, Martin County, Kentucky is a poor but proud county of 12,000 people located in the Appalachian region of eastern Kentucky. Martin Countians are noted for their friendliness, independence and determination. Unfortunately, with less than half of the national average for median income, and extremely low high school and college graduation rates (54% high school degrees for over age 25, and just a little over 1/3 the national average for bachelors degree) Martin County is also known for the distressed economic situation and poor health standards of the County (Kentucky ranks near the bottom in most health studies, and Martin County ranks in the bottom third of the state according to *The Health of Kentucky*, a 2007 statewide county assessment by the Kentucky Institute of Medicine).

But by tapping into the determination and resilience of these people, and working *with* the citizens and community groups of Martin County, the Eastern and Southern Kentucky Healthcare Consortia, a group comprising local and state resource partners, is determined to make a difference. The goals of this project are to help the citizens of Martin County to build a self-sustaining network among for-profits, non-profits, businesses and educational agencies that will ultimately increase access, quality, and the health status of this distressed rural area. In establishing a healthier lifestyle, and by providing participants with the information and resources to maintain this lifestyle, it is our hope that this project will also serve regionally as a catalyst for cooperation and the development of this and similar partnerships across

KENTUCKY

Morehead State University

Grant Number: D06RH09051

Southern and Eastern Kentucky. After community meetings and discussion with partners, we have already begun our first active role in the community in the form of an obesity pilot project. Kentucky adults rank seventh (7th) as the most obese in the country, and her youth the third (3rd) most overweight, according to a recent 2007 report by Trust for America's Health (<http://healthyamericans.org/reports/obesity2007/release.php?StateID=KY>). Morehead State University is serving as the lead applicant for the consortia, and as such we are requesting funding help from the Department of Health and Human Services to help us not only implement and oversee the obesity project, but to expand and strengthen the existing network that we have in place so that it will be more complete, sustainable, and lead to a truly positive difference in the lives of the citizens of Martin County, Kentucky.

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KENTUCKY

Ohio County Hospital Corp

Grant Number: D06RH09001

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 163,958.00
- Year 2- 155,139.00
- Year 3- 172,504.00

PARTNERS TO THE PROJECT

The Green River Regional Health Council (GRRHC), a committee of the Green River Area Development District (GRADD) Board of Directors.

AREAS SERVED

Daviess, Hancock, Henderson, McLean, Ohio, Union and Webster Counties in Kentucky

PROJECT SUMMARY

The Green River Regional Health Council (GRRHC), a committee of the Green River Area Development District (GRADD) Board of Directors, is a network composed of health professionals and community leadership responsible for assessing and defining the health needs of a rural seven county region of Western Kentucky, subsequently offering strategies to the regions most critical health issues GRRHC's service area includes Daviess, Hancock, Henderson, McLean, Ohio, Union and Webster Counties in Kentucky.

Four of the counties (Ohio, Union, Webster and Hancock) in GRRHC's seven-county service area have been designated HPSA and/or MUA and rural by HRSA and in multiple census tracts. Collectively, their constituents score higher than national and state in the areas of physical inactivity, smoking, obesity and diabetes. Other weaknesses identified were high pregnancy rates, low first trimester prenatal care, high stroke death, high heart disease death rate, low birth weight and infant mortality and high overall cancer death rate. These health disparities are exacerbated by the fact that over 16% of the citizens cannot afford health care and must travel a great distance to obtain it. Health literacy issues due to a low high school graduation rate further complicate the situation.

Finally, a lack of financial resources has made attempts at education and outreach very sporadic. The four rural counties in GRRHC are very much in need of a multi-functional, one-stop-entity that will fill in the current missing gaps in health care.

KENTUCKY

Ohio County Hospital Corp

Grant Number: D06RH09001

In 1996, GRRHC developed a Community Health Report Card consisting of regional data in 22 key health categories. This multi-functional appraisal was intended to direct the efforts of the GRRHC while serving as a means of raising public awareness to the areas existent problems. In 2002, after years of performing the Report Card the GRRHC realized a recurrent problem, the proposed strategies of the council were not being fulfilled. In large part, the high profile volunteer board was to blame for the lack of activity. These individuals did not have the time or the energy to turn the strategies of the council into motion.

The GRRHC proposes to utilize Office of Rural Health Policy, Rural Health Network Development Grant funds to hire an Network Director to coordinate the network's activities in its rural communities and establish Local Health Councils in the four rural counties of Ohio, Union, Hancock and Webster, thus creating a rural health network capable of addressing the comprehensive needs of their communities.

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LOUISIANA

Hospital Service District No. 1-A of the Parish of Richland

Grant Number: D06RH09025

PROGRAM DIRECTOR

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TOPIC AREAS

Health Assessment, Promotion, Education

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1 - 179,936.00
- Year 2 - 179,970.00
- Year 3 - 179,960.00

AREAS SERVED

Parishes of Caldwell, East Carroll, Franklin, Madison, Morehouse, Ouachita, Richland, Tensas & Union, State of Louisiana

TARGET POPULATION SERVED

Health Professional Shortage Area and a Medically Underserved Population

PROJECT SUMMARY

The applicant, Richland Parish Hospital (RPH), is a Critical Access Hospital with a 501(c)(3) nonprofit designation. RPH is located in Delhi, Louisiana, Richland Parish, in the northeast corner of the state. The hospital is a main provider of health care services in the parish. The Richland Parish Hospital-Delhi's (RPH-Delhi) Community Wellness and Prevention Program is a model program designed to provide health assessments, health promotion, and health education in settings such as the school, worksite, health care facility, and community.

Richland Parish has been classified as a Health Professional Shortage Area and a Medically Underserved Population by the Health Resources and Services Administration. There are significant barriers to access to health care in Richland Parish as reflected in the income and poverty demographics, health status indicators, and health disparities.

The primary needs to be addressed through the Rural Health Care Services Outreach Grant are:

- a) The need to increase the quality, availability, and effectiveness of community-based programs designed to prevent cardiovascular disease and improve health and quality of life
- b) The need to expand the availability of health education resources to underserved, vulnerable and special-needs population to reduce cardiovascular disease in these populations.
- c) The need to decrease the risk factors and the *resulting* high incidence rate of cardiovascular disease and correlating chronic diseases in Richland Parish

LOUISIANA

Hospital Service District No. 1-A of the Parish of Richland

Grant Number: D06RH09025

- d) The need to strengthen the health care infrastructure and health care delivery systems in Richland Parish as they relate to the management and treatment of cardiovascular disease and correlating chronic diseases.

To address the above identified needs the network has developed the following goals:

- **Goal 1:** Develop a model comprehensive community cardiovascular disease program in Richland Parish that can be reproduced in the existing ten parish Better Health for the Delta, Phase II Network Grant Project.
- **Goal 2:** Increase the community's awareness of cardiovascular disease and associated risk factors with a focus on Syndrome X, tobacco use and personal stress management.
- **Goal 3:** Decrease the incidence of cardiovascular disease and incidence of associated risk factors through a behavioral modification focus that targets dietary habits, physical activity, tobacco use and personal stress levels.
- **Goal 4:** Enhance the management and treatment of cardiovascular disease and associated risk factors with a focus on early detection, education, behavior modification, and pharmacotherapy.

Federal funding will be used to expand the existing RPH Community Wellness & Prevention Program to provide services to the underserved, vulnerable and special needs population in Richland Parish. The Parish has a population of 20,981.

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MARYLAND

Mid-Shore Mental Health Systems, Inc.

Grant Number: D06RH09052

PROGRAM DIRECTOR

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TOPIC AREAS

Telehealth/Telemedicine services

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

Maryland Department of Health and Mental Hygiene (DHMH)/Mental Hygiene Administration (MHA), the University of Maryland School of Medicine's (UMSOM) Department of Psychiatry, the Garrett County Core Service Agency and the Mental Health Authority of St. Mary's, Inc. (MHASM)

AREAS SERVED

Seven Maryland Counties: Caroline, Dorchester, Garrett, Kent, Queen Anne's, Talbot and St. Mary's

TARGET POPULATION SERVED

Targeting rural population is 40,000 people, of which 25,000 have no health insurance.

PROJECT SUMMARY

The goal of this proposed Telepsychiatry Network Program is to significantly increase and improve access to mental health services for minorities, uninsured, unserved and underserved at risk rural populations in seven Maryland jurisdictions (target rural population is 40,000 people, of which 25,000 have no health insurance). The lead agency applicant, Mid-Shore Mental Health Systems, Inc. (MSMHS), a local mental health authority serving five rural counties, in a collaborative partnership with the Maryland Department of Health and Mental Hygiene (DHMH)/Mental Hygiene Administration (MHA), the University of Maryland School of Medicine's (UMSOM) Department of Psychiatry, the Garrett County Core Service Agency and the Mental Health Authority of St. Mary's, Inc. (MHASM) proposes to develop telepsychiatry (real time telehealth/telemedicine services via live interactive videoconferencing) in seven rural Maryland counties. The applicant, MSMHS, is a private non-profit 501(c)(3) Core Service Agency (CSA), established by State mandate as an agent of County government, governed by an independent Board of Directors, and accountable to the Secretary of DHMH. The Garrett County CSA is a department of the Garrett County Health Department and the MHASM is a private nonprofit CSA—all three CSAs are located in rural areas of Maryland. The MHA is the State mental health authority that will provide additional grant funding to purchase psychiatric services from the University of Maryland Department of Psychiatry.

MARYLAND

Mid-Shore Mental Health Systems, Inc.

Grant Number: D06RH09052

Together, these entities, which have worked together for many years, formed a Consortium Network two years ago to establish and implement a seven-county rural psychiatric project. The proposed project will address a crucial need in specific rural Maryland communities with the greatest mental health disparities among its residents. Nineteen percent of the State is considered rural and psychiatric services in these areas are extremely scarce. The HRSA award will provide funding to purchase videoconferencing equipment for end-user sites, located in community mental health centers, to increase access and improve services in the public mental health system (PMHS) for indigent residents at seven sites proposed to serve Caroline, Dorchester, Garrett, Kent, Queen Anne's, Talbot and St. Mary's county residents. The proposed culturally sensitive and competent psychiatric services include individual and family/group consultation, assessment, and individual therapy for children, adolescents, adults and elderly residents, including people with co-occurring substance use and mental disorders, and hearing-impaired low-income individuals eligible under the Public Mental Health System (PMHS) to receive mental health services. The hub site for the psychiatrists, located in Baltimore, is already established at the UMSOM's Department of Psychiatry, and will be utilized for this project. Tandberg Video conferencing equipment, ISDN and IP connections are proposed for operation at the seven sites. The most current encryption technology will be employed to ensure HIPAA confidentiality compliance. The University of Maryland will provide project evaluation services. Technical assistance and training on utilization of the equipment will also be provided by the UMSOM, Department of Psychiatry. End-user "consumers" in the seven rural areas are expected to receive substantial mental health benefits from this new technology. Clearly, telepsychiatry will improve access and utilization of mental health care in the seven Maryland rural jurisdictions targeted in this project.

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MAINE

Blue Hill Memorial Hospital

Grant Number: D06RH09023

PROGRAM DIRECTOR

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TOPIC AREAS

Chronic Diseases

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

AREAS SERVED

Hancock County

TARGET POPULATION SERVED

Health Professional Shortage Area and Medically Underserved Communities

PROJECT SUMMARY

Blue Hill Memorial Hospital represents 11 healthcare organizations in the Hancock County Chronic Disease Patient Self Management Network (the Network) that are dedicated to improving patient-self management (PSM) strategies and chronic disease outcomes in Hancock County, Maine. Chronic diseases (heart disease, stroke, cancer, chronic lower respiratory disease and diabetes) account for five of the six leading causes of death and two-thirds of all deaths nationwide. When combined with other health conditions, 70% of all deaths can be attributed to chronic diseases. Poor diet, sedentary lifestyle, and tobacco use are recognized as the leading contributing factors to chronic diseases making them the most preventable and controllable of all health conditions. Each year the prevalence of these conditions continue to climb placing unnecessary and increased demands on the healthcare system, patients and families. The use of PSM strategies is widely recognized as effective in managing chronic conditions and improving treatment adherence. Assisting patients to understand their health conditions, linking them to prevention and support services, teaching them better medication adherence, how to set goals, take action steps and overcome barriers, are all part of the process of empowerment in self-management. Patients who feel empowered to manage their health can effectively learn to incorporate healthy behaviors into their daily routine and comply with the medical treatment recommended by their healthcare provider (Bodenheimer, 2002; Coulter and Ellins, 2007).

The population of Hancock County, Maine (estimated at 51,791) lives in towns ranging in populations of less than 100 to over 6,400 each (avg. 33 persons per square mile). The area is officially designated by the U.S. Department Health and Human Services as a Health Professional Shortage Area (HPSA), and includes Medically Underserved Communities (MUC) and serves Medically Underserved Populations

MAINE

Blue Hill Memorial Hospital

Grant Number: D06RH09023

(MUP). Since 2001, there has been a 3.5% increase in the number of people with 3 or more chronic medical conditions (from 19% to 23% of adults). In 2006, 14.5% of adults (age 18 and older) estimated their health as either “fair” or “poor” and 8% estimated being unable to perform their usual daily activities for 11 or more days in the last year, due to poor physical health (EMHS, 2006). In an effort to address the burden of chronic disease on patients and the healthcare system, the Network will establish a comprehensive, evidence based, chronic disease patient self-management and prevention system. Using a collaborative process coupled with decentralized planning and implementation the Network will empower and connect patients with essential education and resources. The Network consists of local providers, community organizations, and regional and statewide resources/experts. It will work with both practices and communities. Individuals will benefit from the Network by gaining access (including web-based) to information, tools (designed for levels of health literacy) and resources that have demonstrated value in the management of chronic conditions. Providers will benefit from the Network through collaboration with other providers and the community, through access to needed tools and resources that promotes patient continuity of care, more effective service delivery methods, reduces duplication, and facilitates integration of clinical best practices PSM strategies. Network implementation will benefit local communities, the county, and the State of Maine through the improved health of residents, and increased efficiency in the current healthcare delivery system.

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MAINE

Maine General Medical Center

Grant Number: D06RH09019

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

Kennebec Internal Medical Association, Kennebec Valley Ob/Gyn, Kennebec Region Health Alliance, Maine-Dartmouth Family Medicine Residency, Maine General Health Associates, Maine General Medical Center, Mark E. Bolduc, M.D., Mid-Maine Internal Medicine (NV), Waterville Anesthesia Association, and Waterville OB/Gyn

AREAS SERVED

Kennebec, Somerset, Lincoln, Waldo, and Sagadahoc Counties, Maine

TARGET POPULATION SERVED

Patients with chronic disease

PROJECT SUMMARY

The Kennebec Region Health Alliance (KRHA) Network Development program partners will plan and pilot integrated health services in a re-designed and expanded network to deliver quality, cost effective planned care for all 137,000 people served in the rural mid-Maine region. The applicant, Maine General Medical Center is a participating member of KRHA, the region's Physician Hospital Organization formed in 1997. In addition, the network is currently comprised of 240 provider members representing 64 individual healthcare provider organizations. The network will take advantage of its recent years building a broad platform of practice redesign and a shared community health record currently holding records for 50% of the population and growing steadily. The challenge faced in the region is the lack of primary care and specialty providers for the population. At an average patient panel of 1500 patients per physician, there is a primary care workforce deficiency of 43 physicians. Factoring in the Rand Study observation that only 55% of indicated interventions are delivered in the typical healthcare encounter, it is reasonable to estimate that, using traditional methods of primary care delivery, a primary care workforce of 166 physicians is needed in the Kennebec Region to deliver all indicated treatment, preventive interventions, and chronic disease management interventions to all patients. Believing there is no evidence of an increase in production of primary care physicians, improvement in the observed deficiency of primary

MAINE

Maine General Medical Center

Grant Number: D06RH09019

care physicians will require identification and dissemination of techniques that leverage each physician's effectiveness and productivity. An increase in patient panel size to 3,000 patients per physician and a doubling of the capacity for interventions per visit will fill the local need for primary care services. Specialist coverage is equally difficult. Health data in the region demonstrates that these shortages have had a detrimental effect on the population.

To address the need for access to quality care, this project seeks to develop a network capable of clinically integrating provider processes to streamline and improve the quality of care for patients, while enhancing primary care reimbursement to insure continuity of care with trusted providers. There will be three phases of the project including 1) study, analysis and consensus building; 2) Selection of 5 possible service lines offering maximum quality and cost benefits (examples of possible services include prevention scorecards and centralized reminder systems, central document scanning, practice management/coding interventions, etc.); and 3) Piloting these services to test acceptance, quality and sustainability. Several models developed by practices from across the U.S. have been studied to improve efficient design, communication and evaluation within the network and offer possible solutions which can be adapted to the program.

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MISSOURI

Lafayette County Health Department

Grant Number: D06RH09545

PROGRAM DIRECTOR

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TOPIC AREAS

Primary health care and social support services

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

AREAS SERVED

Lafayette County, Missouri and surrounding areas

TARGET POPULATION SERVED

The target population is medically underserved and uninsured residents of Lafayette County, MO

PROJECT SUMMARY

The goal of the Lafayette County 4 Health Project, a rural health education and outreach project, is to improve access to primary health care and social support services in the county through an integrated network of local providers. The project will incorporate community education and outreach approaches to connect vulnerable low-income populations to an integrated network of health and social services providers. In the first year, the project will use community education and health promotion activities to address disease prevention issues and mental health topics.

The project, which includes outreach to a seasonal migrant community, will strengthen and expand a referral process among local providers by developing a technology-aided information system to expedite patient scheduling, intake and follow-up. Years 2 and 3 will focus on increasing primary care, dental care and mental health care, while maintaining and expanding prevention programs focused across the age groups.

The target population is medically underserved and uninsured residents of Lafayette County, MO. There is little ethnic diversity in the population, which are 96.6% white, 2.6% African American, 1.2% Latino and .5% Asian/Pacific Islander and .9% Native American. The target population includes nearly 500 seasonal migrant workers and their families. Of the county population, 25.5% of the residents have incomes at or below 200% of the Federal Poverty Level.

In addition to poverty, barriers to accessing services include distance, transportation difficulties, lack of insurance and lack of providers. There are 19,466 uninsured individuals throughout the county (32,960

MISSOURI

Lafayette County Health Department

Grant Number: D06RH09545

total population), and the entire population is classified as underserved because of the dearth of medical providers. The physician to population ratio is 3,619:1. Lafayette County is a designated Health Professional Shortage Area.

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MISSOURI

Samaritan Hospital

Grant Number: D06RH09013

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

The Samaritan Scotland Putnam Rural Health Network (SSPRHN) consists of three county/district governmental Critical Access Hospitals.

AREAS SERVED

Clark, Knox, Linn, Macon, Mercer, Putnam, Schuyler, Shelby, Sullivan, and Scotland counties, Missouri

TARGET POPULATION SERVED

Rural, underserved, and uninsured communities with a large percentage of elderly, poor, uneducated, and a shortage of medical professionals.

PROJECT SUMMARY

The Samaritan Scotland Putnam Rural Health Network (SSPRHN) consists of three county/district governmental Critical Access Hospitals (CAHs) who came together in late 2005 to collaborate. Areas of collaborative interest included exploring models of networking, conducting a needs assessment of the institutions, and developing a strategic plan to formalize a network both in their best interest and the interest of the communities they serve. In 2006, SSPRHN was awarded a HRSA Network Development Planning grant. The goal of the SSPRHN Network Planning grant was to assist the three critical access hospitals in furthering their collaboration.

The area served by the Scotland Putnam Rural Health Network (SSPRHN) CAH members is characterized as being rural, underserved, and uninsured communities with a large percentage of elderly, poor, uneducated, and a shortage of medical professionals in ten (10) north central and northeastern Missouri counties it encompasses. In the past two years the network of three CAHs participated in a series of strategic meetings that consisted of educational, discovery, and planning activities. As a result of these activities, the original collaborating partners have successfully signed a Memorandum of Agreement, agreed to a set of bylaws, performed needs assessments of their institutions, and developed a strategic

MISSOURI

Samaritan Hospital

Grant Number: D06RH09013

plan that includes mission, vision, goals, and objectives to further their desire to become a formalized horizontal network.

An integral part of moving the SSPRHN toward becoming operational, now that it has completed the planning phase, is to secure funding to further the network development. In order to continue with the process of network development, funds will be used to complete capacity building network formalization activities, implement collaborative strategies to improve health care delivery, develop network strategies and partnerships to improve health of the communities, and develop a network sustainability strategy. Collaborative strategies will include workforce development, performance improvement, operational improvement including health information technology and community health improvement.

Transitioning the SSPRHN from the formative stage to the evolving stage will provide the vehicle whereby collaboration between CAHs will be increased. Increased collaboration will result in 1.) economic efficiencies through development of shared services; 2.) issues being addressed that threaten CAH survival and access to care in rural communities such as workforce and quality; 3.) improved CAH operational sustainability being achieved, and 4.) new partnerships and collaborations being established resulting in improved health of the community.

Ultimately the beneficiaries of SSPRHN will be the people that make up the communities served with improved access to health care, quality, and health status.

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MONTANA

Community Hospital of Anaconda

Grant Number: D06RH09014

PROGRAM DIRECTOR

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TOPIC AREAS

Ambulatory healthcare

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 178,680.00
- Year 2- 179,485.00
- Year 3- 179,581.00

PARTNERS TO THE PROJECT

The Montana Rural Healthcare Performance Improvement Network, the Diabetes Quality Care Management System (DQCMS), the Chronic Care Outreach Program in Harlowton, Montana, and a Shared Electronic Patient Registry to Assist Small Rural Practices with Quality Improvement and Continuity of Care in Anaconda

AREAS SERVED

Anaconda, Deer Lodge County, Montana Deer Lodge, Powell County, Montana Philipsburg, Granite County, Montana Circle, McCone County, Montana

PROJECT SUMMARY

The Applicant is Community Hospital of Anaconda (CHA), a participating member of the Montana Frontier Healthcare Network (MFHN).

This Rural Health Network Development (RHND) grant will allow MFHN to implement an ambulatory healthcare performance improvement network and quality improvement (QI) program using shared staffing, clinical, technology and workflow approaches.

The target population for this program includes all residents of Deer Lodge, Powell, Granite, McCone and Prairie counties, Montana. The Applicant and all facilities and providers in all five counties are eligible rural applicants. In addition, all five counties are designated as "Frontier" by the National Center for Frontier Communities.

MFHN expects that the capabilities resulting from its integration of clinical and technical approaches will allow this program to positively impact the health of our communities and the viability of our providers. Community health will be improved by better preventive care, chronic disease management and disaster preparedness. Facility and provider viability will be improved by the network's ability to help its providers to meet reporting requirements in a cost-effect way and by generating additional revenue for its

MONTANA

Community Hospital of Anaconda

Grant Number: D06RH09014

member facilities and providers. It will strengthen its provider's intellectual viability by fostering collegial discussion and reducing professional isolation.

The designs of healthcare programs that have worked in other communities across Montana have influenced this project. These include: (1) the Montana Rural Healthcare Performance Improvement Network, funded with a grant from HHS, HRSA, ORHP's RHND program; (2) the Diabetes Quality Care Management System (DQCMS) funded in part by the Montana Department of Public Health and Human Services; (3) the Chronic Care Outreach Program in Harlowton, Montana funded with a grant from HHS, HRSA, ORHP's Rural Outreach Program; and (4) A Shared Electronic Patient Registry to Assist Small Rural Practices with Quality Improvement and Continuity of Care in Anaconda, Montana funded by HHS, HRSA, ORHP's Small Healthcare Provider Quality Improvement Program.

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MONTANA

Glacier Community Health Center, Inc.

Grant Number: D06RH08999

PROGRAM DIRECTOR

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TOPIC AREAS

Health records

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

Seven independently owned and operated rural/frontier, critical-access hospitals and two community health clinics.

AREAS SERVED

Glacier, Flathead, Lake, and Lincoln County - Montana

TARGET POPULATION SERVED

Medically underserved region of Northwest Montana

PROJECT SUMMARY

The Health Information Exchange of Montana (HIEM) is a consortium of seven independently owned and operated rural/frontier, critical-access hospitals and two community health clinics located in a geographically far-flung and medically underserved region of Northwest Montana.

Spanning four counties and more than 13,000 miles, the region is home to approximately 144,000 people, accounting for a population density of 10.9 persons per mile—roughly one-eighth of the national average of 79.6. Located in the Northwestern most part of the US Rockies, rugged terrain makes travel throughout this rural/frontier land uneconomical and serves as a significant barrier to healthcare access. Multiple HPSA and MUA designations throughout the service area compound these barriers.

The primary motivation of network members in establishing HIEM is the improvement of healthcare delivery and safety via an interoperable “real time” shared electronic health record. In focusing on this objective HIEM has taken critical foundation building steps to establish a viable network in the form of a Regional Health Information Organization (RHIO). While prepared for further development, modest revenues and the lack of available funding dollar have impeded the forward progress the network.

MONTANA

Glacier Community Health Center, Inc.

Grant Number: D06RH08999

In alignment with the aim of the Rural Health Network Development Program the goals of the proposed project are:

Goal 1: Complete the formation of a self-perpetuating sustainable network

Goal 2: Implement a regional integrated electronic information exchange among network partners to improve quality patient care and expand clinical data reporting capabilities. Working toward these goals the proposed project activities focus on two distinct areas:

Planning: Recognizing that sufficient planning is critical to the success of the network on multiple levels HIEM has committed to hiring an experienced Executive Director and proven consultants to guide the board in the development and implementation of a comprehensive strategic plan, a robust evaluation plan and a comprehensive IT Implementation Plan.

Implementation: Taking a multi-tier approach to project implementation, HIEM seeks to integrate the health information systems of a three key providers, establishing a core with which to add other area providers and key stakeholders including physicians, pharmacies, home health, mental health, EMS/police/fire, schools, payers, Indian Health Services and long term care/nursing homes. A fully integrated network solution will create a continuity of care improving the service delivery of all participants.

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MONTANA

St. Lukes Community Hospital

Grant Number: D06RH07921

PROGRAM DIRECTOR

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TOPIC AREAS

Telehealth systems

PROJECT PERIOD

May 1, 2007 – April 30, 2010

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 165,900.00
- Year 2- 179,532.00
- Year 3- 179,571.00

PARTNERS TO THE PROJECT

Together with five other Western Montana CAHs, we are members of Montana Healthcare Network, a mature Network based in Missoula.

AREAS SERVED

Montana counties of Beaverhead, Granite, Lake, Mineral, Powell, and Sanders

PROJECT SUMMARY

St. Luke Hospital is a rural Critical Access Hospital located in Ronan, Montana. Together with five other Western Montana CAHs, we are members of Montana Healthcare Network, a mature Network based in Missoula. We have been collaborating through Montana since 1996, and are seeking Rural Health Network Development grant funding to assist in immediately implementing Network-level clinical training, staffing, and recruiting services and solutions.

Western Montana is among the most intensely rural regions in the continental United States, with a total population of over 62,000 spread across 6 counties. Every county has at least one HPSA designation, and four are designated MUAs. Staffing shortages are extremely costly for rural hospitals. Our 6 CAH's pay over \$1 million per year in agency fees just for clinical support and therapy staff. At the same time, Montana's extremely successful rural Outreach grant project (awarded in 2003) has established 20 different specialist clinics in 8 different communities. Specialists often desire/expect clinical support staff to have advanced training in current state-of-the-art surgical, post-surgical, diagnostic, or complex medical care.

Federal grant assistance is vital to implementing the primary goals of this project, which are I) to establish Network-level clinical competency assessment, training capabilities, and telehealth systems to improve access to quality care for rural patients and II) to develop practical, effective, shared staffing resources to support the ongoing workforce needs of Network members.

MONTANA

St. Lukes Community Hospital

Grant Number: D06RH07921

We expect to train an average of 20 clinical support personnel from each rural CAH each year. Training will include surgical, post surgical, diagnostic, and complex medical care, and will emphasize identified current, state-of-the-art clinical protocols for diagnostic indicators, initial treatment, patient management, physician support, and Performance Improvement mechanisms.

We will also develop improved rural staffing models and recruiting for hard-to-recruit positions including physical therapists, occupational therapists and OT aides, speech therapists, OR technicians, RNs, CNAs, certified registered nurse anesthetists, information systems technicians, respiratory therapists, RN diabetic educators, and pharmacists. The project will specifically develop a shared pharmacist capability.

If the Network Development project's shared staffing interventions can defray even 10% of the current identified costs to members (or \$100,000), these savings can easily and directly sustain the shared staffing service indefinitely. This project's clinical education initiative will be similarly supported after grant funding sunsets by member dues deriving from savings from the shared staffing initiative. Administrative fees for discrete services will also play a major role in sustainability.

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NEBRASKA

Blue Valley Mental Health Center, Inc.

Grant Number: D06RH08995

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TOPIC AREAS

Behavioral Health Services

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

Southeast Nebraska Behavioral Health Information Network and Blue Valley Mental Health Center

AREAS SERVED

Hancock County

TARGET POPULATION SERVED

Behavioral health treatment in southeast Nebraska.

PROJECT SUMMARY

Blue Valley Mental Health Center is a private non-profit corporation providing behavioral health services to 15 rural counties in southeast Nebraska and is a member of the Southeast Nebraska Behavioral Health Information Network. Blue Valley Mental Health Center is applying for the Rural Health Network Development Grant on behalf of the Southeast Nebraska Behavioral Health Information Network, who is a private, non-profit corporation serving as a collective effort of behavioral health care providers to develop, implement, and operate a regional health information network. When operational, the Health Information Network will connect all behavioral health providers in southeast Nebraska including primary care physicians, rural hospitals, behavioral health outpatient services, community support, and emergency behavioral health services to develop a shared database of patient information. The target population for this grant application is recipients of behavioral health treatment in southeast Nebraska. The population includes 413,557 residents with 163,266 residents in 15 rural counties. Residents living in the rural counties struggle to access behavioral health specialty services due to the centralization of specialty services in urban Lincoln, Nebraska. It is estimated that 116,000 individuals, or 28 percent of individuals residing in southeast Nebraska, have a behavioral health disorder.

Access to specialty behavioral health services in southeast Nebraska is particularly scarce. Only eight of fifteen rural counties have some form of psychiatric coverage and of those eight counties that do have psychiatric coverage, there is a two- to three- month wait for appointments or a waiting list of more than

NEBRASKA

Blue Valley Mental Health Center, Inc.

Grant Number: D06RH08995

twenty-five people. Many rural residents access their behavioral health services from their primary care physician or travel to urban Lincoln, Nebraska for specialized behavioral health treatment and emergency services. As a result, consumers of behavioral health services in the area often access more than one clinician for treatment.

Improvements in technological linkages and communication between clinicians providing treatment to shared patients will improve access to quality behavioral health care. The behavioral health providers in the area applied and received a planning grant in 2004 from the Agency for Healthcare Research and Quality Health Information Technology Planning Grant to pursue the development of improved linkages and communication through a health information technology system. The resulting study, made possible by the planning grant, indicated the need for the development of a unified network of providers to develop and implement an Electronic Health Environment. That would electronically link clinicians. Specifications were developed for a patient index, global database, and standardized referral system to provide linkages clinicians need to deliver quality behavioral health care to shared patients. The study serves as the foundation for this grant application, which is intended to: strengthen the viability of the Southeast Nebraska Behavioral Health Information Network and its members; develop a strategic plan to further the sustainability and business aspects of the Network; and develop, implement, and operate an Electronic Health Environment between behavioral health providers. Efforts will result in improved access to quality behavioral health services to persons residing in southeast Nebraska.

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NEBRASKA

Good Samaritan Hospital Foundation

Grant Number: D06RH07933

PROGRAM DIRECTOR

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2007 – April 30, 2010

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 160,786.00
- Year 2- 127,131.00
- Year 3- 135,063.00

PARTNERS TO THE PROJECT

Good Samaritan Hospital, Dundy County Hospital, Kearney County Health Services, Franklin County Memorial Hospital, Regional West Medical Center, Valley Ambulance, Box Butte General Hospital, Chadron Community Hospital, Garden County Health Services, Gordon Memorial Hospital, Kimball County Health Services, Chase County Community Hospital, Rock County Hospital, and Brown County Community Hospital

AREAS SERVED

50 counties located in Nebraska

TARGET POPULATION SERVED

Medically Underserved Populations

PROJECT SUMMARY

The overall focus of the Rural Nebraska Regional Ambulance Network is to provide better coordination of ground and air ambulance transportation to the citizens of central and western Nebraska through an integrated and collaborative network of ambulance services, hospitals, dispatch agencies and any other interested entities. The project represents a partnership of fourteen health care providers in the formative stage of network development. These organizations are the appropriate collaborators as they are the primary providers of emergency medical services within the service area for the project. The target population identified in the proposed service area for the Rural Nebraska Regional Ambulance Network includes individuals residing within Nebraska Trauma Regions 1, 3 and 4. These regions are located in central and western Nebraska. The service area is comprised of 50 of Nebraska's 93 counties, representing 54% of the State's counties and 53,051 square miles or 70% of the State's geography. According to the 2000 Census, the total population to be served is 377,350 individuals. The Rural Nebraska Regional Ambulance Network service area includes 33 MUPs and 19 HPSAs.

NEBRASKA

Good Samaritan Hospital Foundation

Grant Number: D06RH07933

Project Goals

Goal 1: The Network will develop the necessary network structure to be successful in the provision of emergency medical services in central and western Nebraska.

Goal 2: The Network will concentrate on the area of restructuring to better coordinate service provision to the target population residing in the project's service area.

Goal 3: The Rural Nebraska Regional Ambulance Network will concentrate on the area of EMS reimbursement to identify opportunities to increase revenue to support service providers.

Goal 4: The Network will concentrate on the area of recruitment and retention to identify opportunities to provide a more collaborative and regional approach.

Desired Outcomes of the Network grant:

The Rural Nebraska Regional Ambulance Network project will assist the EMS providers in the project service area by development of their plans in order to respond to all patients in a collaborative and consistent method. Additionally, because of the similarity of the plans and goals of Nebraska Trauma Regions 1, 2 and 3, the Network will be able to assist in promoting those plans and goals, resulting in the improvement of overall patient care for the citizens of rural Nebraska.

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NEW HAMPSHIRE
Northern Human Services, Inc.
Grant Number: D06RH09010

PROGRAM DIRECTOR

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TOPIC AREAS

Mental illness

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 178,693.00
- Year 2- 179,655.00
- Year 3- 179,713.00

PARTNERS TO THE PROJECT

The New Hampshire Department of Health and Human Services (DHHS) Bureau of Behavioral Health, and the Upper Connecticut Valley Hospital are the initial members of the network and additionally the DHHS Rural Health and Primary Care Sections will serve on the Emergency Telepsychiatry Network Advisory Board.

AREAS SERVED

Carroll County, Coos County and Upper Grafton County in New Hampshire

PROJECT SUMMARY

Northern Human Services will develop the Emergency Telepsychiatry Network to connect the regional critical access hospitals with Northern Human Services emergency staff via a 24/7 video-conferencing network. The purpose of the Emergency Telepsychiatry Network is to provide the highest possible quality of care to all patients regardless of their rural location. The Emergency Telepsychiatry Network will reduce the response time by Northern Human Services staff to the critical access hospital emergency rooms, will relieve the pressure on the emergency room staff, will improve the efficiency of evaluating the incoming patient, will avert unnecessary admission of patients to the state hospital, and will expedite transfer to an in-patient psychiatric facility when it is deemed necessary. The Emergency Telepsychiatry Network will also reduce costs of travel and time away from work for Northern Human Services staff, hospital staff, law enforcement and any other petitioners required to attend the Involuntary Emergency Admission hearing by conducting the hearings via video-conferencing on the Emergency Telepsychiatry Network. Without the added pressure of having to care for acute mental illness, the emergency room staff will have more time to care for those in need of trauma care, which is their primary mission. The Emergency Telepsychiatry Network will serve a geographically challenged and medically underserved area. The area served, referred to as North Country, includes Carroll, Coos and northern Grafton counties and covers 4,447 square miles. The recent closure of the in-patient psychiatric facility at Androscoggin Valley Hospital in Berlin makes it necessary for patients with acute mental illness to be sent to their local regional hospital. Unfortunately, the regional hospitals are not equipped to handle patients with acute

NEW HAMPSHIRE
Northern Human Services, Inc.
Grant Number: D06RH09010

mental illness. Currently the hospitals call Northern Human Service and the emergency staff responds by going to the hospital. Due to the vast geography, rural roads, and frequently inclement weather, this can sometimes be a lengthy and dangerous process.

Another issue arises when there are simultaneous calls by multiple hospitals. Northern Human Services has a system of back-up emergency staff but when multiple calls arise and the locations are far apart this can cause delays. The Emergency Telepsychiatry Network would enable the hospital and the Northern Human Services emergency staff to connect via video conferencing for an immediate assessment.

For 36 years, Northern Human Services has provided quality individualized community based services in the geographically isolated region of northern New Hampshire. The administrative model for the effective service delivery has been cited by the Commissioner of the New Hampshire Department of Health and Human Services as a model for the delivery of social services in New Hampshire. Throughout its history, Northern Human Services mission has been to assist people affected by mental illness, developmental disabilities and related disorders to live meaningful lives in their communities.

The Emergency Telepsychiatry Network will be lead by the applicant, Northern Human Services. The New Hampshire Department of Health and Human Services (DHHS) Bureau of Behavioral Health, and the Upper Connecticut Valley Hospital are the initial members of the network and additionally the DHHS Rural Health and Primary Care Sections will serve on the Emergency Telepsychiatry Network Advisory Board. The network will be expanded over the period of the project to include all seven critical access hospitals.

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NEW MEXICO
Community Wellness Center
Grant Number: D06RH08998

PROGRAM DIRECTOR

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TOPIC AREAS

Access to care

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 177,628.00
- Year 2- 178,636.00
- Year 3- 177,847.00

PARTNERS TO THE PROJECT

Community Wellness Center, the fiscal agent and funding applicant for this grant, is also a member of the Taos CARES network.

AREAS SERVED

Taos County, western Colfax County, Town of Taos, Penasco, Questa, Red River, Arroyo Hondo, Arroyo Seco, Taos Pueblo, Picuris Pueblo, New Mexico

TARGET POPULATION SERVED

Young children age birth to three and their families, as well as pregnant women.

PROJECT SUMMARY

- a. **Applicant.** Community Wellness Center, the fiscal agent and funding applicant for this grant, is also a member of the Taos CARES network. Activities in this grant address the community's **access to care** priority, implemented by the Clinic Without Walls, an action team of Taos CARES. Clinic Without Walls provides relationship-based connectivity between provider organizations and with families to ensure that children have the preventive care they need in order to reach their physical, cognitive and social-emotional developmental milestones.
- b. **The primary opportunity to be addressed.** Community members in our rural multicultural northern New Mexico region face challenges accessing care because of rural isolation, lack of trust in systems, system fragmentation, language barriers and financial difficulties. These challenges have led to a low rate of prenatal care, low preventive care services utilization and lack of community engagement to support new families. The Clinic Without Walls serves pregnant women and young children by building a relationship-based system where organizations work collectively to increase services and service coordination to meet new families' needs. It also results in organizational and community financial and social returns. To this end, we will implement the following objectives:

NEW MEXICO
Community Wellness Center
Grant Number: D06RH08998

1. *Strengthen leadership:* Clinic Without Walls will strengthen multi-disciplinary leadership to foster sustained community engagement, inter-organizational partnerships and promote culturally competent service delivery.
 2. *Increase access through coordination:* Clinic Without Walls will link provider organizations and clients through a relationship-based model.
 3. *Leverage resources.* Clinic Without Walls will leverage additional resources to financially strengthen the individual organizations and the independent healthcare system overall
- c. **Population to be served.** The entire CARES network serves the 40,000 residents of Taos and western Colfax Counties. Clinic Without Walls builds the capacity of at least 30 organizations who serve our target population of 12,250 people, including young children age birth to three and their families, as well as pregnant women. We serve all new families, with a special focus on two criteria of our target population: Underinsured and uninsured pregnant women and children; and, children at risk of developing special healthcare needs, as defined by the Maternal Children Health. Our community of three distinct cultures is dominated by severe poverty and its associated risk factors. American Indian, Hispano, and Anglo cultures, with diverse senses of family, time, work and environment co-exist. There are two American Indian Pueblos in the service area—Taos and Picuris. Thirty-one percent of children live in poverty (compared to 26% in NM and 18% nationally).
- d. **Benefit.** Our long-term outcomes are that: Mothers have adequate prenatal care; Children have access to preventive health care; Healthy parent involvement with children; Positive home and learning environments for children; and Community policies support young families.

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NEW YORK

Finger Lakes Migrant Health Care Project, Inc.

Grant Number: D06RH09021

PROGRAM DIRECTOR

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TOPIC AREAS

Comprehensive Primary Care Services

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

Oswego County Opportunities-Fulton Health Center, Cayuga County Public Health, Oswego Migrant Education, Carthage Area Hospital – Adams Community Health, Port Byron Health and Medical Center, Niagara Falls Memorial Medical Center, The Resource Center, ViaHealth of Rochester, Western New York Rural Area Health Education Center (WNY RAHEC), and Mohawk Regional Migrant Education.

AREAS SERVED

Wayne Ontario Yates Cayuga Oswego The following counties: Wayne, Ontario, Yates, Cayuga, Oswego, Jefferson, Lewis, Steuben, Niagara and Chautauqua.

TARGET POPULATION SERVED

Isolated pockets of migrants spread out in New York State's rural communities.

PROJECT SUMMARY

The Finger Lakes Migrant Health Care Project, Inc. (FLMHCP) is a 501c(3), Article 28 community-based organization and a federally-qualified 330(g) Migrant Health Center providing comprehensive primary care services to roughly 6,200 migrant and seasonal farm workers and their families New York state each year.

The mission of FLMHCP is to assure accessible and affordable health care and related support services to migrants and seasonal farm workers. The role FLMHCP has played for some time across a large portion of New York State has been to identify the gaps in services, coordinate any existing health care providers in an attempt to eliminate the gap, and when necessary, identify resources to implement a new program when there are few, if any, other options for the care of migrant and seasonal farm workers and their families.

NEW YORK

Finger Lakes Migrant Health Care Project, Inc.

Grant Number: D06RH09021

FLMHCP is responsible for:

- 1) the implementation of new health and dental clinics,
- 2) increasing provider participation across New York State,
- 3) implementing DV, Mental Health and Substance Abuse programs, where there were none, and
- 4) inspiring four county-wide round-table coalition groups, among numerous other health-related initiatives.

The structure of FLMHCP permits providing primary care services directly in those areas where there are greater, and more concentrated, numbers of migrants, such as in Wayne County (which has the highest concentration of migrant and seasonal farmworkers in New York State) and the Finger Lakes region. FLMHCP also provides health care services to isolated pockets of migrants spread out in New York State's rural communities by utilizing the voucher mechanism with a large network of Voucher Sites in 10 additional rural counties (Cayuga Niagara, Chautauqua, Ontario, Herkimer Oswego, Jefferson Steuben, Lewis Wayne, and Yates).

These rural communities of upstate New York are an important agricultural sector that lies in the west-central section of the state. Major crops include apples, barley, cabbage, corn, hay, potatoes, soybeans, sweet corn and wheat, among others. Wayne County, located on the southern shore of Lake Ontario is the second largest apple producing county in the nation, producing approximately 32% (370 million bushels) of the state's apple crop. As a result the region has a large population of migrant and seasonal farm workers that peaks during the harvest months of September and October.

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NEW YORK

Hudson Headwaters Health Network, Inc.

Grant Number: D06RH09009

PROGRAM DIRECTOR

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TOPIC AREAS

Primary care

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

CVPH Medical Center, Elizabethtown Community Hospital, Adirondack Medical Center, and Smith House Family Health Care Center and Inter-Lakes Health

AREAS SERVED

Clinton, Essex, Franklin, Hamilton and Warren Counties.

TARGET POPULATION SERVED

Targeting the rural poor and elderly of the service area and is home to a high percentage of population over the age of 65.

PROJECT SUMMARY

The applicant, Hudson Headwaters Health Network, and its partners, CVPH Medical Center, Elizabethtown Community Hospital, Adirondack Medical Center, Smith House Family Health Care Center and Inter-Lakes Health, have proposed the establishment of the Adirondack Primary Care Network (APCN) to stabilize, grow and sustain primary care services in the five county Adirondack region of Clinton, Essex, Franklin, Hamilton and Warren Counties.

The Adirondack Primary Care Network proposes the creation of a new organizational model to address the growing primary care crisis in the Adirondack Park region. Government and private assessments of the service area indicate a growing shortage of primary care providers, increasing demand in salary costs for primary care providers and a lack of sustainable revenue to support primary care services in this region.

The proposed Adirondack Primary Care Network will bring together the creative talents of the individual Network members in support of primary care services in this five county region that is home to 239,650 people over 7,057 square miles. The target population includes the rural poor as evidenced by a high percentage of the population below the federal 200% poverty levels, median household income levels

NEW YORK

Hudson Headwaters Health Network, Inc.

Grant Number: D06RH09009

below the state average and by the high percentage of students who are provided free or reduced lunch programs. Additionally, the proposal will target the elderly of the service area and is home to a high percentage of population over the age of 65 as compared to New York State as a whole.

The Adirondack Primary Care Network will assess the viability of critical rural health designations to the area including Medically Underserved Area of Medically Underserved Population and Health Professional Shortage Area. The Network will deliver provider education and assess the feasibility of regional organizational models including the Federal 330 Program.

The Network will develop a Business Plan to provide shared, cost-effective services among the Network's primary care providers including practice management, recruiting, health information technology and grants management.

The Network will assess the feasibility of recruiting additional members including the area county public health agencies as well as other acute and primary care providers in the five county region. The long term goals of the Network are to stabilize, grow and sustain primary care services so that they are accessible in this rural five county area and so that the population will be served through a medical home and coordinated services across the continuum of care supported by a vibrant provider community that has the ability to recruit and retain primary care providers and support staff.

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NEW YORK

Mary Imogene Bassett Hospital

Grant Number: D06RH10758

PROGRAM DIRECTOR

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TOPIC AREAS

Chronic disease management and wellness/health promotion

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 179,894.00
- Year 2- 179,819.00
- Year 3- 179,826.00

PARTNERS TO THE PROJECT

Bassett Healthcare, in partnership with Tri-Town Regional Healthcare (TRH), At-Home Care, Inc., (AHC) a home health agency currently serving Delaware and Otsego Counties, and the local Amphenol Corporation manufacturing plant, has formed the Susquehanna River Valley Rural Health Network (SRVRHN).

AREAS SERVED

Chenango, Delaware, and Otsego Counties in New York State

TARGET POPULATION SERVED

The SRV service area has lower median household income (MHI), lower per capita income (PCI), and slightly lower unemployment and poverty levels than New York State and the nation.

PROJECT SUMMARY

Bassett Healthcare is a rural academic medical center committed to providing excellence in health care services, educating physicians and other health care professionals and pursuing health research. Responding to the needs of the many communities it serves, in the past two decades Bassett Healthcare has created a system of 25 community health centers and four hospitals within an eight county service region. These health centers provide primary and specialty care services to rural communities in Chenango, Delaware, Fulton, Herkimer, Madison, Montgomery, Otsego, and Schoharie Counties. As a result, patients are provided convenient and top-quality local health care services, with immediate and ready access to the resources (e.g. specialty and hospital care) of Bassett Healthcare in Cooperstown. Dedicated physicians, nurse practitioners, physician assistants, nurses, technicians, and support personnel staff Bassett's regional health care system. Bassett Cooperstown-based specialists make regular visits to several of the health center sites in order to improve access and complement the extensive services provided at the health centers.

NEW YORK

Mary Imogene Bassett Hospital

Grant Number: D06RH10758

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NORTH CAROLINA
Albermarle Hospital Foundation, Inc.

Grant Number: D06RH09008

PROGRAM DIRECTOR

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

Albermarle Hospital and Albermarle Regional Health Services

AREAS SERVED

Northeastern North Carolina: Camden, Chowan, Currituck, Gates, Pasquotank and Perquimans

TARGET POPULATION SERVED

26,000 medically indigent, uninsured and underserved adults

PROJECT SUMMARY

The applicant, Albermarle Hospital Foundation (AHF), organized by Albermarle Hospital as a 501 (c)(3) in 2003, is unique in the hospital industry because it addresses the region's most pressing health care needs for more than 26,000 medically indigent, uninsured and underserved adults. Two community care clinics (CCCs) – Elizabeth City and Tyner – serve a rural six county catchment area in northeastern North Carolina: Camden, Chowan, Currituck, Gates, Pasquotank and Perquimans.

Through this grant effort, the AHF is formalizing a Network Member's Agreement with Albermarle Hospital and Albermarle Regional Health Services to become viable, proactive agents within the shared catchment area to improve access and quality of care with new capital and new technologies. Why these three entities? A majority of medically indigent, uninsured and underserved adults use these three entities as their primary care gate-keeper.

The new capital will expand new technologies across the network by providing:

- Efficiencies gained from shared expertise of contracted IT staff; and
- Enhancing the continuum of care through new technologies.

As an evolving network, the members have developed shared services, joint community-based initiatives, and more importantly this proposal to share new technologies. At the conclusion of this RHND grant

NORTH CAROLINA

Albermarle Hospital Foundation, Inc.

Grant Number: D06RH09008

funding, the Members will be a highly functioning Network Board, offering fully integrated healthcare services that better support the target populations.

Until now, all new technology activities have been a collaborative effort of in-kind support between Network Members and their technology solutions partners SabiaMed, SabiaNet and SciHealth and the 2007 NC Rural Health and Community Care Grant. Progress at a more rapid pace is needed so the Network Members can realize the benefits of a system that improve care for medically indigent and uninsured chronic disease patients, ranging from automated disease registries that combine encounter, lab, and pharmacy data to more functional electronic medical records.

Completing the new technology will provide:

- Final interface activities between the Emergency Department and Pharmacy of Albemarle Hospital, Albemarle Hospital Foundation and Albemarle Regional Health Services;
- Complete the establishment of the EHR and make them accessible and interoperable between Network Members; and
- Install the capabilities for regional surveillance and tools for prevention education.

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NORTH CAROLINA

Transylvania Community Hospital, Inc.

Grant Number: D06RH09053

PROGRAM DIRECTOR

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TOPIC AREAS

Disease Prevention

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

Transylvania Community Hospital and its two wholly-owned clinics, along with Brevard Family Practice, Medical Associates of Transylvania, Sylvan Valley OB/GYN, the Transylvania County Department of Health and Land of Waterfalls Partnership for Health, Inc.

AREAS SERVED

All of Transylvania County, North Carolina, part of Henderson County, North Carolina, a small part of Jackson County, North Carolina, a small part of Pickens County, South Carolina, and a small part of Greenville County, South Carolina.

TARGET POPULATION SERVED

Diabetic patients and those populations with cardiovascular and addictive diseases.

PROJECT SUMMARY

The 7 Network Members: Transylvania Community Hospital and its two wholly-owned clinics, along with Brevard Family Practice, Medical Associates of Transylvania, Sylvan Valley OB/GYN, the Transylvania County Department of Health and Land of Waterfalls Partnership for Health, Inc., a non-profit 501c (3), local health advocacy and research group; all in Brevard, NC and WNC Health Network, Inc., a non-profit, 501c (3), Asheville, NC-based RHIE collaborative.

Overall Network & Project Goal: Facilitate the exchange of health information by implementing an interoperable North Carolina Regional Health Information Technology (NCRHIT) Network along the continuum of care, which is patient-centered, facilitating patient safety, disease prevention, wellness and public health, as well as the efficiency and effectiveness of health care services.

- a. The applicant is a participating member of the Network entity.

NORTH CAROLINA

Transylvania Community Hospital, Inc.

Grant Number: D06RH09053

b. The primary problem(s), circumstance(s), and/or opportunity to be addressed by the network through the grant:

Transylvania Community Hospital (TCH) and its partners are creating a North Carolina Rural Health Information Technology (NCRHIT) Network, to integrate the existing legacy Health Information Technology (HIT) systems the members are using now. This will implement the most advanced technology available so that patient information and public health data can be shared securely, in real time, among Network providers.

c. Population groups to be served; target population size and characteristics:

The NCRHIE will serve the populations of Transylvania County, the western part of Henderson County and a small part of Jackson County, North Carolina, along with small parts of Pickens and Greenville counties in South Carolina. The U.S. Census Bureau identifies approximately 35,000 people in this area, with an estimated 12.6% below the poverty level. Particular emphasis is being placed on the care of diabetic patients and those populations with cardiovascular and addictive diseases.

d. How the local community to be served will benefit from and be involved in the activities carried out by the network:

The real-time, secure exchange of patient information and health statistics will lead to better treatment outcomes, increased efficiency, fewer errors, lower costs for patients, healthcare providers and third-party payers and most importantly, a healthier population in the Network coverage area.

Models That Work & Best Practices: Network partners identified and incorporated parts of two (2) HIT models that are using proven, mature systems designed for Critical Access Hospitals (CAH), including a 2007-2009 HRSA-supported project at the Univ. of North Dakota (Ref: HRSA FLEX CAH HIT Implementation Grant No. H54RH08680 (PI Miller) and a 2005-2008 AHRQ-supported project based at a CAH in Vermont. (Ref: AHRQ Grant No. 1 UC1 HS016142-01, *Improving Rural Healthcare: Implementing Innovative Integration Solutions* (PI: Sims)).

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NORTH DAKOTA
Minot State University
Grant Number: D06RH09005

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 179,997.00
- Year 2- 179,997.00
- Year 3- 179,996.00

PARTNERS TO THE PROJECT

The North Dakota Center for Persons with Disabilities (NDCPD), Family Voices of ND (FVND), and the University of North Dakota Center for Rural Health (UNDCRH).

AREAS SERVED

North Dakota

TARGET POPULATION SERVED

Families are all living in rural counties with Medically Underserved Populations.

PROJECT SUMMARY

Children with special health care needs and their families have a right to access and receive the necessary specialized supports and care to achieve successful health outcomes in their communities. Families raising children with special health care needs experience additional stress that can impact their ability to cope with unique parenting and care challenges, solve health-related problems, access specialized services and maintain a stable family life. The Rural Health Network for Family Support (RHN-FS) will enhance health outcomes (i.e. access to new/expanded services, number of people trained throughout the project) and strengthen collaboration (i.e. number of members; and annual network revenue) by developing a rural health network comprised of several public and private non-profit family support agencies.

The RHN-FS network will be led by three key partners: **the North Dakota Center for Persons with Disabilities (NDCPD) – the applicant**; Family Voices of ND (FVND), and the University of North Dakota Center for Rural Health (UNDCRH) – Family to Family Network.

The RHN-FS will include: PATH Inc. the Federation of Families for Children’s Mental Health, the ND Department of Health – Children’s Special Health Services, and Pathfinders Inc, the state Parent Training Center.

NORTH DAKOTA
Minot State University
Grant Number: D06RH09005

The goals of the NDRHN-FSP will be to: 1) Operate a rural health network, 2) Increase collaboration to enhance family support, and 3) Secure the sustainability of the network.

Objectives for network implementation guide development of the board structure, implementation of strategic and business plans, new member recruitment and evaluation. The objectives for collaboration target development of joint training programs, planning for creation of a universal application, implementation of rural leadership development models, and creation of an educational policy platform for system change. The objectives for sustainability address implementation of a sustainability plan for the network and identifying collaborative services that support efficiencies in health service delivery.

The RHN-FS will serve rural ND families in 50 counties whose children “have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally” (Maternal Child Health Bureau, 1998). The estimated size of the target population is about 12.4% of the target counties’ population (Maternal and Child Health Bureau/SLAITS data) or an estimated 13,327 ND children that have SHCN. These families are all living in rural counties with Medically Underserved Populations as defined by HSRA.

The RHN-FS will provide families and providers with a comprehensive set of information on family support that can be accessed through a single source. Additional benefits will include access to proposed network resource maps, planning for joint trainings and educational platforms as well as information on rural models to enhance family support in rural communities. Access to information at this level will help physicians to expand the level of services they can offer families and thus advance the status of ND’s medical home and achievement of the 5 year plan for health coordination.

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NORTH DAKOTA
Presentation Medical Center

Grant Number: D06RH09017

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TOPIC AREAS

Health records

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

Presentation Medical Center, St. Andrew's Health Center, Towner County Medical Center, St. Luke's Hospital, St. Aloisius Medical Center, Kenmare Community Hospital, Trinity Medical Center, Heart of America Medical Center, Mountrail County Medical Center, Tioga Medical Center, and McKenzie County Healthcare Systems Hospital.

AREAS SERVED

Northwestern North Dakota, including the following Counties: Benson, Bottineau, Burke, Cavalier, Divide, McHenry, McKenzie, Mountrail, Pierce, Renville, Rolette, Sheridan, Towner, Ward, Wells and Williams

TARGET POPULATION SERVED

Poverty

PROJECT SUMMARY

Presentation Medical Center (PMC) in Rolla, ND; St. Andrew's Health Center in Bottineau, ND; Towner County Medical Center in Cando, ND; St. Luke's Hospital in Crosby, ND; St. Aloisius Medical Center in Harvey, ND; Kenmare Community Hospital in Kenmare, ND; Trinity Medical Center in Minot, ND; Heart of America Medical Center in Rugby, ND; Mountrail County Medical Center in Stanley, ND; Tioga Medical Center in Tioga, ND; and McKenzie County Healthcare Systems Hospital in Watford City, ND have joined together to develop the Northwest Alliance for Information Technology: A Multi-Hospital Health Information Technology Network Serving Rural Northwestern North Dakota.

PMC is a participant in the Northwest Alliance for Information Technology and serves as the grant applicant. The development of the Northwest Alliance for Information Technology represents the development of an actual network – both in theory and physically. By joining together to build an electronic network, it is our belief that the development of an electronic health record and the software

NORTH DAKOTA
Presentation Medical Center

Grant Number: D06RH09017

components will become accessible within three to five years. If attempted independently, access to an electronic health record is only a future dream for many of our facilities.

The service area of the Northwest Alliance for Information Technology includes the northwestern quarter of North Dakota. The counties in the service area include the following: Benson, Bottineau, Burke, Divide, McHenry, McKenzie, Mountrail, Renville, Rolette, Sheridan, Towner, Ward, Wells and Williams. The population of the service area is 141,521 individuals and comprises 21,998.42 square miles. The percent of the population in service area whose poverty status has been determined to be below the poverty level is 14.56%. With the exception of one, the per capita income for every county is less than North Dakota's per capita income of \$17,769. The per capita income of the Wells County, at \$17,932, is only slightly higher than the state average. Four counties, Benson; McKenzie; Mountrail and Rolette have a greater than 20% population of Native Americans. The percentage of individuals over the age of 65 in the service area is 16.19% compared with the State of North Dakota of 14.7%.

The Institute of Medicine document *Quality Through Collaboration: The Future of Rural Health*, recommends that rural health clinics and critical access hospitals convert to an electronic health record over the next five years. The electronic health record is the primary component of clinical software. The electronic health record will contain current and historical patient information that includes the following: physician orders, medication history, laboratory results, clinical documentation, diagnostic imaging documents, and transcribed documents. By joining together to build this network, an electronic health record and the associated software components will be accessible to the members of the Northwest Alliance for Information Technology. Most importantly, the expansion and utilization of clinical software will enhance the safety and provision of care provided to the citizens of our communities in Northwestern North Dakota.

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NORTH DAKOTA
Southwest Healthcare Services

Grant Number: D06RH09026

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1 - 175,759.00
- Year 2 - 174,323.00
- Year 3 - 166,522.69

PARTNERS TO THE PROJECT

Southwest Healthcare Services and ten (10) other members of the Northland Healthcare Alliance (Network).

AREAS SERVED

Bottineau, Bowman, Burleigh, Emmons, McIntosh, McLean, Rolette, Stark, Williams Counties in ND and Walworth County in SD

TARGET POPULATION SERVED

Poverty; Approximately one fifth of North Dakota, 12,440 square miles, eight (8) counties in North Dakota and one (1) county in South Dakota with a total population of 89,468. The Tertiary care participant's population and square miles were not included in the above statistics, as their county is not designated rural. Seven of the counties involved in the project have a poverty level higher than their state averages of 11.9% (ND) and 12.9% (SD). The Poverty Level ranges from 8.2% (Bowman, ND) to 31% (Rolette County, ND.) Rolette County's population is 73% Native American. The Percentage of over 65 Population in 9/10 participating counties is greater than the states' and US averages. In the RIDS Project counties, persons per square mile ranges from 2.8 in Bowman, ND to 16.9 in Stark County. The ND average is 9.3 and the US is 79.6.

PROJECT SUMMARY

Critical to the safety and efficient delivery of care to patients in this region is the need to insure that information is available to providers at the point of care delivery. Southwest Healthcare Services and other members of the Northland Healthcare Alliance (NHA), a rural healthcare facility Network lack the ability to exchange healthcare information electronically with referring providers, transferring critical access and acute care facilities and nursing homes. In surveying Network members regarding their use of information technology (IT) applications and comparing it the national survey results of the "The Current Status of Health Information Technology Use in Critical Access Hospitals, Northland Healthcare Alliance found their region in North Dakota was seriously behind the rest of the nation's rural facilities. The results

NORTH DAKOTA
Southwest Healthcare Services

Grant Number: D06RH09026

were alarmingly low compared to the national results. Patients in this region travel from 75 to 200 miles when referred for additional care. Having access to a patient's clinical, demographic and financial data electronically improves the quality, safety and timeliness of the care provided and decreases the expense of duplicate testing when results are not readily available.

Solution: The Rural Information and Data Sharing (RIDS) project is a network based pilot program to develop a cafeteria of IT services that can provide affordable solutions to rural healthcare entities and a vehicle to integrate all of these capabilities and efforts into a centralized health data and clinical transaction system. Included in the RIDS project will be the development of a common patient registry system, the creation of a clinical data exchanges service and the development of standardized claim forms and data sets. Southwest Healthcare Services and ten (10) other members of the Northland Healthcare Alliance (Network) will participate in the pilot program.

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OHIO

Ohio University

Grant Number: D06RH07920

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2007 – April 30, 2010

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

Our efforts are supported by both the Ohio Department of Health's State Office of Rural Health, who have agreed to serve on IPAC's Board of Directors and the Ohio Department of Mental Health, which provides funding for our region's early childhood mental health consultant. Our University partners from three colleges (Arts and Sciences, Health and Human Services and College of Osteopathic Medicine) join an additional 6 separately-owned agencies and consumers to complete the network.

AREAS SERVED

Athens, Meigs, Hocking and Vinton Counties

TARGET POPULATION SERVED

7,000 children between 0 and 6 years of age live who are in Low Income HPSA and Medically Underserved Areas.

PROJECT SUMMARY

Interpersonal Partners for Appalachian Children (IPAC) will use the RHND grant to improve access and quality of health and mental health services. Across the next three years, IPAC will (1) implement our strategic plan for improving our capacity to improve our ability to identify, to refer and to provide coordinated care, and comprehensive care for young children in our community with special needs through clinical and functional integration across partners, and (2) IPAC will strengthen infrastructure of its network and develop its capacity to become a self-sustaining network capable of developing innovative sustainable solutions to the challenges facing our community. Two SAMSHA model programs, Circles of Care and Starting Early Starting Smart, have guided our proposal for transforming the delivery of services to children between 0 – 6 years of age.

To accomplish the first goal, IPAC will (a) improve early identification by training frontline providers in 11 early childcare programs and 4 primary care practices to routinely screen young children for developmental and socio-emotional risk; (b) establish a Family Care Navigator program to improve care

OHIO

Ohio University

Grant Number: D06RH07920

coordination and empower families; (c) develop the infrastructure to co-locate service providers creating a sustainable interprofessional behavior and development assessment clinic, and (d) develop the infrastructure to support co-locating mental health providers in four primary care settings (Both c and d improve coordination and comprehensiveness of services).

IPAC is a newly incorporated entity, with an independent Board of Directors. To strengthen its capacity to function effectively as a rural health network, IPAC will (a) operate within the adopted governance structure, create functional committees to achieve our goals, strengthen community participation, file for 501c3 status, write policies, evaluate the network and write a comprehensive sustainability plan; (b) pursue staff development to support integration efforts, interprofessional teams, and clinical expertise; and (c) develop a communication strategy for internal and external stakeholders including a web site and a narrative awareness campaign.

The service area for this project includes four Appalachian counties: Athens, Meigs, Hocking and Vinton Counties, where over 7,000 children between 0 and 6 years of age live. All are single county MHPSA; Vinton is whole county HPSA, Meigs and Hocking are Low Income HPSA. Vinton and Meigs County are whole county Medically Underserved Areas (MUA); Athens and Hocking are Partial County MUAs.

Additionally, Athens, Vinton and Meigs Counties are designated distressed by the Appalachian Regional Commission.

IPAC is a community-consumer-university partnership. Our membership includes 11 community service partners, including consumers, and five University-affiliated service partners. Community partners comprise nearly 70% of our membership. IPAC is a mix of “doers” and “directors,” informed by “consumers,” transforming the way our community delivers health and mental health services through network integration.

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OKLAHOMA

Little Dixie Community Action Agency, Inc.

Grant Number: D06RH09057

PROGRAM DIRECTOR

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1 - 180,000.00
- Year 2 - 180,000.00
- Year 3 - 180,000.00

PARTNERS TO THE PROJECT

The Southeast Oklahoma Rural Health Network (SORHN) would be classified as vertical, in that it is composed of different types of entities - two Community Health Centers and a community-based social service organization.

AREAS SERVED

The areas affected by this project include Census tracts 9976 and 9978 in Pushmataha County, and Census tracts 9982, 9983, and 9988 in McCurtain County, which are located in the State of Oklahoma.

TARGET POPULATION SERVED

Medically Underserved Areas, as well as a primary care Health Professional Shortage Area

PROJECT SUMMARY

Little Dixie Community Action Agency, Inc., a private, nonprofit 501(c)3 organization, is a participating member of the Southeast Oklahoma Rural Health Network. On behalf of this network, Little Dixie Community Action Agency is requesting \$180,000 for each of three years from the United States Department of Health and Human Services, Health Resources and Services Administration: Federal Office of Rural Health Policy for a Rural Health Network Development Grant.

The Southeast Oklahoma Rural Health Network (SORHN) would be classified as vertical, in that it is composed of different types of entities - two Community Health Centers and a community-based social service organization. Although some of the activities of this grant project will be similar to that of an evolving network, in that staff and services will be shared, the developmental stage of the SORHN is best classified as formative. The SORHN has been in operation for less than two years, and still is in the start-up phase of becoming organized. The motivation behind forming this network was to be able to develop ways in which to solve the problem of limited access to health care in our rural area. Through this grant project, the SORHN will become a formal, integrated rural health network, as a result of needs and systems analysis, incorporation of functions, program and strategic planning.

OKLAHOMA

Little Dixie Community Action Agency, Inc.

Grant Number: D06RH09057

The target population for this proposed grant project is the residents living within Census tracts 9982, 9983, and 9988 in McCurtain County, Oklahoma, and Census tracts 9976 and 9978 in Pushmataha County, Oklahoma. The Office Rural Health Policy has designated these two counties as eligible rural counties. Based on U.S. Census Bureau data, the approximate size of this combined population is 11,759. McCurtain and Pushmataha Counties are both designated as Medically Underserved Areas, as well as a primary care Health Professional Shortage Area (HPSA), a dental HPSA, and a mental health HSPA. This region is also very sparsely populated, with an average 4.45 persons per square mile. Many low-income and older residents of southeast Oklahoma do not have adequate transportation to access needed health care services. Given the rural frontier status of the area, high rates of poverty, and the larger than average geriatric population, transportation is a major barrier to access of quality health care. Therefore, the ultimate goal of this proposed grant project is to improve the health of rural Oklahomans living in McCurtain and Pushmataha Counties through the development of the Southeast Oklahoma Rural Health Network. This will be accomplished by building a sustainable network of integrated and refined services offered by network members in order to increase the access to and quality of rural health care provided.

The local community and area served will greatly benefit from an increase in access to quality health care services. We expect to see an improvement of health outcomes and disparities as a result of network activities. In addition, community members will be invited to participate in annual needs assessments in order to determine whether the network is improving health care access and the quality of health care for our rural residents.

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OREGON

Center for Human Development, Inc.

Grant Number: D06RH09011

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TOPIC AREAS

Public health, behavioral health, human services, primary care and acute care

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

AREAS SERVED

Union, Wallowa and Baker counties

PROJECT SUMMARY

The Northeast Oregon Network (NEON) is a group of health providers and agencies from Union, Baker and Wallowa Counties in the areas public health, behavioral health, human services, primary care and acute care who are seeking to form a formal health care network. The mission statement of the NEON is to create a network focused on meeting the diverse health needs of rural communities. The purpose of the network is to strengthen the rural healthcare system in Union, Wallowa and Baker counties by integrating expertise and effort, expanding resources, joint grant writing, regional advocacy, joint planning and community education. Because the population of the network area is notably poorer than the state average on most health status indicators, the focus of the network projects will be increasing access to health care, preventive care, and health promotion services, and creating a unified voice to achieve critical mass and strength to influence policy formation and increase resources. The network themes are creating unified VOICE and developing a SYNERGY of efforts in order to increase ACCESS and ALLIANCES.

The applicant entity, CHD, is a participating member of NEON. The network is not legally incorporated at this point, but has been in existence for three years. The network sees the lack of access to care in all areas, including preventive health care and health promotion, resulting in a poor population health status, and the lack of a cohesive and powerful rural regional voice in state public health policy formation as the most compelling needs facing the region at this time.

The population of the combined tri-county network area is 47,841. Two counties are designated frontier counties and the third is designated rural, with 5.7 persons per square mile. The combined uninsurance rates of 24.6% are indicative of the access to care issues. The poverty rate is significantly higher and the median income is significantly lower than both state and national averages. Eighty percent of the workforce has less than a bachelors degree, with most of the work force employed by either government, or in natural resource based industries.

OREGON

Center for Human Development, Inc.

Grant Number: D06RH09011

The network's primary goals are as follows:

- Creating long term organizational stability and continuity by formal incorporation with independent staffing;
- Creating and implementing long term financial sustainability;
- Increasing access to health promotion, primary care services and medical home in the network area by establishing an outreach and enrollment program based upon the national model of Covering Kids and Families;
- Influence local, state and national rural health policy development.

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TENNESSEE

Hickman Community Health Care Services, Inc.

Grant Number: D06RH09544

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TOPIC AREAS

Health Disparity

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

Hickman Community Hospital (Hickman County) serves as the applicant organization and is considered one of the network's 12 partnering members. The other members include hospitals and medical centers from the remaining eleven counties. Saint Thomas Health Services is considered a network resource.

AREAS SERVED

Tennessee's Cumberland, Franklin, Logan, and Monroe counties. Hardin, Henry, Hickman, Lawrence, Lincoln, Overton, and White counties and Kentucky's Christian.

TARGET POPULATION SERVED

The target population is all residents of Tennessee's Cumberland, Franklin, Hardin, Henry, Hickman, Lawrence, Lincoln, Overton, and White counties and Kentucky's Christian, Logan, and Monroe counties. The population size of all 12 counties combined is approximately 400,408. Eleven of the 12 counties are considered Medically Underserved Areas.

PROJECT SUMMARY

It is well documented in health disparity research that despite medical advancements, certain populations are more vulnerable to coronary heart disease and stroke than others. Among the more vulnerable groups, according to Rural Healthy People 2010, are "rural populations, particularly those in the South and Appalachian region." Risk factors that contribute to increased rates of heart disease and stroke deaths among these groups include social and behavioral factors, preventative care service gaps and insufficient availability of health care personnel, training and equipment. Due to a lack of resources, many rural health care providers, including first responders and emergency departments, do not have a consistent and effective approach by which they partner in care to respond to cardiac and stroke emergencies – often resulting in treatment delays and poor patient outcomes.

TENNESSEE

Hickman Community Health Care Services, Inc.

Grant Number: D06RH09544

The goal of this project is to implement a standardized approach, consistent with evidence-based protocols, among partnering network sites for responding to cardiac and stroke emergencies in the Middle Tennessee/Southern Kentucky region. This will be accomplished through education and protocol implementation at each rural facility identified in the proposed network and will involve 9-1-1 dispatch, first responders, emergency departments and tertiary referral centers. The end result will be improved education, diagnosis, treatment and intervention related to chest pain and stroke, ultimately reducing regional heart disease and stroke deaths. Importantly, through this process, partnering rural facilities will be strengthened through their affiliation with a formalized network of like providers. A number of key elements form the network's strategy for accomplishing its goals, including:

- Establishment of a multi-disciplinary governing board.
- Engaging an experienced rural health administrator to serve as project leader.
- Leveraging clinical resources and in-kind support available regionally through Saint Thomas Health Services (STHS). *The proposed network is an expansion of the chest pain network already established by STHS.*
- Hiring a Registered Nurse Quality Improvement Specialist/Clinical Educator (proposed grant-funded position) to coordinate and implement proposed activities.
- Monthly chart reviews, audits and annual mock drills to assess progress.
- The target population is all residents of Tennessee's Cumberland, Franklin, Hardin, Henry, Hickman, Lawrence, Lincoln, Overton, and White counties and Kentucky's Christian, Logan, and Monroe counties. The population size of all 12 counties combined is approximately 400,408. Eleven of the 12 counties are considered Medically Underserved Areas.

Hickman Community Hospital (Hickman County) serves as the applicant organization and is considered one of the network's 12 partnering members. The other members include hospitals and medical centers from the remaining eleven counties. Saint Thomas Health Services is considered a network resource.

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TEXAS

Burke Center

Grant Number: D06RH09022

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TOPIC AREAS

Health Screening and Treatment

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 179,397.00
- Year 2- 179,842.00
- Year 3- 179,877.00

PARTNERS TO THE PROJECT

The Burke Center (Regional Community Mental Health Center), Memorial Medical Center of San Augustine (Critical Access Hospital), Nacogdoches Memorial Hospital (Nacogdoches County Medical-Surgical Hospital), School of Social Work, Stephen F. Austin State University (Higher Education Institution).

AREAS SERVED

East Texas

TARGET POPULATION SERVED

Underserved, vulnerable, impoverished and/or migrant populations.

PROJECT SUMMARY

Rural East Texas Health Network is a collaborative initiative of multiple health care providers and entities that support the delivery of health care services in rural East Texas: The Burke Center (Regional Community Mental Health Center), Memorial Medical Center of San Augustine (Critical Access Hospital), Nacogdoches Memorial Hospital (Nacogdoches County Medical-Surgical Hospital), School of Social Work, Stephen F. Austin State University (Higher Education Institution). The network seeks to improve access to comprehensive health screening and treatment in order to develop an integrated system of care capable of serving individuals utilizing emergency care services in a 12 county area in East Texas. The initiative will work to develop a rural health care infrastructure that provides systematic screening and assessment for health and mental health needs, health education, professional consultation and training, and the direct delivery of mental health and primary care to the target population of mostly persons utilizing emergency care services through local hospitals. A significant portion of the target population includes underserved, vulnerable, impoverished and/or migrant populations. Health information technology will be developed and upgraded as a flexible platform within the service area playing an integral role in the planning and simultaneous coordination of service procedures, treatment, and continuum of care, along with educational components of this regional project.

TEXAS

Burke Center

Grant Number: D06RH09022

The project will improve the quality of service, enhance the operating efficiency, and expand the capacity of behavioral healthcare in communities of East Texas through greater regional integration of emergent service delivery. Services to be provided are in the area of 1) increased access to care, 2) ensuring continuous quality improvement, 3) cost savings, 4) data gathering and reporting, and 5) coordinating cooperative efforts. Expected outputs and outcomes include; integrated telehealth system, web-based access to electronic information shared among members, standardized consistent protocols among members, web-based training to support member service delivery and a video conference bridge.

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TEXAS

Community Health Coalition of Caldwell County

Grant Number: D06RH09547

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TOPIC AREAS

Chronic Disease

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

Community Health Coalition of Caldwell County, The Indigent Care Collaboration, City of Lockhart, City of Luling, Caldwell County Indigent Health Care Program, Luling Community Health Center, and Seton Edgar B. Davis Hospital

AREAS SERVED

Hays, Travis and Williamson counties

TARGET POPULATION SERVED

Uninsured Diabetes Patients

PROJECT SUMMARY

The service area of the proposed Rural Health Network Development Project is rural Caldwell County, TX. Caldwell County is located approximately 40 miles from downtown Austin and has more than 35,622 residents scattered across 546 square miles. The county is composed of 7 separate zip codes (78648, 78644, 78616, 78622, 78655, 78656, 78661) and three school districts (Lockhart Independent School District, Luling Independent School District & Prairie Lee Independent School District), with the population being almost split between cities and rural settings. The county seat, Lockhart has a population of 13,360 and the next largest city, Luling has a population of 5,510.

Texas has the highest uninsured rate in the Nation. In Caldwell County the rate is even higher than the State average. More than 9,600 Caldwell County residents (or 27%) have no health insurance compared to the State average of 24.1% and the National average of 15.8%. In March 2002, Caldwell County was designated both as a Health Professional Shortage Area and a Medically Underserved Area by the U.S. Department of Health and Human Services. This is demonstrated by the County's ratio of population per Direct Care Physician which is 3,436 as compared to the State's ratio of 661. Many Caldwell County residents are, subsequently, forced to leave the County for care. In fact, neighboring Travis and

TEXAS

Community Health Coalition of Caldwell County

Grant Number: D06RH09547

Williamson County safety net hospital and clinics provided services to approximately 1,430 Caldwell County uninsured residents in 2005 (over 14% of Caldwell County's uninsured).

The poverty rate in Caldwell County is 14.7%. The Federal Poverty Level for a family of four is \$20,650 income for one year. Twelve percent of adults and 21% of the children in Caldwell County live below 100% of the Federal Poverty Level. The median household income in Caldwell County is \$36,573, compared to the state average of \$40,934. The per capita personal income in Caldwell County is \$20,175, compared to the state average of \$29,074.

In Texas, the counties are *only* responsible for providing health care for uninsured individuals with incomes lower than 21% Federal Poverty Level. As such, an individual above 21% of poverty (around \$2,144 annually) is not eligible for county indigent programs. Counties are required to provide certain basic services, similar to the mandatory services provided under Medicaid. The Caldwell County Indigent Health Care Program provides care to approximately 75 to 100 chronically ill patients per month. Caldwell County Indigent Health Care Program contracts with area providers to provide care. The program is under the management of the County Judge.

Many indigent patients in Caldwell County have no medical "home" and look to the local hospital emergency room for their medical needs. The only acute care hospital in the county is Seton Edgar B. Davis (SEBD), a private, non-profit hospital operated by Austin-based Seton Healthcare Network. ER visits increased by 48% at SEBD from 1998 to 2004 (about 10% per year). Twenty-five percent of patients visiting the SEBD emergency department are uninsured. For FY (July – June) 2005 SEBD absorbed \$4.5 million and in FY 2006 SEBD absorbed \$5.1 million in care for the unfunded.

A 2005 study completed by the Indigent Care Collaboration suggests that over 50% of the Austin area Emergency Department visits for the commercially insured and self-pay adult populations were considered preventable (or non-emergent). For uninsured children and the Medicaid population nearly two-thirds to three-fourths of Emergency Department visits were considered preventable.

Accelerating population growth is adding to health care access problems in Caldwell County. From April 2000 to July 2001, the U.S. Census Bureau estimates that Caldwell was the 51st fastest-growing county in the United States. In that 15-month period, the population of Caldwell County increased by 1,999, from 32,194 to 34,193 (6.2 %). Caldwell County officials believe that the official population increase almost certainly undercounts immigrants. Most of these immigrants are uninsured and either ineligible or unwilling to enroll in Medicaid. According to the Urban Institute, 40% of the children of immigrants in Texas are uninsured, and 66% of Latino children live in low-income families. According to the 2000 US Census data, 32% of the population reported speaking a language other than English at home.

Forty percent (40%) of Caldwell residents are Hispanic. All estimates indicate that the Hispanic/Latino population, in Texas, will continue to grow. Data suggests that the Hispanic/Latino population is poorer, less educated, and more likely to be enrolled in public assistance programs. Because of limited resources, lack of education and no health insurance, Hispanics/Latinos are often forced to compromise their health. Symptoms of compromised health are evident in the poor health status indicators in Caldwell County. Caldwell County has the highest percent of low birth weight births (9.6%) in the 5-county Austin area region, and the lowest percentage of women receiving early prenatal care (78.9%). In addition, 70% of Hispanic females in Caldwell County are under the age of forty; all indications are that a significant number of these women are uninsured.

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Community Health Coalition of Caldwell County

Grant Number: D06RH09547

Diabetes is the most common chronic disease in Caldwell County. In 2001, 7.1% of adults in Caldwell County were diagnosed with diabetes compared to 6.2% of adults in the State. The Hispanic and Black populations experience the most severe consequences of diabetes. According to a national study, from 1986 to 1998, overweight prevalence rose by more than 120 percent among African-American and Hispanic children, compared with more than 50 percent among whites. Among adults, overweight and obesity are highest among African-American (77.2 percent) and Mexican-American females (71.7 percent) and Mexican-American males (73.1 percent).

The target population is the uninsured adults, approximately 9,600, in Caldwell County. The target population for uninsured adults with diabetes is estimated to be 672 people (7.1%) over the age of 18 years. The 2001 Texas Behavioral Risk Factor Surveillance System for Diabetes indicates Race/Ethnicity for White – 6%; for Black - 9.7%; for Other - 3.1% and for Hispanic - 8.1%. With Caldwell County having a Hispanic population over 40% of the total and with the Hispanic diabetes risk factor over 8%; the Hispanic population both male and female will be a sub-population.

The demographic data cited is from various government sources, state and federal and the data is footnoted to the source. Primary research was completed for use at the 2004 Community Summit. Also referenced is data compiled through the integrated information systems of the Indigent Care Collaboration of Austin, Texas a network of safety net health care providers from the counties of Hays, Travis and Williamson.

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TEXAS

Leon County Government

Grant Number: D06RH07934

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2007 – April 30, 2010

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 169,700.00
- Year 2- 179,917.00
- Year 3- 179,914.00

PARTNERS TO THE PROJECT

The network includes the county, our local federally qualified health center, two local hospitals, the Area Agency on Aging, two institutions of higher education, the United Way.

AREAS SERVED

Leon County

TARGET POPULATION SERVED

An older population with more disability, lower socioeconomic status, lower educational attainment, and poor access to care.

PROJECT SUMMARY

The Leon County Government is submitting this application on behalf of the Leon Health Access Network, a network of community organizations and healthcare providers committed to a collaborative process of developing locally sustainable strategies, processes, and protocols for increasing Leon County residents' access to specialty care, including mental health services.

The network includes the county, our local federally qualified health center, two local hospitals, the Area Agency on Aging, two institutions of higher education, the United Way, and a regional health partnership that helped establish the foundation for the activities described.

Through the proposed grant, the Leon Health Access Network will focus on establishing a sustainable network to increase access to specialty care for Leon County residents. A recent health status assessment indicated that Leon County has extensive health needs and few health resources currently available. In spite of a dearth of health resources, the non-financial resources of the community are astounding. Mobilized by a few concerned residents, the county was able to appoint a formal health resource commission to oversee planning and development for a newly opened health resource center, established with seed funding from a Healthy Communities Access Program grant awarded to the Brazos Valley

TEXAS

Leon County Government

Grant Number: D06RH07934

Health Partnership for the region. The momentum created by these new developments presents a unique opportunity for the Leon Health Access Network to move forward in creating new strategies for addressing local needs.

Leon County is home to 16,344 residents. As a rural county in east Texas, the population possesses characteristics common of other rural communities: an older population with more disability, lower socioeconomic status, lower educational attainment, and poor access to care.

The network proposes to develop activities targeting all residents of the county. If funded, the residents of Leon County will benefit by realizing improved access to specialty care and mental health services that will be sustainable past the end of the grant period. This will improve productivity, children's performance in school, residents' ability to manage chronic disease, as well as limit disability resulting from unmanaged conditions. The network will also improve the viability of local providers and regional providers offering local services.

Several of the activities proposed are based upon those developed through the Brazos Valley Health Partnership, whose model was funded by HRSA through the Healthy Communities Access Program. The community health resource center and volunteer-based transportation activities in Leon County were initiated through that funding and have been adapted to fit unique local needs and resources.

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TEXAS

Stephen F. Austin State University

Grant Number: D06RH09012

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TOPIC AREAS

Quality health care and social services

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

The proposed Network Partners consist of Piney Woods Health Education Center (Piney Woods AHEC), East Texas Community Health Services, Inc. (ETCHSI), East Texas Health Access Network (ETHAN), Southeast Texas Regional Planning Commission (SETRPC), and Texas DSHS Public Health Service Region 4/5N. All five (5) of the proposed Network Partners are physically located within the East Texas AHEC Program service area, which serves the 111 counties of East Texas.

AREAS SERVED

Counties affected: Jasper, Nacogdoches, Newton, Red River, Sabine, San Augustine, and Tyler, plus the rural census tracts of Hardin, Jefferson and Orange Counties.

TARGET POPULATION SERVED

Lack of access to affordable quality health care and social services is a major disparity, due primarily to a disproportionately large, and steadily increasing, percentage of the population is under/uninsured and to the fact that transportation to healthcare services is a major barrier as public transportation is nonexistent and private transportation is extremely problematic for many of the impoverished residents of the area.

PROJECT SUMMARY

Five healthcare and/or health education entities who serve various areas of Deep East Texas have joined forces to create the Network for East Texas Rural Health (NETRH). The lead applicant, Piney Woods Area Health Education Center (AHEC)/Stephen F. Austin State University, along with its four partners, East Texas Community Health Services, East Texas Health Access Network, the South East Texas Regional Planning Commission and Texas DSHS Public Health Service Region 4/5N, share a common vision and mission of improving the health of the underserved of this region. These Network Partners also share a common bond by having contributed to the creation and/or sustained services of the East Texas Rural Access Program (ETRAP), funded by Robert Wood Johnson Foundation, and they continue to collaborate as such although ETRAP funding has ended.

TEXAS

Stephen F. Austin State University

Grant Number: D06RH09012

The population to receive services through NETRH is in the original ETRAP service area, which includes the 38 counties of Deep East Texas. Deep East Texas is a region whose population experiences myriad, often extremely serious, health disparities. Lack of access to affordable quality health care and social services is a major disparity, due primarily to a disproportionately large, and steadily increasing, percentage of the population is under/uninsured and to the fact that transportation to healthcare services is a major barrier as public transportation is nonexistent and private transportation is extremely problematic for many of the impoverished residents of the area. A fragmented healthcare delivery system and lack of readily available cost effective services also contribute to health disparities.

The Network Partners agreed that since these physical and socioeconomic barriers would be a continuing problem, they would have to provide services in a way that would negate the impact of the barriers: they would have to take health services and education to the clients. The Partners agreed that Community Health Workers (CHWs) would provide the most cost effective services and that the best way to secure competent services would be to form a rural health network to hire, train and deploy CHWs to provide services among the Partners. Piney Woods AHEC does not provide clinical services, although it does provide health literacy/education, and it was agreed that Piney Woods AHEC will be the Administrative Manager of the Network. Stephen F. Austin State University, which houses the Piney Woods AHEC, will hire the CHW-trainees, and Piney Woods AHEC will train and certify the CHWs through the services of its sister AHEC Center, Coastal AHEC. Coastal AHEC is collaborating with Texas Department of State Health Services (DSHS) to finalize a DSHS-approved CHW certification curriculum, which will be beta-tested to train and certify the NETRH CHWs. Piney Woods AHEC as Network Manager will then direct and assign the CHWs as appropriate among the clinical Network Partners. The Partners will then supervise, develop and deploy the CHW to provide appropriate services directly to regional client locations, thereby improving the health of the community, and minimizing the effect of existing health disparities.

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TEXAS

Texas A&M University-Kingsville

Grant Number: D06RH09012

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 208,380.00
- Year 2- 179,791.00
- Year 3- 179,556.00

PARTNERS TO THE PROJECT

5-member Kleberg Rural Health Network

AREAS SERVED

Kleberg County, TX

TARGET POPULATION SERVED

Low-income and uninsured citizens

PROJECT SUMMARY

a. Applicant & Project Summary: Texas A&M University-Kingsville, a participating Network member, requests ORHP funding on behalf of the 5-member Kleberg Rural Health Network. The Network's mission is "To improve the health of Kleberg County residents and the health care system that serves them through the successful adoption of health information technology. Network members, including three rural primary care practices, a rural university campus, and a children's health insurance plan, request grant support of \$539,335 and pledge \$81,557 in kind support for a 3-year total Network budget of \$620,912.

b. Network Rationale & Goals: The Network will serve Kleberg County, Texas, where over 30% of the 30,353 residents live without the protection of health insurance, and where incomes and educational levels are far lower than Texas and US averages. The Network enables the County's health care providers to collaboratively implement health information technology and other health system integration activities. The Network's goals are to (1) improve access to care for Kleberg County residents, and office operating efficiencies for Kleberg County health care providers, through the successful adoption of health information technology, (2) develop a health information exchange (HIE) in cooperation with the Alcanee Regional Health Information Organization (RHIO) and use the HIE to improve care outcomes, and

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Texas A&M University-Kingsville

Grant Number: D06RH09012

(3) sustain the Network through effective governance processes, strategic business planning, network expansion, network evaluation, and project dissemination.

c. Target Population Groups: The Network aims to improve access to care, clinic operating efficiencies, and care outcomes for Kleberg County's predominantly low-income, uninsured citizens, while upgrading the quality of care and financial viability of the region's health delivery system for the benefit of all County residents.

d. Local Health Care System Benefits: The Network will enable Kleberg County consumers to more effectively access the County's limited number of safety-net providers. For providers, the Network offers a means to work individually and collaboratively to improve the local health care delivery system. The Network will help streamline primary care office work processes by facilitating providers' access to electronic medical record keeping. The Network's health information exchange will promote system integration, more consistent, evidence-based medical decision making, and enhanced care outcomes.

e. Models That Work/Best Practices: The Kleberg Network design is based in part on Project Alcance, a HCAP coalition which has worked to implement innovative health information technology in South Texas since 2001. The Network has learned from Alcance's experience in implementing electronic medical record, and will put greater emphasis on preparing and training health care providers to successfully migrate to advanced health information technology. The Kleberg Network has developed five strategies to sustain itself after federal funding ends.

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VERMONT

Behavioral Health Network of Vermont

Grant Number: D06RH09049

PROGRAM DIRECTOR

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TOPIC AREAS

Behavioral Health Services

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

Clara Martin Center, Howard Center for Human Services, Counseling Service of Addison County, Health Care & Rehabilitation Services of Southeastern Vermont, Northwestern Counseling and Support Services, Inc., Lamoille County Mental Health Services, Northeast Kingdom Human Services, Inc., Northeastern Family Institute, United Counseling Service of Bennington County, and Washington County Mental Health Services.

AREAS SERVED

Statewide

TARGET POPULATION SERVED

Rural Vermonters

PROJECT SUMMARY

The Behavioral Health Network (BHN) of Vermont is proposing a three year plan to fully develop a sustainable organization that helps member agencies in their work while improving quality and access to behavioral health services for rural Vermonters. Specifically, BHN will focus on network development activities including finalizing its strategic and business plans, developing a sustainability plan and budget, and identifying specific business opportunities and areas of further integration between member agencies. BHN will also develop and implement a technology initiative that will enhance communication between health partners, improve access to mental health specialists, provide a consistent training and professional development forum, and provide networking and other opportunities for consumers. There is also a focus on quality improvement through an annual training conference and related initiatives. Mental health is essential to overall health, and Vermont is a leading state in implementing nationally recognized best practices within its community service delivery system for people with mental illness and substance abuse treatment needs. Its mental health insurance parity law is a national model that includes coverage of substance abuse. Vermont has a strong culture of rehabilitation and recovery.

VERMONT

Behavioral Health Network of Vermont

Grant Number: D06RH09049

However, the unmet need related to the broad category of behavioral health remains great. It is estimated that nearly 28 percent of Americans have diagnosable behavioral health conditions, but few seek treatment. Vermont also faces barriers related to behavioral health service delivery based on its rural landscape and characteristics, and a rapidly changing system of health care. These changes include the Governor's Blueprint on Health and an ongoing focus on the reorganization of roles and services, a Global Commitment waiver that makes Vermont the only state in the nation facing a fixed-dollar limit on the amount of federal funding available for its Medicaid program, and the closing the Vermont State Hospital which will result in even further reliance on community based services. Community mental health centers are seeing more difficult patients while there is continued scrutiny over state allocations for these services. It is critical that behavioral health providers – who are officially designated to do the state's business - come together during this important period and beyond, if they are to face these challenges and others while improving both the viability of their agencies and the delivery of care to the people they serve.

A Rural Health Network Development Grant from HRSA will significantly improve BHN's ability to access the technical assistance and other expertise needed to build a continually self-perpetuating sustainable network with business (network partner return) and social (community return) competencies that increases access and quality of rural health care and ultimately, the health status of rural residents.

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VERMONT

Bi-State Primary Care Association

Grant Number: D06RH09020

PROGRAM DIRECTOR

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

Bi-State, six Federally Qualified Health Centers, one Federally Qualified Health Center Look-Alike, one Critical Access Hospital and its affiliated Rural Health Clinics, the 11 sites of the Vermont Coalition of Clinics for the Uninsured, the 16 Vermont sites of Planned Parenthood of Northern New England, Vermont's Area Health Education Center (AHEC) network, the Vermont Program for Quality in Health Care (VPQHC), and Vermont Information Technology Leaders (VITL), the statewide RHIO.

AREAS SERVED

State of Vermont

TARGET POPULATION SERVED

The uninsured with significant health issues.

PROJECT SUMMARY

Bi-State Primary Care Association will serve as the grantee and fiscal agent for the ORHP Rural Health Network Development Grant on behalf of the Vermont Rural Health Alliance (VRHA).

The initial membership of VRHA consists of Bi-State, six Federally Qualified Health Centers, one Federally Qualified Health Center Look-Alike, one Critical Access Hospital and its affiliated Rural Health Clinics, the 11 sites of the Vermont Coalition of Clinics for the Uninsured, the 16 Vermont sites of Planned Parenthood of Northern New England, Vermont's Area Health Education Center (AHEC) network, the Vermont Program for Quality in Health Care (VPQHC), and Vermont Information Technology Leaders (VITL), the statewide RHIO.

The state of Vermont has launched an ambitious health care reform agenda. VRHA's role is to help put that policy into practice. VRHA clarifies and demystifies state reform initiatives to convey concrete and actionable steps to its members. The Alliance acts as catalyst and facilitator between numerous top down health care reform initiatives and rural providers at the ground level, who are themselves struggling with

VERMONT

Bi-State Primary Care Association

Grant Number: D06RH09020

day-to-day issues of patient care, practice operations, reimbursement, and recruitment and retention. The Alliance also provides a forum for members to learn from each other's experiences and provide a feedback loop to policy makers about the challenges and successes of implementing the reform initiatives. VRHA serves the entire rural population of Vermont, approximately 76% of Vermonters.

Vermont is one of the most rural states in America: 224,917 (36%) Vermonters live in towns with populations of less than 2,000 people (Population Division, U.S. Census). Rural Vermonters are more likely to be uninsured, have significant health issues including diabetes, coronary heart disease, stroke, and high blood pressure, and experience disproportionately higher rates of poverty. The resources currently available to rural health care providers are stretched to capacity. VRHA will provide an additional resource, allowing them to embrace and excel at the challenges that are being presented to them by statewide initiatives such as Vermont's Blueprint for Health, Medicaid Chronic Care Management and Care Coordination Programs, and outreach for the newly enhanced Green Mountain Care Medicaid expansion programs. Together, VRHA members are in a prime position to pilot the system change that is envisioned in the health care reform efforts. Rural Vermont will consequently be better served by a comprehensive and coordinated health care system that provides expanded coverage and access to quality care.

VRHA responds to the need that policymakers have identified to strengthen and enhance health care systems, and improve access to, and quality of care. VRHA has identified four goals to achieve these ends: (1) support participation in the all-encompassing Vermont Blueprint for Health and other quality improvement initiatives; (2) optimize Health Information Technology (HIT) and Health Information Exchange (HIE) utilization and effectiveness in accordance with the objectives of the *Vermont HIT Plan*; (3) support and enhance outreach and enrollment activities for Medicaid and the new Medicaid expansion programs; and (4) develop the statewide infrastructure for a health center-owned 340B prescription drug program and telepharmacy.

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WASHINGTON

Yakima Valley Farm Workers Clinic

Grant Number: D06RH09548

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TOPIC AREAS

Healthcare

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1 - 248,584.00
- Year 2 - 179,287.00
- Year 3 - 179,395.00

PARTNERS TO THE PROJECT

The applicant, Yakima Valley Farm Workers Clinic (YVFWC), is a participating member of the Children's Village (CV) Network (Network)

AREAS SERVED

Central Washington

TARGET POPULATION SERVED

4,188 Hispanic CSHCN ages birth to 17 in the service area

PROJECT SUMMARY

The applicant, Yakima Valley Farm Workers Clinic (YVFWC), is a participating member of the Children's Village (CV) Network (Network).

CV Sunnyside will improve access to care and quality of care for primarily Hispanic children with special health care needs (CSHCN) and their families in central Washington. Although data show there is less prevalence of special health care needs in Hispanic children, Hispanic CSHCN and their families at both national and state levels have poorer health and functional status, less access to care, less care coordination, less satisfaction with care, and less adequacy of health care coverage than non-Hispanic White CSHCN and their families.

Moreover, Hispanic CSHCN and their families in Washington experience greater disparity in these outcomes than Hispanic CSHCN and their families in the nation.

Based on state prevalence rates, there are 4,188 Hispanic CSHCN ages birth to 17 in the service area. Compared to non-Hispanic White children, Hispanic children in the service area are more likely to live in poverty; and live with family members that have limited English proficiency, are undocumented immigrants, and have not graduated from high school.

WASHINGTON

Yakima Valley Farm Workers Clinic

Grant Number: D06RH09548

By the end of the project, CV Network members expect to implement new and/or expanded integrated services, thereby increasing access to comprehensive care for CSHCN and their families in the service area. They expect to strengthen the information technology at CV by developing a shared electronic medical record. By accessing shared clinical information, providers will be better able to integrate treatment, thus improving consumer satisfaction with care coordination. CV Network members anticipate that staff will provide more culturally and linguistically appropriate care, and more family-centered care, thereby improving consumer satisfaction. Finally, they anticipate that by building financial reserves, they will be able to provide services to underinsured consumers, thus increasing the number of CHSCN and their families whose health care needs are met.

CV Network members will adapt the strategic planning and business planning approaches outlined in reports produced under the *Networking for Rural Health Project*. From 2000-03, the Alpha Center, a leading health policy center, directed this Project, an initiative to strengthen the rural health care delivery system by fostering the development of rural health networks. The Project was supported by The Robert Wood Johnson Foundation. Because the strategic planning and business planning approaches were developed specifically for rural health networks, members expect them to succeed for the CV Network, and will not make any adaptations.

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WEST VIRGINIA
New River Health Association, Inc.
Grant Number: D06RH09024

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TOPIC AREAS

Primary care services

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1- 180,000.00
- Year 2- 180,000.00
- Year 3- 180,000.00

PARTNERS TO THE PROJECT

New River Health Association, Inc. is a member of the Partners In Health Network (PIHN), applying for the Rural Health Network Development Grant on behalf of the PIHN. In existence since 1995, the mission of the PIHN is: *The Members of Partners in Health Network, Inc.*

AREAS SERVED

Fayette and Raleigh Counties, West Virginia

TARGET POPULATION SERVED

Medically Underserved Area and parts are designated Health Professional Shortage Area (WVDHHR, Office of Community Health Systems).

PROJECT SUMMARY

New River Health Association, Inc. is a member of the Partners In Health Network (PIHN), applying for the Rural Health Network Development Grant on behalf of the PIHN. In existence since 1995, the mission of the PIHN is: *The Members of Partners in Health Network, Inc. will meet the health care needs of our communities striving for quality care throughout the network by leveraging existing resources while working collaboratively to improve organizational efficiencies.*

Within this context 3 members of the network are collaborating on a national demonstration project, rural PACE (Program for All-Inclusive Care for the Elderly). The rural PACE site will create access to the full range of preventive, primary, acute and long-term care services that enable the aging population to live in the community as independently as possible. PACE programs use an interdisciplinary team approach to integrate, deliver and coordinate all the care and services that PACE enrollees need. Because of the complex issues of caring for older individuals with multiple diagnoses in community settings, the flexibility and creativity provided by the PACE model of care is key to successfully maintaining frail older adults in the community for as long as possible. Each of the three PIHN members brings their

WEST VIRGINIA
New River Health Association, Inc.

Grant Number: D06RH09024

unique knowledge and skills to the project for provision of comprehensive health care services for the aging population:

- New River Health as a Federally Qualified Health Center provides primary care services
- Raleigh County Commission on Aging provides in-home care management services, medical transportation, wellness and fitness services, home delivered meals, health and wellness education and training, and adult day care
- Charleston Area Medical Center offers hospital and specialty care
- Working in two rural counties in the third oldest state in the country (“65+ in the United States”, www.census.gov/prod/2006pubs/p23-209.pdf), the target population of PACE is the aging population.

Raleigh County with 15.4% (of 79,302 residents) and Fayette County with 16.1% (of 26,446 residents) both have higher percentages of people 65 years old and older than WV (15.3%) and the US (12.4%), making the target population for this project 19,717 people (US Census Bureau, July 2007). As of March 2007 much of this 2-county service area is designated as a Medically Underserved Area and parts are designated Health Professional Shortage Area (WVDHHR, Office of Community Health Systems).

Residents of the project service area suffer with higher than national and WV state rates of heart disease, lung cancer, diabetes, Chronic Obstructive Pulmonary Disease, unintentional injuries (motor vehicle and non-motor vehicle), intentional injuries, physical inactivity, cigarette and smokeless tobacco use, no health insurance (ages 18-64) and difficulty seeing a doctor because of cost (WV County Health Profiles – 2004, <http://www.wvdhhr.org/bph/oehp/hsc/profiles2004/>). An extensive community needs assessment including key informant interviews and a population survey was conducted, identifying gaps in services and barriers to care for the aging population, which will be addressed by the rural PACE program.

Through rural PACE primary care services, ancillary services such as nutrition/meals and specialist consultations will be more easily accessible, positively impacting the quality of life for PACE enrollees in the service area. Implementation of the rural PACE site also creates access to more services for seniors who may have struggled to receive services in the past. The Rural Health Network Development grant will support the rural PACE program by providing staffing, technology, training and consultants to make the program more viable in the long-term and ensure access to quality services for seniors.

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WYOMING
University of Wyoming
Grant Number: D06RH08996

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TOPIC AREAS

Telehealth

PROJECT PERIOD

May 1, 2008 – April 30, 2011

FUNDING LEVEL EXPECTED PER YEAR

- Year 1 - 180,000.00
- Year 2 - 180,000.00
- Year 3 - 180,000.00

PARTNERS TO THE PROJECT

The consortium partners are: the University of Wyoming, Cheyenne Regional Medical Center, Wyoming Hospital Association, a non-profit organization representing most of the hospitals and clinics in the state.

AREAS SERVED

State of Wyoming - Counties: Albany, Carbon, Converse, Goshen, Laramie, Niobrara, Platte

TARGET POPULATION SERVED

168,000 residents of southeastern Wyoming, nearly half of whom live in designated health professional shortage areas.

PROJECT SUMMARY

Internet-based health technologies, often referred to as telehealth technologies, have long been put forward as ways to address the inequities of health care delivery to consumers in rural areas; studies have shown that, when available, these technologies address the challenge of delivering quality health care services to isolated communities. The development of a formal telehealth network can provide services and coordination for health care organizations in a rural service region to take advantage of available resources while maintaining the organizations' independence. Using Internet-based technology to provide connections among health care facilities in a well-defined service region can promote sharing of resources and contribute to improved quality of service in the network region.

In 2006, a consortium of three independent organizations received a Network Development Planning Grant from the Office of Rural Health Policy to develop a strategic plan for the Southeast Wyoming Telehealth Network (SEWTN), which had been recently formed from hospitals representing Wyoming's southeastern region, specifically Albany, Carbon, Converse, Goshen, Laramie, Niobrara, and Platte counties. The consortium partners are: the University of Wyoming, the state's only four year/graduate research university; Cheyenne Regional Medical Center, a large regional referral hospital; and the Wyoming Hospital Association, a non-profit organization representing most of the hospitals and clinics in

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the state. The SEWTN is now in operation, with an established board of directors representing the hospitals in these seven counties as well as other parties with interest in telehealth.

The SEWTN consortium now proposes to implement the strategic plan currently being created through an ORHP Network Development Grant. The University of Wyoming will be the applicant organization on behalf of the network partners. The overall objective of the proposed project will be to address the severe shortages of health care professionals in the rural counties served by the participating hospitals through the development of telehealth technology. Specific goals of the project will be to:

- Goal 1: Develop SEWTN processes and programs to promote and facilitate network utilization by its members and the residents of their communities.
- Goal 2: Increase administrative use of the network.
- Goal 3: Increase educational and training opportunities for the network partners.
- Goal 4: Develop and promote clinical applications among the network partners.
- Goal 5: Create the infrastructure for a sustainable, independent organization.

Central to the development of the SEWTN will be the incorporation of best practices from successful rural telemedicine programs. We are working closely with the Eastern Montana Telemedicine Network (EMTN), which has been in operation since 1993 and has received funding from the USDA Distance Learning and Telemedicine program and (twice) from HRSA. In addition, we expect continued support from the Northwest Regional Telehealth Resource Center (NRTRC), which received operational funding from the Office for the Advancement of Telehealth in 2006.

The development of the SEWTN will provide many benefits to the roughly 168,000 residents of southeastern Wyoming, nearly half of whom live in designated health professional shortage areas. These benefits include expanding availability of services, providing more opportunity for education and support of local health care professionals, and encouraging collaboration among the partners to improve care and reduce costs. In addition, the leadership to be developed through the Southeast Wyoming Telehealth Network project will serve as the foundation for sustained efforts to bring telehealth to the entire state of Wyoming.

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