#	Project Description
Domain 2: Systems Transformation Projects	
2.a.i	Create an Integrated Delivery System Focused on Evidence-Based Medicine and Population Health Management –**Advanced Primary Care—Patient Centered Medical Home for all PCPs; support for Information informed care, "Meaningful Use," Closing the Referral Loop, Medication Reconciliation**
2.a.iii	Health Home At-Risk Intervention Program –**PCP linked care coordination for Chronic Conditions**
2.a.iv	Create a Medical Village Using Existing Hospital Infrastructure
2.b.iv	Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions-**Link discharge planning to Primary Care**
2.d.i	Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care (Project 11) Focus on **Primary Care sites serving the uninsured (FQHCs & Hospital Clinics)** and Community Based Organizations
Domain 3: Clinical Improvement Projects	
3.a.i	**Integration of Primary Care and Behavioral Health Services**
3.a.ii	Behavioral Health Community Crisis Stabilization Services
3.c.i	Implementation of Evidence-Based Strategies in the Community to Address Chronic Disease – **Diabetes**
3.d.iii	Implementation of Evidence-Based Guidelines for **Asthma Management**
Domain 4: Population-Wide Prevention Projects	
4.b.i	Promote Tobacco Use Cessation, Especially Among Low SES Populations and Those with Poor Mental Health – **Promote tobacco cessation counseling—Primary Care, Dental, Behavioral Health providers**
4.b.ii	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings – **Cancer Support PCP based cancer screening FU and referral for treatment**