Grantee DIRECTORY

Rural Health Network Development Planning Program

2019

U.S. Department of Health & Human Services

HRSA

Federal Office of Rural Health Policy

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Rural Health Network Development Planning Program

Background of the Rural Health Network Development Planning Program

The purpose of the Rural Health Network Development Planning Program (Network Planning Program) is to assist in the development of an integrated health care network for consortia that do not have a history of formal collaboration. Health care networks can be an effective strategy to help smaller rural health care providers and health care service organizations better align resources and strategies, achieve economies of scale and efficiency, and address challenges more effectively as a group than as single providers. This program brings together key parts of a rural health care delivery system, particularly to establish and improve local capacity and coordination of care.

The Network Planning program promotes the planning and development of health care networks to: (i) achieve efficiencies; (ii) expand access to, coordinate, and improve the quality of essential health care services; and (iii) strengthen the rural health care system. The program supports one year of planning with the primary goal of helping networks create a foundation for their infrastructure and focus member efforts to address important regional or local community health needs.

(FY)19 Rural Health Network Development Planning Grantees – Programmatic Focus Areas

Collaboration is a key factor in addressing the challenges and disparities in rural health care planning, delivery, access, and outcomes. Disproportional chronic disease rates, a higher incidence of mental health problems and substance abuse, hospital closures, limited broad band, and health care provider shortages are among the issues facing rural communities. With funding provided by the (FY)19 Network Planning Program, twenty-five grantees in sixteen states are addressing these challenges by bringing together a broad range of partners to form rural health networks. Recognizing the importance of leveraging their combined resources, more than sixty-percent of these grantees are placing a primary (eight grantees) or secondary (eight grantees) focus on strengthening their network organization/infrastructure development with the intend of formalizing their collaboration by identifying leadership and decision-making structures and establishing policies and procedures.

In addition to the network infrastructure development, Network Planning grantees are drawing on their combined expertise and resources to address a number of health care issues. Fifteen of the twenty-five (FY)19 Network Planning grantees are focusing on behavioral health/mental health issues through varying approaches. Five of the networks with a primary emphasis on network organizational/infrastructure development are focusing their programmatic work on behavioral health. Three additional grantees also have a primary focus on behavioral health, with one focusing on school-based mental health. Five cite mental illness/mental health as their primary focus, four of which include behavioral health as a secondary focus area. Substance abuse is another high priority area for the (FY)19 grantees, with eight including opioid abuse as a secondary focus of their planning efforts.

Creating efficiencies in the delivery of health care is another important focus for these rural health networks.

- Twelve are expending some of their resources on increasing efficiencies and/or the integration of health services, seven of which have a programmatic focus on behavioral health/mental health services.
- Three are exploring the feasibility of increasing efficiencies through the use of telehealth or telepsychology, and one other is designing a transportation system to address the problem of revenue lost through missed medical appointments.
- Four more are exploring methods for coordinating the care of patients with chronic diseases such as diabetes, chronic obstructive pulmonary disease, and congestive heart failure. One of which is also exploring options for the reimbursement of care coordination services. Another is developing a plan for coordinating palliative care services.

Understanding the complexity of health and the need to promote health, eight of the (FY)19 grantees are taking a broad approach by looking at population health and taking the social determinants of health into consideration in their planning efforts.

Contents of the (FY)19 Rural Health Network Development Planning Grantee Directory

In addition to the programmatic focus areas of the Network Planning grantees, this Directory provides a description of their programs and network structures, as written and submitted by the individual grantees. The geographic areas served by the network, a listing of network partners, and the primary contact person for the network are also provided.

2019 Rural Health Network Development Planning Grantees

Focus Areas

State	Grantee	Network Name	Primary Focus Area	Other Focus Areas
AZ	Arizona Community Health Workers Association	Rural Arizona CHW Workforce Development Network	Increase Health System Efficiencies	• Behavioral Health • Integrated Health Services • Network Organizational/ Infrastructure Development • Population Health/ Social Determinants of Health • Workforce Development
AR	1st Choice Healthcare, Inc.	Northeast Arkansas Opioid Coalition	Substance Abuse/ Addiction - Opioid	
AR	University of Arkansas Winthrop Rockefeller Institute	The Arkansas Rural Health Network Initiative	Network Organizational/ Infrastructure Development	• Health Education • Increase Health System Efficiencies
AR	White River Health System	Arkansas Community Health Network	Network Organizational/ Infrastructure Development	• Behavioral Health • Integrated Health Services • Substance Abuse/Addiction – Opioid • Telehealth
CO	Mountain Family Health Centers	West Mountain Regional Health Alliance	Network Organizational/ Infrastructure Development	• Behavioral Health • Increase Health System Efficiencies • Integrated Health Services • Population Health/ Social Determinants of Health

State	Grantee	Network Name	Primary Focus Area	Other Focus Areas
CO	Southeast Mental Health Services	CO Behavioral Health Training Cooperative	Behavioral Health	• Mental Illness/Mental Health • Obesity – Childhood • School Based Health Services • Workforce Development
CO	The Memorial Hospital	Moffat County Mental Wellness	Mental Illness/Mental Health	• Behavioral Health • Network Organizational/ Infrastructure Development • Substance Abuse/Addiction – Opioid • Substance Abuse/Addiction – Other than Opioid
FL	St. Johns River Rural Health Network	Putnam County Care Connect	Behavioral Health	• Increase Health System Efficiencies • Mental Illness/Mental Health • Substance Abuse/Addiction – Opioid • Telepsychology
GA	Glascock County Board of Education	Tri-County School Health Network	School Based Health Services	• Behavioral Health • Health Education • Increase Health System Efficiencies • Network Organizational/ Infrastructure Development

State	Grantee	Network Name	Primary Focus Area	Other Focus Areas
IL	Arukah Institute of Healing	C4-Rural: Collaborative, Complementary & Conventional Care for Rural Populations	Mental Illness/Mental Health	• Behavioral Health • Increase Health System Efficiencies • Integrated Health Services • Network Organizational/ Infrastructure Development
IA	Avera Health	Emmet County Behavioral Health Network	Mental Illness/Mental Health	• Behavioral Health
KY	Livingston Hospital and Healthcare Services, Inc.	LCL Health Alliance	Network Organizational/ Infrastructure Development	• Behavioral Health • Substance Abuse/Addiction – Opioid • Substance Abuse/Addiction – Other than Opioid
MI	Central Michigan District Health Department	Central Michigan Regional Rural Health Network	Behavioral Health	• Mental Illness/Mental Health Services • Network Organizational/ Infrastructure Development • Substance Abuse/Addiction – Opioid • Substance Abuse/Addiction – Other than Opioid
MI	Huron, County of	Thumb Community Health Partnership	Increase Health System Efficiencies	• Care Coordination • Integrated Health Service • Network Organizational/ Infrastructure Development • Population Health/ Social Determinants of Health

State	Grantee	Network Name	Primary Focus Area	Other Focus Areas
MO	County of, Taney	The Ozarks Wellness Network	Population Health/ Social Determinants of Health	• Network Organizational/ Infrastructure Development
MO	West Central Missouri Community Action Agency	Rides to Health and Wealth Network	Network Organizational/ Infrastructure Development	• Increase Health System Efficiencies • Population Health/ Social Determinants of Health • Transportation
NE	South Heartland District Health Department	Rural Behavioral Health Network	Network Organizational/ Infrastructure Development	• Behavioral Health • Mental Illness/Mental Health Services • Workforce Development
NY	Council on Addictions and Recovery Services	Appalachian Substance Use Disorder and Mental Health Services Coalition	Mental Illness/Mental Health Services	• Network Organizational/ Infrastructure Development • Population Health/ Social Determinants of Health • Substance Abuse/Addiction – Opioid
NC	Granville Vance Public Health	Integrated Care Planning Network (ICPN)	Integrated Health Services	• Behavioral Health • Substance Abuse/Addiction- Opioid • Substance Abuse/Addiction – Other than Opioid
OH	Hopewell Health Centers	Partnering to Achieve Compliance and Savings	Reimbursement for Health Services	• Care Coordination • Care Transitions • Chronic Disease Management – Diabetes • Chronic Disease Management – Other than Diabetes

State	Grantee	Network Name	Primary Focus Area	Other Focus Areas
OK	Rural Health Network of Oklahoma	Rural Health Network of Oklahoma	Network Organizational/ Infrastructure Development	• Behavioral Health • Substance Abuse/Addiction – Opioid • Workforce Development
SD	Coteau Des Prairies Hospital		Care Coordination	• Integrated Health Services • Network Organizational/ Infrastructure Development • Population Health/ • Social Determinants of Health
WA	Adams County Public Hospital District #2	Grand Columbia Health Alliance	Increase Health System Efficiencies	• Integrated Health Service • Network Organizational/ Infrastructure Development • Population Health/ Social Determinants of Health • Workforce Development
WA	Columbia, County of	Southeast Washington Health Partnership	Network Organizational/ Infrastructure Development	• Care Coordination • Telehealth
WA	Family Health Centers	Okanogan Palliative Care Team	Palliative Care	• Care Coordination • Chronic Disease Management – Other than Diabetes • Increase Health Efficiencies • Integrated Health Services

Arizona

Arizona Community Health Workers Association, Inc
Rural Arizona CHW Workforce Development Network

P10RH33036

Project Focus Area: Increase Health System Efficiencies

Other Focus Areas: Behavioral Health
Integrated Health Services
Network Organization/Infrastructure Development
Population Health/Social Determinants of Health
Workforce Development

Special Populations: Tribal

Network Description

The Rural Arizona Community Health Worker (CHW) Workforce Development Network is a new, vertical, statewide rural health network that launched in 2018. The Arizona Community Health Worker Association (AzCHOW), a statewide nonprofit organization founded in 2001, is the fiscal agent for the Network. The Rural Arizona CHW Workforce Development Network formed to address the changing landscape in Arizona health care. First, the Arizona Legislature and Governor signed voluntary certification for CHWs into law in 2018. AzCHOW and many of the Network partners advocated for voluntary CHW certification for two years to that Arizona's CHW workforce is officially recognized and to prepare the CHW Workforce for reimbursement. Second, the transformation of health care to a value-based model is increasing the value of CHWs as a part of clinical care and care teams. CHW advocates in Arizona have a lot of work to do to be ready for these changes. The need is particularly great in rural Arizona, which tends to lag behind in workforce development and health care system change.

The Rural Arizona CHW Workforce Development Network consists of twelve health care partners located in seven of Arizona's fifteen counties. Partners include county health departments, federally qualified health centers, tribal health departments, other nonprofit organizations, universities, and state entities. The founding partners are key, as they represent the entities in rural Arizona that most use CHWs, plus policy makers and researchers that are helping advance the CHW workforce in our state. The participation of tribal governments is key, as more than one third of CHWs in Arizona are Community Health Representatives (CHRs) that serve tribal communities. The fact that CHRs and tribal communities are fully integrated within the new Network is critical to statewide success.

Program Description

The goal of the Rural Arizona CHW Workforce Development Network is to assess needs and address gaps to increase effectiveness of CHWs in care coordination and the integration of primary care and behavioral health in rural areas as critical to health care transformation and value-based reimbursement in rural Arizona. CHWs have many titles, but the primary types of CHWs working in Arizona's rural service area are Promotores de Salud (Health Promoters) in Hispanic/Latino communities and Community Health Representatives (CHRs) serving American Indian communities. The Network will fulfill three objectives in order to achieve our goal over the twelve-month planning period: 1) assess rural CHW training needs regarding care coordination and behavioral health integration; 2) identity and/or design training to meet the needs; and 3) develop a strategic plan on how to enhance and sustain rural CHW capacity-building services. Although capacity building is focused on CHWs themselves, we realize that the

Network will also need to build the understanding and ability of health care providers to train, supervise and support CHWs as a part of their transformation from volume to value. Additionally, health care is moving toward an integrated model. In fact, Arizona's Medicaid program now requires the health plans that it contracts with to integrate primary care and behavioral health services for its members. CHWs will play an increasing role in integrated care, care coordination and care teams. The Rural Arizona CHW Workforce Development Network is proactively addressing the anticipated workforce gap.

The Network supports the CHW Scope of Practice recently updated by the CHW Core Consensus (C3) Project. This scope of practice includes ten roles and eleven skills. In keeping with the changing health care landscape, care coordination, care management and system navigation were added as a new skill set for CHWs. Capacity building will align with the Chronic Care Model of care coordination and also with the Integrated Behavioral Health Model. Network communication is horizontal, is bilingual as needed (in English and Spanish) and is culturally appropriate for our diverse membership. Although we take advantage of technology to keep our statewide network connected, in-person meetings are critical to cultural exchange as we move forward together.

Region Covered by Network Services

County, State	County, State
Mohave County, AZ	Santa Cruz County, AZ
Coconino County, AZ	Cochise County, AZ
Navajo County, AZ	Navajo Nation
Apache County, AZ	Hualapai Tribe
Maricopa County, AZ	Yuma County, AZ
Pima County, AZ	

Network Partners

Organization	City, State	Organization Type
Arizona Community Health Worker Association (AzCHOW)	Douglas, AZ	Non-Profit
Chiricahua Community Health Centers, Inc.	Douglas, AZ	Federally Qualified Health Center (FQHC)
North County Health Care	Flagstaff, AZ	Federally Qualified Health Center (FQHC)
Cochise Health and Social Services	Bisbee, AZ	Public Health
Yuma County Health Department	Yuma, AZ	Public Health
Navajo Nation Department of Health	Kayenta, AZ	Tribal Nation
Hualapai Health Education and Wellness	Peach Springs, AZ	Tribal Nation
Southeast Arizona Area Health Education Center	Nogales, AZ	Area Health Education Center
Campesinos Sin Fronteras	Somerton, AZ	Non-Profit
University of Arizona Prevention Research Center AzPRC	Tucson, AZ	College/University
Arizona Department of Health Services (ADHS)	Phoenix, AZ	Government
Northern Arizona University Center for Health Equity Research	Flagstaff, AZ	College/University

Grantee Contact Information

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Arkansas

1st Choice Healthcare, Inc.
Northeast Arkansas Opioid Coalition

P10RH33034

Primary Project Focus Area: Substance Abuse/Addition-Opioid

Network Description

Northeast Arkansas Opioid Coalition (NAOC) was conceived in November 2018 to implement a collective effort to address the opioid epidemic in a six-county region of northeastern Arkansas. Founding Members have structured the coalition by formalizing Governing Rules and developing a Membership Application for Advisory Members. Six county-wide meetings were conducted to broaden the existing coalition with a wide array of advisory members.

NAOC stakeholders are addressing the impact of the opioid epidemic and serve as a safety net in the communities. Each member has a mutual commitment in carrying out the planning activities, as evidenced by prior collaborative successes and the expertise they bring. These partners include 1st Choice Healthcare, Inc. (Federally Qualified Health Center), Piggott Community Hospital (Critical Access Hospital), Mid-South Health Systems (Community Mental Health Center), and Arkansas Methodist Medical Center.

Program Description

The mission of NAOC is to complete a six-step planning process culminating in the development of a stakeholder-driven Strategic Plan that sets forth reality-based, sustainable strategies to increase access to quality Opioid Use Disorder (OUD) services. This goal is supported by five complementary strategies: 1) broaden NAOCs membership beyond the four Founding Members to include a wide array of participants including hospitals, physicians, clinics, social service organizations, public health, law enforcement, faith-based entities, and the recovery community; 2) create documents to formalize the organization to include the development of a membership process and governing laws; 3) develop an inventory of existing opioid resources within the six-county region to include opioid education, prevention, treatment, and aftercare services; 4) complete a Gap Analysis to identify shortfalls in needed services and develop a preliminary plan to increase access to those services; and 5) develop a web-based and hard-copy directory of services available to in each county.

Region Covered by Network Services

County, State	County, State
Clay County, AR	Fulton County, AR
Greene County, AR	Lawrence County, AR
Randolph County, AR	Sharp County, AR

Network Partners

Organization	City, State	Organization Type
1st Choice Healthcare, Inc.	Corning, AR	Federally Qualified Health Center (FQHC)
Mid-South Health Systems	Jonesboro, AR	Behavioral Health
Arkansas Methodist Medical Center	Paragould, AR	Hospital
Piggott Community Hospital	Piggott, AR	Critical Access Hospital (CAH)

Grantee Contact Information

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Organization Type	Federally Qualified Health Center
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Website	www.naoc.com

Arkansas

University of Arkansas Winthrop Rockefeller Institute
The Arkansas Rural Health Network Initiative

P10RH33056

Primary Project Focus Area: Network Organization/ Infrastructure Development

Other Focus Areas: Health Education
Increase Health System Efficiencies

Network Description

The beginning of our network was formed at the 2017 Rural Health Summit (RHS), held at the Winthrop Rockefeller Institute in Morrilton, AR., which was a convening of leaders from organizations working at various points in the rural health ecosystem in the state of Arkansas. The 2017 RHS was a chance to take a look at what shared issues existed in the rural health care space in Arkansas, under certain criteria. Those criteria were that the issues or challenges could be acted on, if not solved, within two to three years; required collaborative effort to overcome; and, addressed true gaps in health care delivery not currently being substantively worked on. To parse through the over 140 unique issues produced at the 2017 RHS, the Summit attendees selected a twelve-person Rural Health Summit COMMITtee. Over two more years of Summits, the Summit network and the COMMITtee have created a consortium among the three medical schools in the state, a comprehensive guide to available school programs providing a pathway to medical careers, a pilot certificate program for community health workers in the state, and a focused patient utilization survey for rural non-emergent transportation needs.

The Rural Health Summit COMMITtee represent many major health organizations and state agencies. Between their expertise and their connections to the growing Summit network, it made perfect sense to turn to many long-term COMMITtee members to form the base partnership in our network planning. We have nine organizations as our designated partners in building up our network including an FQHC, two medical schools, several non-profit organizations, an EMS provider, a regional hospital network, community health centers, and community health workers. Combined, our organizational partners have a steady presence in sixty-one out of seventy-five Arkansas counties. With the intent to create a network that can serve as a state-wide support organization for collaborations and partnerships, it is extremely beneficial to have core planning partners that have established reach across the state. Additionally, they bring the combined knowledge of working in the many different regions of Arkansas and the existing community connections they share.

Program Description

The programmatic focus of our planning effort is to build and develop our network organization and infrastructure to form a stand-alone support organization that is the major coordinator of rural health initiatives in Arkansas. The immediate programmatic areas that need to be supported by our network relate to health education, increasing efficiencies, and workforce development. We have chosen these priorities after continual examination of the rural health landscape during each yearly Rural Health Summit. While there are great efforts occurring regionally and at the community level around our state, there is no one organization looking holistically at those efforts and the connections between them. Consequently, there is a lack of statewide sharing of best practices, new collaborations, and collective advocacy occurring across differing fields and programs in rural Arkansas health care.

As we recognize that any lasting organization hoping to support collaboration must be built collaboratively itself, we

are looking beyond just the expertise of our planning partners and the RHS COMMITtee as we continue to develop our network's independent organization. In response to guidance from our Summit members during their 2019 Summit, we are adding more Arkansas health organizations and programs to our planning process. These represent industries and agencies that would work closely with our network organization that haven't been part of our COMMITtee thus far. We are also looking outside the state of Arkansas and receiving guidance and organizational models from State Rural Health Associations and the National Rural Health Association. As Arkansas is currently without an organization acting as a State Rural Health Association, our hope is to have our network organization fill that role, connecting Arkansas to numerous outside resources and expertise and to a national advocacy platform for rural health issues facing the state. By connecting to State Rural Health Associations, we are able to compare organizational structures with differing levels of impact and overall best practices. We seek to combine the specific knowledge of our in-state collaborators and the outside guidance of established networks to create the best possible foundation for our network organization, ensuring it can accomplish our long-term goals.

Region Covered by Network Services

County, State	County, State
Ashley County, AR	Cross County, AR
Benton County, AR	Drew County, AR
Calhoun County, AR	Franklin County, AR
Chicot County, AR	Garland County, AR
Clark County, AR	Hempstead County, AR
Craighead County, AR	Jefferson County, AR
Crittenden County, AR	Johnson County, AR

Network Partners

Organization	City, State	Organization Type
Winthrop Rockefeller Institute	Morrilton, AR	Non-Profit
ARCare	Augusta, AR	Federally Qualified Health Center (FQHC)
Arkansas College of Osteopathic Medicine	Fort Smith, AR	College/University
Arkansas Rural Health Partnership	Lake Village, AR	Non-Profit
Arkansas Community Health Workers Association	Little Rock, AR	Non-Profit
Community Health Centers of Arkansas, Inc.	Little Rock, AR	Non-Profit
Metropolitan Emergency Medical Services	Little Rock, AR	Emergency Medical Services (EMS)
University of Arkansas for Medical Sciences - Regional Programs	Little Rock, AR	College/University
University of Arkansas for Medical Sciences - Institute for Digital Health & Innovation	Little Rock, AR	College/University

Grantee Contact Information

Name	Payton Christenberry
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E-mail	PChristenberry@uawri.org
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Arkansas

White River Health System
Arkansas Community Health Network (ACHN)

P10RH33058

Primary Project Focus Area: Network Organization/Infrastructure Development

Other Focus Areas: Behavioral Health
Integrated Health Services
Substance Abuse/Addition-Opioid
Telehealth

Network Description

The consortium is composed of four independent health systems in north central Arkansas, which serves a population of approximately 385,000 across seventeen rural counties. Fifteen of the seventeen counties are designated Primary Care Health Professional Shortage Areas. All seventeen targeted counties are designated mental health professional shortage and medically underserved rural areas. The four health systems include acute care hospitals, critical access hospitals, rural health clinics, primary and specialty services, and behavioral health services. Each system operates a clinically integrated network of providers. Combined, the consortium represents the major healthcare providers for this seventeen-county rural area. Trusted relationships amongst system leaders, shared industry knowledge and experience, common rural service area needs and challenges, and similar organizational and governance structures are a few of the factors that led to this partnership.

The consortium began forming in 2017 for the following purposes: (i) improving efficiencies and reducing the rising cost of health care, (ii) enhancing patient access to and the quality of health care, (iii) improving the delivery, coordination, and transition of health care, including the exchange of electronic information and data management, (iv) bettering population health and patient experience, (v) accommodating new, innovative, and alternative programs and arrangements for health care delivery and payments, (vi) helping to provide relief to the poor and distressed or the underprivileged. The consortium has engaged in several initiatives including (i) membership in an Arkansas provider-led entity for behavioral health and developmentally disabled Medicaid beneficiaries, (ii) response to the opioid epidemic, (iii) certain efficiency efforts. The consortium created a Limited Liability Corporation to be the locus for further consortium development.

Program Description

White River Health System (WRHS) intends to use the HRSA grant funds to plan for the development of Arkansas Community Health Network (ACHN), a rural health network, with the aim of transforming health care delivery into a patient and value-driven system by (i) expanding access to primary care, (ii) improving access to mental/behavioral healthcare, including substance abuse treatment, (iii) improving access to quality and specialty healthcare, (iv) adopting and increasing the appropriate utilization of telehealth and other health information technologies.

Our approach to and the primary goals/objectives of network planning are to (i) identify barriers to accessing and receiving healthcare, as well as strategies to reduce or mitigate such barriers; (ii) identify technologies, such as telehealth, which expand and extend current resources; (iii) explore potential opportunities and strategies for needed collaboration, sharing of resources, joint programming/services; and (iv) determine if Integrated Medical Behavioral Health or other emerging “whole person primary care” models, including telehealth, are a practical model for increasing access to primary healthcare and mental/behavioral health services, including substance use disorder.

Region Covered by Network Services

County, State	County, State
Baxter, AR	Marion, AR
Boone, AR	Newton, AR
Carroll, AR	Prairie, AR
Cleburne, AR	Searcy, AR
Fulton, AR	Sharp, AR
Independence, AR	Stone, AR
Izard, AR	White, AR
Jackson, AR	Woodruff, AR
Lawrence, AR	

Network Partners

Organization	City, State	Organization Type
White River Health System, including White River Med Ctr & Stone County Med Ctr	Batesville, AR Mountain View, AR	Hospital
Baxter Regional Health System, including Baxter Regional Medical Center	Mountain Home, AR	Hospital
North Arkansas Medical System, including North Arkansas Regional Medical Center	Harrison, AR	Hospital
Unity Health, including White County Medical Center & Harris Medical Center	Searcy, AR Newport, AR	Hospital

Grantee Contact Information

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Organization Type	Healthcare System
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Colorado

Mountain Family Health Center
West Mountain Regional Health Alliance

P10RH33050

Primary Project Focus Area: Network Organization/Infrastructure Development

Other Focus Areas:
Behavioral Health
Increase Health System Efficiencies
Integrated Health Services
Population Health/Social Determinants of Health

Network Description

West Mountain Regional Health Alliance (WMRHA) formed in 2010 to address an access gap for prenatal care for low-income women, which resulted in a collaborative Pitkin/Eagle County Program. This success highlighted the need to continue, and then in 2015, WMRHA became its own 501(c)(3) organization. Since then WMRHA has accomplished much, including: creation of a common Health Information Exchange through QHN, expanded access to health insurance through Connect for Health Colorado, Thriving Colorado Dashboard Region 12 implementation, working on a social needs screening and navigation for those experiencing social determinant of health needs, and convened and lead facilitating an action plan for permanent supportive housing. All of WMRHA's programs uphold its values and strive to accomplish its mission to build an integrated health care system to achieve optimal health for all people who live in the western region.

WMRHA is comprised of thirteen board members and over forty partners working together to complete its mission to build an integrated health care system. The WMRHA Board is comprised of decision-makers who provide services in the region. WMRHA brings together multi-sector stakeholders, organizations, and community members to set direction, align efforts, and set strategy. WMRHA members and partners are comprised from the region with health sectors, government, community organizations, and more including all the region's FQHC, health organizations, local public health agencies (LPHAs), health insurance, schools, and other non-profit safety-net agencies to work together to address health and the social determinants of health. The wide variety of partners and stakeholders for WMRHA allows the organization to work with multi-disciplinary projects and connect related resources, all in the hope to create an integrated community health system.

Program Description

The goal of West Mountain Regional Health Alliance is to create an integrated health care system to achieve optimal health for those within our region. To attain the goal WMRHA works to align all health providers, partners, and initiatives in the West Mountain region to build an integrated and comprehensive health system. Advocate for affordable, integrated medical, behavioral, and dental health care and social determinant supports in the West Mountain region's health system. The key is to improve access to a continuum of affordable, high quality, integrated medical, behavioral, and dental health care and social determinant supports for the medically underserved residents of the West Mountain region.

WMRHA works to build a better system of care. To accomplish this WMRHA is working on initiatives including Care Coordination Capacity Building, Thriving Colorado (West Mountain) Regional Data Dashboard, Accountable Health

Community Model Social Needs Screening and Navigation, Zero Suicide Initiatives, regional goal setting with the Regional Accountable Entity (RAE) and the Hospital Transformation Program (HTP). In the past year, WMRHA focused on education about housing and health, and initiated a Regional Housing Data Assessment Supplement to look at the housing and health needs for vulnerable populations. This report demonstrates a clear need for Supportive Housing for homeless or housing insecure individuals who also have a co-occurring mental health illness disability. WMRHA collaborates with partner organizations to improve integrated health (physical, behavioral, oral, and social).

Region Covered by Network Services

County, State	County, State
Garfield County, CO	Pitkin County, CO
Eagle County, CO	

Network Partners

Organization	City, State	Organization Type
Mountain Family Health Center	Glenwood Springs, CO	Federally Qualified Health Center (FQHC)
Valley Health Alliance	Basalt, CO	Non-Profit
Mind Springs Health	Glenwood Springs, CO	Behavioral Health
Quality Health Network	Grand Junction, CO	Non-Profit
Pitkin County Public Health	Aspen, CO	Public Health
Rocky Mountain Health Plans	Grand Junction, CO	Other
University of Denver – Western Colorado	Glenwood Springs, CO	College/University
Garfield County Human Services	Rifle, CO	Government
Eagle County Public Health	Eagle, CO	Public Health
Aspen Valley Hospital	Aspen, CO	Hospital
Grand River Hospital	Rifle, CO	Hospital
Vail Health	Vail, CO	Hospital
Valley View Hospital	Glenwood Springs, CO	Hospital

Grantee Contact Information

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Organization Type	Non-Profit
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Website	www.westmountainhealthalliance.org

Colorado

Southeast Health Group
CO Behavioral Health Training Cooperative

P10RH33053

Primary Project Focus Area: Behavioral Health

Other Focus Areas: Mental Illness/Mental Health Services
Obesity-Childhood
School Based Health Services
Workforce Development

Special Populations: Children/Adolescents

Network Description

The Colorado Behavioral Health Training Cooperative brings together agencies that serve rural, low income, underserved, and diverse communities to augment and expand the training of postgraduate behavioral health professionals. The members of the cooperative work together to enhance coordination across the healthcare agencies that serve as cooperative partners to improve patient care via resource sharing, information sharing, educational training and supervision, and an enhanced focus on quality standards. The Training Cooperative currently includes three agencies: Southeast Health Group, Rocky Ford School District, and Maria Droste Counseling Center. Southeast Health Group is a private nonprofit corporation providing mental health, substance use disorder, primary care, physical therapy, peer, and wellness services to patients across six rural and frontier Colorado counties. Southeast provides twenty-four hour, seven-day-a-week behavioral health crisis intervention and assessment. Rocky Ford School District serves a diverse population of students in the high plains of Southeastern Colorado. The mission of Rocky Ford School District is to ensure individual success and learning of all students, within a safe environment. Maria Droste Counseling Center was founded to bridge the gaps in available mental health care for underserved, economically disadvantaged populations. Maria Droste's mission is to serve people who need access to counseling regardless of their ability to pay. Maria Droste has a longstanding behavioral health training program to provide training to currently enrolled graduate students and prelicensure behavioral health graduates.

Program Description

The Colorado Behavioral Health Training Cooperative is a multidisciplinary behavioral health postgraduate training cooperative that brings together the resources and faculty of three Colorado-based entities to improve the accessibility of mental health care and substance use treatment in rural and underserved areas of Colorado and to increase the number of behavioral health care providers serving rural and underserved populations. Specifically, the cooperative seeks to expand an existing postgraduate behavioral health training program at one agency to benefit the rural and underserved populations served by the other agencies in the network. The agencies have formed a planning committee comprised of key staff from each agency as well as consultants from Clover Educational Consulting Group, experts in the field of behavioral health training program development. As a new network, the planning committee is focused on establishing, developing, and formalizing the training cooperative as well as planning for future, long-term implementation of activities in order to meet the project's long-term goals. The

planning year allows the planning committee to build the training program's foundation, establish policies and procedures, and recruit post-graduate level trainees to start benefitting when the program goes live the following year.

Region Covered by Network Services

County, State	County, State
Otero County, CO	Adams County, CO
Baca County, CO	Arapahoe County, CO
Crowley County, CO	Broomfield County, CO
Kiowa County, CO	Denver County, CO
Prowers County, CO	Douglas County, CO
Bent County, CO	Jefferson County, CO

Network Partners

Organization	City, State	Organization Type
Maria Droste Services of Colorado	Denver, CO	Behavioral Health
Southeast Mental Health Services	La Junta, CO	Behavioral Health
Rocky Ford School District	Rocky Ford, CO	School System

Grantee Contact Information

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Colorado

The Memorial Hospital (DBA: Memorial Regional Health) Moffat County Mental Wellness

P10RH33049

Primary Project Focus Area: Mental Illness/Mental Health Services

Other Focus Areas:
Behavioral Health
Network Organization/Infrastructure Development
Substance Abuse/Addition-Opioid
Substance Abuse/Addiction-Other than Opioid

Network Description

Memorial Regional Health (MRH), a health system with a Critical Access Hospital (CAH) and Rural Health Clinics (RHC's), formed this consortium in 2018 as a response to the Northwestern Colorado region's increase in high-frequency users of emergency department and county jail services for chronic substance use disorders, mental health diagnoses, and/or complex medical conditions. Initially, the network included Moffat County Sheriff's Office, a law enforcement agency in the state's second-largest county for geographic size, and Mind Springs Health, the largest behavioral health services organization on the Western Slope. MRH has expanded the group with the following entities: the Craig Police Department, a law enforcement entity in the Moffat County hub of Craig; Providence Recovery Services, a new Comprehensive Treatment Program (CTP) and recovery center for addiction in Craig with an Intensive Outpatient Program (IOP), a Partial Hospitalization Program (PHP), medication-assisted treatment (MAT), individual and group counseling, peer recovery coaching, a sober living component, discharge planning, and wilderness retreat therapy; and Open Heart Advocates, a Craig nonprofit and the sole provider of free, confidential services for victims of crime, domestic violence, sexual assault, human trafficking, and other forms of interpersonal violence. Ultimately, these partners share close variations of MRH's mission, which is to improve the quality of life for the communities of Northwestern Colorado. These partners also share MRH's expertise in local issues. Every day, MRH's emergency department and primary care providers strive to help people suffering from mental health disorders, complex medical conditions, and/or substance abuse problems, including opioid addiction. Staff in the county jail deal with similar issues each day. The partner organizations in this project will work together throughout the grant term to best address the multiple unmet needs in Moffat County's population. As MRH operates for the people of Moffat, northern Rio Blanco, western Routt, southern Carbon County (WY), and eastern Uintah County (Utah), this project will seek to reach the people of these counties.

The consortium's accomplishments thus far have centered on the recruitment, hiring, and training of two peer recovery specialists, as well as eventual network expansion beyond Moffat County. The collaborative group recently hired two peer recovery specialists, one of whom is dedicated to working closely with Mind Springs Health for mental health services, while the other is coordinating extensively with Providence Recovery Services for addiction and substance abuse services. These peer recovery specialists are receiving extensive training from Mind Springs Health's peer support program. Finally, the partner entities have taken preliminary steps to expand the network across Northwestern Colorado. In late September, MRH and its partners are hosting a kickoff meeting for potential new partners—including law enforcement, behavioral health, healthcare, prevention, substance abuse, criminal justice, and other entities—to expand the existing network after the grant term in Garfield, Grand, Jackson, Moffat, Rio Blanco, and Routt counties.

Program Description

Through its work for Northwestern Colorado residents with chronic substance use disorders, mental health issues, and/or complex medical conditions, this consortium is operating through the lens of the following focus areas: 1. Achieve efficiencies; 2. Expand access to, coordinate, and improve the quality of essential healthcare services; and 3. Strengthen the rural healthcare system as a whole. Like many parts of rural and frontier Colorado, Northwestern Colorado is struggling to keep pace with the rapid expansion of mental health, substance abuse, and complex medical issues affecting its residents. These problems are multipronged and cut deeply into local communities. Moffat County, for example, which spans more than 4,700 square miles and is home to 13,109 people, has one part-time licensed psychiatrist, does not have a clinical psychologist or psychiatric nurse practitioner, and has only a select few organizations with licensed behavioral health counselors. Mind Springs Health, which operates in 13 counties across Western Colorado, has four licensed behavioral health specialists at its branch in Craig. The county also does not have an in-patient mental health facility. In addition to the area's dearth of providers and treatment options, many residents view mental health services with longstanding resistance. A conservative region built around agriculture, coal mining, oil and gas, and other energy sectors, Moffat County often lags behind the state norms for healthcare innovations and use. Further, Northwestern Colorado has an opioid prescription rate of 8.0 percent, which is higher than both the statewide (7.4 percent) and national (5.7 percent) averages. The area also has a suicide rate of twenty-nine people per 100,000 population, which more than doubles the national average (13.5 people per 100,000). Ultimately, mental health and substance abuse issues, including with opioids, are affecting residents of all ages in Jackson, Moffat, Rio Blanco, and Routt counties. As a result, too many locals rely strictly on emergency department and county jail services for healthcare and mental health issues, a process that strains the resources of local healthcare, behavioral health, law enforcement, and other entities.

Recovery-Oriented System of Care (ROSOC) is serving as the consortium's evidence-based model for this project. ROSOC, which originated in Mendocino County, CA, combines the power of medical providers and law enforcement to help adults in who regularly use jail services and emergency departments for issues with complex medical conditions, mental health diagnoses, and/or chronic substance use disorders. For its community-based program in Moffat County, Memorial Regional Health and its partners have tailored the ROSOC model to include certified peer recovery support. ROSOC creates biopsychosocial profiles, assists patients with needs within the framework of social determinants such as income and housing, provides close case management, supports patient acquisition of services, and engages in collaboration with law enforcement to reduce recidivism and incarceration. Overall, this consortium is relying on extensive coordination among the MRH health system, local behavioral health providers, and local law enforcement agencies, including the county jail, to develop new and expand existing capacity for services, primarily through community outreach and engagement, enhanced referral processes to local primary care and behavioral health services, and the addition of the two peer recovery specialists. The Certified Peer Specialists are currently receiving the training necessary to incorporate the ROSOC model in coordination with project partners.

Region Covered by Network Services

County, State	County, State
Moffat, CO	Uintah, UT
Rio Blanco, CO	Carbon, WY
Routt, CO	

Network Partners

Organization	City, State	Organization Type
Memorial Regional Health	Craig, CO	Critical Access Hospital (CAH)
Moffat County Sheriff's Office	Craig, CO	Law Enforcement
Craig Police Department	Craig, CO	Law Enforcement
Mind Springs Health	Craig, CO	Behavioral Health
Providence Recovery Services	Craig, CO	Other
Open Heart Advocates	Craig, CO	Non-Profit

Grantee Contact Information

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Organization Type	Critical Access Hospital and Rural Health Clinics (Health System)
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Florida

St. Johns River Rural Health Network
Putnam County Care Connect

P10RH33054

Primary Project Focus Area: Behavioral Health

Other Focus Areas:
Increase Health System Efficiencies
Mental Illness/Mental Health Services
Substance Abuse/Addiction-Opioid
Telepsychology

Network Description

The Putnam County Care Connect (PC3) is formative network created to address behavioral health through the implementation of telepsychology services in rural Putnam County Florida. The PC3 consists of three core members: St. Johns River Rural Health Network, Health Planning Council of Northeast Florida, and SMA Behavioral Healthcare. The St. Johns River Rural Health Network (SJRRHN), the lead applicant, is one of eight state-certified regional rural health networks established as an independent 501(c)3 non-profit organizations in 1994 serving a seven-county region in the northeast Florida corridor. SJRRHN supports, connects, and facilitates partnerships and initiatives to improve health in rural communities. SJRRHN partners include emergency medical services, public health departments, federally qualified health centers and faith-based organizations. By working collectively, the SJRRHN achieves greater impact in addressing the health needs of our rural communities. The Health Planning Council of Northeast Florida (HPCNEF) provides health data assessments and strategic planning to a seven-county region in the northeast Florida corridor. Health education, promotion and awareness programs are HPCNEF's key tenets in community collaboration and strategic planning to improve health outcomes. HPCNEF has the full support of WellFlorida Council, the Local Health Council mandated to serve Putnam County.

SMA Healthcare (SMA) serves a four-county area that includes Flagler, Putnam, St. Johns, and Volusia counties. SMA is the largest and most comprehensive provider of behavioral health services for this service area. SMA's Putnam Care Center provides a number of behavioral health services on site and refers to other behavioral health programs offered by SMA and other behavioral health agencies in adjacent counties. SMA has a 24/7 detoxification unit managed by a Director of Nursing, a licensed ARNP, who supervises a staff of registered and licensed practical nurses. Services include a Crisis Triage and Treatment Unit for persons in mental health crisis, adult or child Medication Management, an adult or child Outpatient Substance Abuse Counseling, and Targeted Case Management. SMA's Crisis Stabilization Unit, Detox Unit, and Residential Substance Abuse Treatment programs are located in nearby Volusia and Flagler counties and receive client referrals for behavioral health services.

Program Description

The Putnam County Care Connect (PC3) was created to align resources and strategies, achieve efficiencies, and address challenges in providing behavioral health care services in Putnam County, Florida. In 2018, the County ranked sixty-seven out of sixty-seven counties in Florida by the Robert Wood Johnson Foundation in overall health and in several other health indicators. PC3's focus is to strengthen the current behavioral healthcare system by

enhancing community relationships and promoting network activities. PC3 addresses the clinical priorities of mental health and substance abuse through increased use of data analytics and health information technology. The resulting efforts improve access to behavioral health services in Putnam County through the implementation and use of telepsychology.

As a Health Resources Services Administration designated Medically Underserved Population, the members of PC3 agree that telepsychology is the best way to address this and the Health Professional Shortage Area designation. Despite the easy access to major metropolitan areas, Putnam County needs substantial infrastructure improvements such as upgraded pipes for water and sewage and fiber optics for broadband services. Broadband services are essential for the implementation of telehealth services. The use of telehealth services would help reduce approximately eighty percent preventable hospital stays and greatly increase access to behavioral health services. PCWN's planning process includes a needs assessment and a review of the available telehealth platforms to implement telehealth services in Putnam County.

Region Covered by Network Services

County, State
Putnam County, FL

Network Partners

Organization	City, State	Organization Type
St. Johns River Rural Health Network	Palatka, FL	Non-Profit
SMA Behavioral Healthcare	Palatka, FL	Behavioral Health
Health Planning Council of Northeast Florida	Jacksonville, FL	Non-Profit

Grantee Contact Information

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Georgia

Glascock County Board of Education
Tri-County School Health Network

P10RH33044

Primary Project Focus Area: School Based Health Services

Other Focus Areas:
Behavioral Health
Health Education
Increase Health System Efficiencies
Network Organizational/Infrastructure Development

Special Populations: Children/Adolescents

Network Description

Our network members have been working together for more than eighteen years informally through involvement with their local Family Connection county collaboratives. We conceptualized the Tri-County School Health Network in early 2018 to focus on and formalize our efforts on school-based health services.

The area served by our network are the counties of Glascock, Taliaferro, and Warren. We decided to include all organizations that currently provide health care services in these three counties in the network. Our eight-member partnership provides representation from schools, community collaboratives, public health, and the district Federally Qualified Health Center (FQHC). These are appropriate partners for the work of our network. The three school systems serve one-hundred percent of our school aged children and are the ideal location to provide essential healthcare services. The Georgia Family Connection Partnership, represented by our collaborative partners, is the largest statewide network of communities in the nation that has made a commitment to improve results for families and children. Members of our local collaboratives include area business and educational leaders, local elected officials, faith-based and civic organizations, all existing healthcare organizations, public and private service providers, families, and other concerned citizens. Our collaborative partners have included and supported school health programs in their strategic plans. Each county health department is a legally mandated service of county and state government and currently provides very limited school-based health services. Community Health Systems, Inc. (our FQHC) has offices in each of our counties and is committed to eliminating health status disparities in their service areas.

Program Description

The programmatic focus of Tri-County School Network is to formalize and build capacity to create a network infrastructure to achieve efficiencies, expand access to, coordinate, and improve the quality of essential health care services for children residing in Glascock, Taliaferro, and Warren Counties, and to strengthen the rural health care system as a whole. The three counties that make up our service area are classified as rural and are among the most underserved in the nation. Many of our families do not seek medical care until they are in a crisis situation. None of our counties have a hospital, pediatrician, or access to adequate behavioral health services. Our school systems are the ideal location to provide essential health services to our children, many of whom have no other access to necessary health services. Therefore, our network's focus is school-based health services (including mental/behavioral health).

Tri-County School Heath Network meets regularly through monthly local network meetings, monthly regional network meetings, and quarterly capacity building training sessions in order to create a strong network infrastructure. The network is currently conducting a comprehensive health needs assessment through the distribution and collection of parent surveys, teacher/school system surveys, and Georgia student health surveys. Next month our three local project coordinators will conduct focus groups within their communities. By our regional meeting 10/21/19, survey analysis documents will be complied, providing the network with objective data to drive the network's strategic plan. Using the strategic plan, the network will support the three local school systems as they offer school-based health services. The network will ensure its future through the development of business and sustainability plans.

Region Covered by Network Services

County, State	County, State
Glascock, GA	Taliaferro, GA
Warren, GA	

Network Partners

Organization	City, State	Organization Type
Glascock County Board of Education	Gibson, GA	School System
Taliaferro County Board of Education	Crawfordville, GA	School System
Warren County Board of Education	Warrenton, GA	School System
Glascock County Family Connection and Communities in Schools of Glascock County	Gibson, GA	Collaborative
Taliaferro County Family Connection Collaborative	Crawfordville, GA	Collaborative
Warren County Family Connection and Communities in Schools of Warren County	Warrenton, GA	Collaborative
East Central Health District	Augusta, GA	Public Health
Community Heath Care Systems, Inc.	Gibson, GA	Federally Qualified Health Center (FQHC)
Community Health Care Systems, Inc.	Crawfordville, GA	Federally Qualified Health Center (FQHC)
Community Health Care Systems, Inc.	Warrenton, GA	Federally Qualified Health Center (FQHC)

Grantee Contact Information

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Illinois

Arukah Institute of Healing, Inc.

C4-Rural: Collaborative Complementary & Conventional Care for Rural Populations

P10RH33037

Primary Project Focus Area: Mental Illness/Mental Health Services

Other Focus Areas:
Behavioral Health
Increase Health System Efficiencies
Integrated Health Services
Network Organization/Infrastructure Development

Network Description

This effort forms a new collaborative care network, titled **C**ollaborative **C**omplementary and **C**onventional **C**are for Rural Populations (C4-Rural), that brings together an accomplished team of mental health providers, primary care providers, research scientists, healthcare administrators, complementary health practitioners and expert advisors that have no formal history of collaboration. Network activities aim to increase the capacity and quality of mental health services for underserved populations by working to remove barriers to care and leverage local resources through the integration of researched-based complementary medicine with conventional mental health and primary care medicine.

The five network members were selected based upon these criteria: (i) established histories, track records and reputations in communities; (ii) complementary combinations of expertise and knowledge to inform an impactful mental health-focused collaborative care network, and (iii) broadest patient reach in the catchment area. The desired working relationship among members is to improve communication, streamline patient care, and combine approaches for mental health treatment, all acting to improve the quality of mental health care overall. We recruited two rural hospitals, Perry Memorial Hospital (a critical access hospital) and St. Margaret's Health, which provide the vast majority of primary care services and have the greatest sphere of influence regarding patient care in the service area. Additionally, we have recruited Northcentral Behavioral Health, the premier conventional mental health provider in the area, and Gateway Services which hosts Open Doors Counseling group, who are conventional mental health providers for Medicaid patients and early adopters of evidence-based complementary and holistic approaches to psychotherapies. Importantly, all providers have rural health clinics or satellite offices in multiple locations within the catchment area, thus providing opportunities for decentralized implementation of the collaborative care model for enhanced patient access to services.

Program Description

The programmatic focus of this proposal revolves around integrating conventional mental health strategies with complementary health strategies in rural populations, in order to achieve the aims of achieving efficiencies and expanding access to coordinated and high-quality essential health care services. The programmatic focus was developed to combat gaps and socio-cultural barriers that prevent vulnerable rural patients from receiving adequate mental healthcare. Gaps include the inordinate social stigma surrounding mental illness in rural areas, the high rates of underinsured or uninsured patients, the general lack of education regarding personal mental health and wellness, and the lack of transportation or financial means to reach and use services. These are compounded

by social isolation in rural areas, which is a major risk factor for mental illness. The collaborative care model afforded by C4-Rural strives to integrate evidence-based complementary modalities with primary and conventional mental healthcare in a manner intended to promote innovative, evidence-based approaches to enhance care options for patients, all with the goal of reducing costs, improving access to care, and improving mental health outcomes.

Our approach to implementing the C4-Rural program is to leverage the safe, effective, and affordable treatment modalities of integrative care in parallel with prevention and overall wellness. At the core of collaborative/integrative medicine is a paradigm shift to understand patients, and in our case, rural patients, in new ways. Our program is committed to build into our rural communities and practice paradigms the fundamental truth that each individual patient has innate capacity for healing that can be fostered through integrative care, providing mind and body wellness in parallel with conventional treatment and therapeutics. The C4-Rural Program involves cohesive and multi-faceted planning activities, including building capacity of network partners; identifying/implementing referral networks and billing structure to support collaborative care; developing strategies for integrating a novel mHealth app-based data management system; minimizing barriers for patient access; determining the roles of providers across the continuum of care; creating standards for integration of complementary care into conventional treatment; educating both the community and clinicians; and ultimately testing the new collaborative model with a pilot feasibility study to increase buy-in of stakeholders.

Region Covered by Network Services

County, State	County, State
Bureau County, IL	Putnam County, IL
Marshall County (village of Henry only), IL	

Network Partners

Organization	City, State	Organization Type
Arukah Institute of Healing	Princeton, IL	Non-Profit
St. Margaret's Health	Spring Valley, IL	Hospital
Perry Memorial Hospital	Princeton, IL	Hospital
North Central Behavioral Health Services	LaSalle, IL	Behavioral Health
Gateway Services	Princeton, IL	Behavioral Health

Grantee Contact Information

Name	Sarah B. Scruggs, PhD
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Iowa

Avera Health
Emmet County Behavioral Health Network
P10RH33038

Primary Project Focus Area: Mental Illness/Mental Health Services

Other Focus Areas: Behavioral Health

Network Description

The Emmet County Behavioral Health Network is a formal gathering of three distinct entities in the Emmet County area that seek to involve the community in expanding access to health care and strengthen the rural health care system especially in regards to mental health.

The Network is composed of three local entities: Avera Holy Family, Emmet County Public Health, and the Estherville Lincoln School District. The Network will help to identify the specific behavioral health needs in Emmet County, Iowa, and coordinate a multi-organizational response to the health crisis currently happening in the rural community.

Due to the number of suicide attempts in recent years, all three organizations concluded it was time for an intervention to prevent further suicides.

Program Description

The Emmet County Behavioral Health Network seeks to conduct planning and assessment activities to identify specific behavioral health needs of the target area and coordinate a multi-organizational response that will increase available health resources to impact the area residents positively.

The best/promising practices have yet to be discovered due to being in the planning phase of the project. The understanding is that we will research standard methods in rural areas in regards to mental health. The listening sessions will occur as well as questionnaires to get community-wide input. When all the data is gathered and analyzed, the Network will report the findings and create a plan of action.

Region Covered by Network Services

County, State
Emmet County, IA

Network Partners

Organization	City, State	Organization Type
Avera Holy Family Hospital	Estherville, IA	Hospital
Emmet County Public Health	Estherville, IA	Public Health
Estherville Lincoln School District	Estherville, IA	School System

Grantee Contact Information

Name	Joseph M. May
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KENTUCKY

Livingston Hospital and Healthcare Services, Inc.
LCL Health Alliance

P10RH33048

Primary Project Focus Area: Network Organization/Infrastructure Development

Other Focus Areas: Behavioral Health
Substance Abuse/Addiction-Opioid
Substance Abuse/Addiction-Other than Opioid

Network Description

Several organizations within our area began meeting approximately February 2018, to establish and strengthen our relationships and to discuss how we can collaborate with each other to help meet each other's mission and goals. There are a total of twelve organizations, each with a health-related mission and each having strengths that partner organizations can tap into and learn from the other. After the first couple of meetings, we became aware of the Rural Health Network Planning Grant and reached out to the Kentucky Office of Rural Health as well as the Network Director for the Project Home Network in KY to learn more about the grant opportunity and experience of the Project Home Network and whether the collaborating partners would support applying for this grant opportunity. We also discussed preliminarily the top health related issues in our area that we would like to address after developing the foundation of our network. All the represented organizations fully supported applying for the grant and a subcommittee was formed to research and draft each section of the grant application. After the decision was jointly made to apply for the grant, the partnership was solely focused on strengthening the grant application. The types of organizations included in this network is representative of the full spectrum of healthcare available in the rural counties we serve. Specifically, partners include a hospital (the fiscal agent of the grant), several physician clinics, a behavioral health counselor, emergency medical services, public health department, American Heart Association, local school district, education foundation, hospital foundation and cooperative extension office. The communities we serve exhibit rural health disparities, including child poverty, opioid addiction, obesity and diabetes, older and sicker population with chronic diseases and little to no mental health access. The individuals representing these organizations are highly motivated, engrained in the community, and are committed to improving the communities we live and serve in.

Program Description

Our Rural Health Network Planning Grant focus is on our partnering organizations laying the foundation of our collaboration through planning activities, including 1) establishment of organizational bylaws, policies and procedures; 2) completion of a network self-assessment; creation of a comprehensive community needs report; 3) engagement in strategic planning grounded in evidence-based frameworks for development of our programs and projects. We intend to discuss and develop a plan to fully understand the breadth and depth of mental health and substance abuse in our communities.

Following advancement of network development activities, our focus becomes development of strategies to address mental health and substance abuse. Our initial goals are to increase 1) the number of local providers who offer quality behavioral, mental health and substance abuse care; 2) the number of local organizations who provide community health related support groups; and 3) patient access to quality behavioral, mental health and substance abuse care and support groups through identification and removal of barriers.

Region Covered by Network Services

County, State	County, State
Livingston County, KY	Crittenden County, KY
Lyon County, KY	

Network Partners

Organization	City, State	Organization Type
Livingston Hospital and Healthcare Services, Inc.	Salem, KY	Critical Access Hospital (CAH)
Grand Lakes Clinic	Grand Rivers, KY	Physicians' Clinic
Eddyville Family Medical Clinic	Eddyville, KY	Physicians' Clinic
Millstone Counseling	Paducah, KY	Behavioral Health
Livingston County School District	Smithland, KY	School System
Purchase Area Health Education Center	Murray, KY	Area Health Education Center
Livingston Hospital Foundation	Salem, KY	Philanthropy/Foundation
Livingston County Education Foundation	Smithland, KY	Philanthropy/Foundation
Pennyrile District Health Department	Eddyville, KY	Public Health
Livingston County UK Cooperative Extension Service	Smithland, KY	College/University
American Health Association	Paducah, KY	Other
Livingston County Emergency Medical Services	Smithland, KY	Emergency Medical Services (EMS)

Grantee Contact Information

Name	Elizabeth A. Snodgrass
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Organization	Livingston Hospital And Healthcare Services, Inc.
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Michigan

Central Michigan District Health Department
Central Michigan Regional Rural Health Network

P10RH33039

Primary Project Focus Areas: Behavioral Health

Other Focus Areas:
Mental Illness/Mental Health Services
Network Organization/Infrastructure Development
Substance Abuse/Addiction-Opioid
Substance Abuse/Addiction-Other than Opioid

Network Description

The Central Michigan Regional Rural Health Network (the Health Network) was created in June 2015 with the mission of working collectively to improve the health of and promote wellness among the nearly 190,000 community residents in the six rural central Michigan counties of Arenac, Clare, Gladwin, Isabella, Osceola, and Roscommon, as well as in neighboring communities in the region. The central Michigan region is medically underserved with many community members having poor health outcomes in comparison to other areas of the state and the nation. With the overall focus of increasing capacity to respond to identified health and human services needs, especially in the vulnerable and underserved populations in the region, Health Network members and participants support the mission of improving health and promoting wellness by participating in coordinated, collaborative planning efforts to strengthen the rural health care system as a whole. Goals include expanding access to and improvement of the quality and reach of integrated health care services and achieving efficiencies. Priority areas for health improvement include access to quality health care; behavioral health, including mental health, substance use disorders, and abuse and neglect; healthy lifestyles focusing on nutrition, physical activity, and access to recreation; maternal and child health; family health; reproductive and sexual health; older adult/geriatric health; and health professional workforce education, training, recruitment, and retention.

The Central Michigan Regional Rural Health Network comprises thirty-eight members and more than twenty-five additional participating community organizations serving health and human services needs in the region. With the Central Michigan District Health Department serving as the Lead Network Member, the Network includes: health care providers (including a public health authority; a health system; medical centers/hospitals, including critical access hospitals; federally qualified health centers; a rural health clinic; behavioral health providers, including a substance use disorder treatment provider; and an oral/dental health services provider); health-focused educational organizations and collaboratives and institutions of higher learning with health professions programs (including community colleges, universities, Michigan's land grant university, Area Health Education Centers, and Great Start Collaboratives); health and human services organizations and coalitions; the regional workforce development, Area Agency On Aging, and 2-1-1 systems; and a county transportation authority. Additional participants in the Health Network's activities include representatives from educational, health, law enforcement, judicial, governmental, legislative, economic development, and private sector systems and community members.

Program Description

The Central Michigan Regional Rural Health Network's Network Planning grant activities are focused upon planning to increase systems' capacity to provide integrated, person-centric care and increase the number of individuals accessing available capacity and to develop the Health Network infrastructure capacity. The Health Network's programmatic foci include: 1) developing trauma-informed systems and resilient communities; 2) providing harm

reduction-based care for people who misuse substances and those impacted by substance misuse; 3) encouraging healthy lifestyles; 4) improving maternal and child health; 5) enhancing person-centric, integrated health care services delivery by facilitating access to/use of health and human services capacities via new or enhanced delivery systems, such as increasing use of community health workers in integrated care systems and increasing use of emerging technologies, such as delivery via telehealth and online referral and response systems; and 6) expanding and extending the reach of regional health professional workforce education, training, recruitment, and retention activities.

The Central Michigan Regional Rural Health Network uses a multisector, collaborative approach synergizing the efforts of members and participants who are: serving community members directly and providing access to populations of focus; educating and training students and professionals from health, community services, and other sectors; and/or networking with local champions, county and regional networks, and state and national leaders. Health Network members and participants plan to develop strategies using traditional community health improvement planning processes that include process and outcome monitoring.

Region Covered by Network Services

County, State	County, State
Arenac County, MI	Isabella County, MI
Clare County, MI	Osceola County, MI
Gladwin County, MI	Roscommon County, MI

Network Partners

Organization	City, State	Organization Type
211 Northeast Michigan	Midland, MI	Critical Access Hospital (CAH)
Ascension Standish Hospital (formerly St. Mary's of Michigan Standish Hospital)	Standish, MI	Public Health
Central Michigan District Health Department	Mt. Pleasant, MI	Public Health
Central Michigan University College of Medicine	Mount Pleasant, MI	College/University
Central Michigan University - The Herbert H. and Grace A. Dow College of Health Professions	Mt. Pleasant, MI	College/University
Community Mental Health for Central Michigan	Mt. Pleasant, MI	Behavioral Health
Everyday Life Consulting, LLC	Beaverton, MI	Other
Ferris State University College of Health Professions	Big Rapids, MI	College/University
		Collaborative
Great Start Collaborative - Clare-Gladwin Regional Education School District	Clare, MI	Collaborative
Great Start Collaborative - Gratiot-Isabella Regional Education School District	Rosebush, MI	Collaborative
Isabella Citizens for Health, Inc.	Mt. Pleasant, MI	Federally Qualified Health Center (FQHC)
Kirtland Community College	Roscommon, MI	College/University
Life Choices of Central Michigan	Mt Pleasant, MI	Non-Profit
McLaren Central Michigan	Mt. Pleasant, MI	Hospital

Michigan Health Improvement Alliance, Inc.	Bay City, MI	Non-Profit
Michigan State University College of Human Medicine	East Lansing, MI	College/University
Michigan State University Extension	Cadillac, MI	Other
Michigan Works Region 7B Consortium	Harrison MI	Other
MidCentral Area Health Education Center	Mt. Pleasant, MI	Area Health Education Center
MidMichigan Community Action Agency	Farwell, MI	Non-Profit
MidMichigan Community College - Health Sciences	Harrison, MI	Select One
MidMichigan Community Health Services	Houghton Lake, MI	Federally Qualified Health Center (FQHC)
MidMichigan Health	Midland, MI	Other
MidMichigan Medical Center - Clare	Clare, MI	Hospital
MidMichigan Medical Center - Gladwin	Gladwin, MI	Hospital
MidMichigan Medical Center - Mt. Pleasant	Mt Pleasant, MI	Hospital
Munson Healthcare Grayling Hospital	Grayling, MI	Hospital
My Community Dental Centers	Stanton, MI	Oral Health
Northern Lower Regional Area Health Education Center	Houghton Lake, MI	Area Health Education Center
Recovery Pathways, LLC	Essexville, MI	Physicians' Clinic
Region VII Area Agency On Aging	Bay City, MI	Area Agency on Aging
Roscommon County Transportation Authority	Prudenville MI	Transportation
Rural Community Health Worker Network	Sanford, MI	Non-Profit
Senior Life Solutions/Psychiatric Medical Care, LLC	Gladwin, MI	Behavioral Health
Spectrum Health Reed City Hospital	Reed City, MI	Hospital
Sterling Area Health Center	Sterling, MI	Federally Qualified Health Center (FQHC)
Ten16 Recovery Network	Clare, MI	Non-Profit

Grantee Contact Information

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Michigan

Huron County
Thumb Community Health Partnership

P10RH33046

Primary Project Focus Areas: Increase Health System Efficiencies

Other Focus Areas:
Care Coordination
Integrated Health Services
Network Organization/Infrastructure Development
Population Health/Social Determinants of Health

Network Description

The Thumb Community Health Partnership was formed in response to fragmentation and isolated efforts around health needs assessment and population health. Partners had experience working together on specific projects but had made minimal efforts in creating a regional approach to improving population health outcomes. The region served by the partnership includes the area of the mitten shaped state of Michigan commonly referred to as the Thumb. This region includes Huron, Sanilac, Tuscola counties, and rural census tracts in Lapeer County. Partners met and agreed that forming a partnership that included agencies across sectors (public health, hospitals, primary care, behavioral health, and human services) would increase efficiencies within the system and result in improved community health. The current partners met two times in the fall of 2018. After the grant award, the partnership began meeting monthly. A team of contractors with needs assessment and collaboration expertise was assembled to lead the initiative forward.

All sixteen partners are represented on the decision-making body of the partnership. Membership includes four public health departments, three community mental health agencies, eight hospitals (seven of which are critical access hospitals), and one human service agency. During the project, the Partnership will use a workgroup structure to compile data, establish priorities, research strategies, and create a strategic plan. Four workgroups will be established and include a Data Workgroup, System Coordination Workgroup, Project Planning Team, and Outreach and Awareness Workgroup. The project will build capacity for implementing system wide improvements, moving forward regional projects, and improving quality of care across the care continuum.

Program Description

Presently the Thumb Community Health Partnership is focused on broad areas of improvement. The two main purposes of the project are to align community health assessment processes and to identify priorities for regional strategies. Through developing this network of providers, the Partnership will increase health efficiencies by moving toward coordinated and integrated care across multiple sectors. This work will result in improvements in population health outcomes. At the end of the planning project, the consortium will also have identified priority population health needs and strategies to address those needs. This focus was chosen because partners recognized a duplication of efforts related to community health assessments and a disconnected approach to addressing population health issues.

The partners will be conducting a regional needs assessment guided by the Mobilizing Action through Planning and Partnerships (MAPP) framework (National Association of County and City Health Officials). Strategy development will emphasize a comprehensive system change approach using frameworks such as ABLe Change (Foster-Fishman

and Watson, System Exchange, Michigan State University) and Collective Impact (Kania and Kramer, Stanford Social Innovation Review). Input from the community has already been gathered through individual needs assessment processes in 2018-2019. Based on emerging regional priorities, the Partnership will engage additional stakeholders and community members in root cause analysis processes and strategy development. As needed to address priorities additional organizations will be invited to become members of the partnership.

Region Covered by Network Services

County, State	County, State
Huron County, MI	Lapeer County, MI (rural census tracts)
Sanilac County, MI	Tuscola County, MI

Network Partners

Organization	City, State	Organization Type
Huron County Health Department	Bad Axe, MI	Public Health
Lapeer County Health Department	Lapeer, MI	Public Health
Sanilac County Health Department	Sandusky, MI	Public Health
Tuscola County Health Department	Caro, MI	Public Health
Lapeer Community Mental Health	Lapeer, MI	Behavioral Health
Sanilac Community Mental Health	Sandusky, MI	Behavioral Health
Tuscola Behavioral Health Services	Caro, MI	Behavioral Health
Deckerville Community Hospital	Deckerville, MI	Critical Access Hospital (CAH)
Harbor Beach Community Hospital	Harbor Beach, MI	Critical Access Hospital (CAH)
Hills and Dales General Hospital	Cass City, MI	Critical Access Hospital (CAH)
Marlette Regional Hospital	Marlette, MI	Critical Access Hospital (CAH)
McKenzie Health System	Sandusky, MI	Critical Access Hospital (CAH)
McLaren Hospital-Caro	Caro, MI	Critical Access Hospital (CAH)
McLaren Hospital-Lapeer	Lapeer, MI	Hospital
Scheurer Hospital	Pigeon, MI	Critical Access Hospital (CAH)
Human Development Commission	Caro, MI	Social Services Agency

Grantee Contact Information

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Missouri

Taney County Health Department
The Ozarks Wellness Network

P10RH33055

Primary Project Focus Area: Population Health/Social Determinants of Health

Other Focus Areas: Network Organizational/Infrastructure Development

Network Description

In the Tri-Lakes, we're more than a spot on the map. We're a community**.** A place where we care about each other. So, when the folks at Cox Medical Center Branson and the Taney County Health Department saw the results of the latest Community Health Needs Assessment, they knew it was time to take action: there are children and families in our area who don't know where to find their next meal; sometimes our meals aren't healthy, leading to unhealthy habits; substance abuse and mental health issues are going untreated; and our families have difficulties accessing healthcare.

All of these things threaten our families, our economic stability as a community, and our future in the Tri-Lakes. But even more than that, it means our neighbors are hurting, and that just can't go on**.** There are many great organizations in our community who work every day on these problems, but we found that we can do more when we pool our resources and work together**.** That's how OWN-it was born. The Ozarks Wellness Network is dedicated to promoting healthier and safer lifestyles and committed to working together to get more done. It's good for the community…and it's just the right thing to do.

The initial focus of the Ozarks Wellness Network (OWN-It) is to more effectively meet the health needs and social determinants of health for the two-county area of Stone and Taney in the Tri-Lakes Area of Missouri. We intend to continue this by adopting a collective impact model that encourages resource sharing, continuous communication, and data exchange.

Program Description

During the planning phase, the network will complete an operational and data substructure plan and conduct an ongoing assessment of and collection/monitoring of data to address community needs and social determinants of health. Specifically, local success measures related to the following Social Determinants of Health Categories:

- Demographics
- Food Environment
- Physical Activity
- Economic Stability
- Health/Healthcare
- Safety
- Education
- Housing
- Social/Community Context
- Employment
- Neighborhood/built environment
- Transportation/mobility

The primary focus of the planning effort is to develop a data substructure that allows for collection and monitoring

of relevant data at the zip-code level, with additional qualitative data uploaded to empower communities and neighborhoods to work together to improve indicators. The network will build a web-based dashboard to provide a platform where organizations and community members can view data and engage in efforts to drive change. The network expects to model efforts after work completed by the Springfield Community Focus Report that uses blue ribbons and red flags as indicators. The substructure will be modeled after Community Commons, a widely used tool for county, state and national-level comparison data. The data substructure will allow the network to facilitate local community processes to address specific priorities and social determinants of health.

This focus and approach are part of a long-term strategy to bring together committed partners in the two-county area to impact community health status and outcomes through standardized data, consensus on priorities and collaborative efforts focused on overarching health care issues and
social determinants of health.

Region Covered by Network Services

County, State	County, State
Taney County, MO	Stone County, MO

Network Partners

Organization	City, State	Organization Type
Taney County Health Department	Branson, MO	Public Health
Stone County Health Department	Galena, MO	Public Health
Cox Medical Center Branson	Branson, MO	Hospital
Christian Action Ministries	Branson, MO	Food Bank
Ozarks Wellness Network	Taney/Stone Counties, MO	Collaborative

Grantee Contact Information

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Missouri

West Central Missouri Community Action Agency
Rides to Health and Wealth Network

P10RH33057

Primary Project Focus Area: Network Organizational/Infrastructure Development

Other Focus Areas: Increase Health System Efficiencies
Population Health/Social Determinants of Health
Transportation

Network Description

The Rides to Health and Wealth Network is a set of health sector and social service partners who have committed, by memorandum of agreement, to developing a regional network operating structure and strategic plan for bringing the Missouri Rural Health Association's "HealthTran" medical rides system to rural west central Missouri. In May 2017, the group began exploring the public health and community development potential of using HealthTran's ride sourcing and scheduling model in the ten-county area to reduce missed appointments due to lack of transportation. Through this exploration, the Network has identified a range of interested parties, from hospitals to food pantries. The Network has also identified cross-cutting concerns, such as local governments, banks, and merchants interested in the ability of seniors to "age in place" with better rural transportation options.

Rides to Health and Wealth Network members span the range of direct interests and concerns that emerged during program exploration. Regional health system members are larger-scale "anchor institutions" that can help the Network establish and scale HealthTran regionally with scheduling by their hospitals and clinics. Ambulance district, home health, social service, and health department members represent community health interests and investments. Regional planning commission and community development corporation members bring the perspective of local government, business, and other stakeholders, such as schools.

Program Description

The Rides to Health and Wealth Network's programmatic focus is on reducing the number of people who miss appointments for preventative and follow up care (e.g., lab services, radiology, primary care, specialty care, therapies, etc.) due to lack of transportation. Missed appointments threaten both patient health and rural health provider sustainability. The Network has chosen the HealthTran model because it zeroes in on this double-edged access-to-care problem. HealthTran's initial 2014 pilot in southern Missouri demonstrated that every $1 a hospital invested in transportation assistance through the ride sourcing and scheduling system generated up to $10 in billable services. Getting patients in the door improves health outcomes along with provider revenue, which further benefits the rural health system by reducing emergency services usage and hospital readmissions.

The Network takes a regional approach to making HealthTran work for the range of rural transportation interests and cross-cutting social determinants of health. The Network will develop a community mobility coordination component to service the many independent health providers, social service agencies, and others, such as employers and the courts, that may wish to use HealthTran in addition to hospitals and clinics. This multi-sectoral regional approach addresses wellness needs beyond medical appointments, such as adding a stop at the farmers' market or grocery store for nutrition support. It also has the potential to keep participating ride providers busy and engaged, despite long distances and sparse rural population. Multiple users scheduling transportation through the

shared network system can sustain and grow the network of ride providers (transit, volunteers, fleets), which HealthTran organizes and supports (safety, payment etc.).

Region Covered by Network Services

County, State	County, State
Bates, MO	Hickory, MO
Benton, MO	Morgan, MO
Cass, MO	St. Clair, MO
Cedar, MO	Vernon, MO
Henry, MO	Polk, MO

Network Partners

Organization	City, State	Organization Type
West Central Missouri Community Action Agency	Appleton City, MO	Non-Profit
New Growth Community Development Corporation	Osceola, MO	Community Development Organization
Golden Valley Memorial Healthcare	Clinton, MO	Hospital
Nevada Regional Medical Center	Nevada, MO	Hospital
Kaysinger Basin Regional Planning Commission	Clinton, MO	Other
Polk County Health Department	Bolivar, MO	Public Health
On My Own	Nevada, MO	Home Health
Vernon County Health Department	Nevada, MO	Public Health
Vernon County Ambulance District	Nevada, MO	Transportation

Grantee Contact Information

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Nebraska

South Heartland District Health Department
Rural Behavior Health Network

P10RH33052

Primary Project Focus Area: Network Organizational/Infrastructure Development

Other Focus Areas: Behavioral Health
Mental Illness/Mental Health Services
Workforce Development

Network Description

In 2018, on the heels of a community health assessment where community stakeholders identified lack of adequate behavioral health service provision across the age span as a priority issue, South Heartland District Health Department invited key partners to join them in exploring opportunities for systematic change as a solution to ongoing behavior health needs in our rural communities. The purpose of the network is to develop and maintain a comprehensive mental health services system that empowers, educates and increases accessibility for members of our communities, facilitates smooth referrals among agencies, and improves the health of our population by reducing the incidence of preventable causes of mental illness. The developing network has secured commitment from five partners, was awarded a Rural Health Network Development Planning grant and began meeting to develop a mission statement and supporting infrastructure.

The network represents a four-county region covering 2,286 square miles in rural south-central Nebraska. The five network partners include: (1) the largest healthcare provider in the four-county area (a non-profit hospital) with inpatient and outpatient behavioral services, a clinic with integrated medical and behavioral health care, and behavioral services outreach through specialty clinics to help serve the rural region; (2) a nonprofit rural critical access hospital which has three rural health clinics and offers specialty clinics to include behavior health; (3) a private, nurse practitioner owned and operated health facility providing integrated medical and mental health services to a rural community; (4) a non-profit behavior health services organization providing services for outpatient mental health and substance use, adult intensive outpatient, and 24/7 adult and youth crisis; and (5) the regional public health department, with no direct behavioral health services, that is serving as the collaborative lead for the network. All partners contributed to the community health assessment, priority-setting, and strategy development processes that led to the creation of the region's new community health improvement plan for 2019-2024. This network brings together the most relevant services in the area to address regional behavioral health concerns.

Program Description

The South Heartland Rural Behavioral Health Network partners recognize that factors contributing to a lack of adequate mental health care include rurality, large geographic service area, changing population demographics, low median and per capita income, lack of trained and licensed behavioral health professionals, lack of training in evidence-based practices and lack of financial supports for treatment of behavioral health disorders. The network is focused on overhauling the local behavioral health system with workforce training and the translation of effective evidence-based practices into practice. Our approach is to (1) strengthen the new Network by developing partnership infrastructure, (2) conduct a multi-agency behavioral health needs assessment (BHNA) with input from

behavioral health users, primary care providers and behavioral health providers, (3) choose priorities based on the BHNA, and (4) create a joint behavioral health implementation plan which identifies opportunities for the Network to address local behavioral health patient and workforce needs. The behavioral health improvement plan will include evidence-based practices for each prioritized behavioral health strategic issue.

Region Covered by Network Services

County, State	County, State
Adams County, NE	Nuckolls County, NE
Clay County, NE	Webster County, NE

Network Partners

Organization	City, State	Organization Type
South Heartland District Health Department	Hastings, NE	Public Health
Mary Lanning Healthcare and The Lanning Center for Behavioral Services	Hastings, NE	Hospital
Brodstone Memorial Hospital	Superior, NE	Hospital
Quality Healthcare Clinic, LLC	Sutton, NE	Other: Integrated Medical and Behavioral health
South Central Behavioral Services	Hastings, NE	Behavioral Health

Grantee Contact Information

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New York

Council on Addictions and Recovery Services, Inc. (CAReS) Appalachia Substance Use Disorder and Mental Health Services Coalition

P10RH33042

Primary Project Focus Area: Mental Illness/Mental Health Services

Other Focus Areas: Network Organization/Infrastructure Development
Population Health/Social Determinants of Health
Substance Abuse/Addiction-Opioid

Network Description

The Appalachia Substance Use Disorder and Mental Health Services Coalition is currently an informal group of eight key organizations providing mental health, public health, and substance use disorder services in Allegany and Cattaraugus Counties, New York. The two-county rural service area has 124,252 residents, is located in western New York state and borders Pennsylvania to the south. It is designated as an Appalachian community by the federal Appalachian Regional Commission (ARC) and, like most Appalachian counties, it has hilly mountainous terrain which poses telecommunication and access to care difficulties. The Coalition is comprised of four not-for-profit organizations and four divisions of county governments which directly operate or fund critical services in the service area that influence health status.

Coalition partners have an extensive history of collaboration on an ad-hoc basis. All partners impact people at risk of or experiencing substance use disorders. Coalition partners are interested in developing programs which improve health, mental health or substance use status through a formal collaborative network infrastructure emphasizing multi-sector collaboration as a means to strengthen local systems of care. The Coalition is administered by the Council on Addiction and Recovery Services, Inc. (CAReS), the grant recipient.

Program Description

The rapid pace of the introduction of value-based payment mechanisms and the increased importance of the social determinants of health in New York State's Medicaid program is expected to have considerable influence on the Coalition's priorities. Ultimately, it is the intent of the project to plan to improve the efficiency, access, coordination, quality, and overall viability of the local system of services. Specific plans and objectives are to be defined for each of these aims and are a major deliverable for the community.

Our Rural Health Network Development Planning effort entails a series of inter-related activities which include:

1. Assessing organizational and environmental factors which influence the viability of local health, mental health, and substance use disorder services
2. Identifying the areas of most pressing or high priority needs
3. Developing a strategic plan addressing those priority needs
4. Defining, aligning, and operating a sustainable Coalition infrastructure consistent with priority needs which emphasizes collaboration as a major vehicle for change

Region Covered by Network Services

County, State	County, State
Allegany County, NY	Cattaraugus County, NY

Network Partners

Organization	City, State	Organization Type
Council on Addiction and Recovery Services, Inc. – CAReS	Olean, NY	Non-Profit
Allegany Council on Alcohol and Substance Abuse, Inc. - ACASA	Wellsville, NY	Non-Profit
Southern Tier Health Care System, Inc. - STHCS, Olean, NY	Olean, NY	Non-Profit
Allegany County Community Services	Wellsville, NY	Government
Allegany County Public Health	Belmont, NY	Public Health
Cattaraugus County Community Services	Olean, NY	Behavioral Health
Clarity Wellness Community, Inc. (new member)	Wellsville, NY	Behavioral Health
Cattaraugus County Public Health (new member)	Olean, NY	Public Health

Grantee Contact Information

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North Carolina

Granville Vance Public Health
Integrated Care Planning Network (ICPN) in Rural NC

P10RH33814

Primary Project Focus Area: Integrated Health Services

Other Focus Areas: Behavioral Health
Substance Abuse/Addiction-Opioid
Substance Abuse/Addiction-Other than Opioid

Network Description

Members of the ICTN were identified based on previous working relationships that evolved in recent years based on similar needs across communities. For example, a top health priority in Community Health Needs Assessments across the five-county area include mental health and substance use disorders. Also, these partners already work together on other related efforts, including the VIBRANT Coalition, a regional Stepping Up Initiative, and a Community Case Management Team that meets monthly to address social determinants of health referral options in the region. Cases are presented from the local hospital for the group to work on re-admission rates and assist high emergency department utilizers as a community of providers. Many of the needs addressed in the community case management group trace back to mental health and substance use disorder among patients who frequent the emergency department. It's a natural development for this proposed network to have some planning time to get the referral, treatment, and follow-up process organized and accessible within our system that right now doesn't meet the needs for this group of high-need patients. The network agencies include, but may not be limited to:

- Granville Vance Public Health (GVPH) is the two-county district health department providing prevention, public health, and primary care services to the community. GVPH will lead and monitor all aspects of the grant-funded program, provide staffing support for management, supervision, and health promotion services, and will direct regular communication exchange with the network members
- Recovery Innovations International (RII) is a global organization, offering services in Crisis, Health, Recovery and Consulting. RI focuses on these practices including; recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments to safety for consumers and staff, and collaboration with law enforcement.
- Alliance Rehabilitative Care (ARC), is responsible for assuring the delivery of community based mental health, mental retardation, substance abuse and/or behavioral health services to individuals with those disabilities and will be a valued connection to those who need additional types of treatment than what the other two agencies in the network can provide.
- Cardinal Innovations Healthcare is a community-focused, managed care organization serving over 850,000 people in North Carolina. Cardinal Innovations helps members and caregivers get access to mental and behavioral health services.

Program Description

GVPH will serve as collaborative leader and convener. We will assist clinical sites in obtaining baseline data and needs assessment and later in developing local policies and procedures to allow the implementation phase of the project (after the planning grant period) to be a success. Network activities will be communicated and integrated into individual network members' organizational activities though our collaborative meetings and site-specific planning meetings. High-level planning for the collaborative and five-county area as a whole will also occur during

these meetings. Data collected for individual counties will be shared at collaborative meetings in order to best plan interventions that will broadly fit different geographic sites. Planning for implementation at individual sites will be coordinated by GVPH staff members with particular attention to local needs and resources.

Increased care coordination and better access to quality health care services should result from the planning activities carried out by the network in a number of ways. The network intends to re-organize and improve the system of care to become more focused on value, quality and efficiency. It's always critical to form and maintain trusting relationships across different parts of a rural health system. This grant opportunity offers an important pause-plan-and-ponder time for providers that otherwise is rare in the busy world of competing priorities that rural, under-resourced and capacity-strapped agencies experience. With this resource, we can create a truly meaningful, innovative, and actionable plan to improve care in our local five-county community that will integrate and coordinate services.

By the end of the project period, we plan to have developed a functioning collaborative network focusing on strengthening the healthcare system in our rural area through partnerships. Our initial focus of expanding access to, coordination of, and improvement of the quality of essential health care services expanding access to Medication-Assisted Treatment (MAT) for OUD will serve as an opportunity to develop this network and perform a needs assessment and more detailed work plan. The final goal of the planning year is a generic roll-out plan for implementation of integrated care services in rural NC. We also hope to strengthen the relationships between our current MAT program and those at other rural sites through our relationship with Recovery Innovations International and other local behavioral health providers who specialize in the treatment of opioid use disorder and peer bridging services.

Region Covered by Network Services

County, State	County, State
Granville County, NC	Vance County, NC

Network Partners

Organization	City, State	Organization Type
Recovery Innovations International (RII)	Henderson, NC	Behavioral Health
Alliance Rehabilitative Care (ARC)	Henderson, NC	Behavioral Health
Meigs County Health Department	Henderson, NC	Behavioral Health
Granville Vance Public Health	Oxford, NC	Public Health

Grantee Contact Information

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Ohio

Hopewell Health Centers Inc.
Partnering to Achieve Compliance and Savings (PACS)

P10RH33045

Primary Project Focus Area: Reimbursement for Health Services

Other Focus Areas:
Care Coordination
Care Transitions
Chronic Disease Management-Diabetes
Chronic Disease Management-Other than Diabetes

Network Description

Our network, Partnering to Achieve Compliance and Savings (PACS), has grown out of previous work with Marshall University and the Appalachian Regional Commission. That work was focused on diabetes, and one major outcome of that work was the relationships that were developed with payer agencies. Because using Community Health Workers (CHWs) on patients whose diabetes was out of control was so successful (A1C reductions of between 2 and 3 points within 6 months; ROI estimated at 5:1), insurers are interested in participating in other efforts that involve CHWs and high-risk conditions.

Most of PACS membership comes from that work with Marshall University: The Washington, Athens, and Meigs County Health Departments, Hopewell Health Centers, United Healthcare, and The Health Plan. We have added Community Health Improvement Associates (CHIA), the Perry and Ross County Health Departments along with Molina because of their interest in the project. Health departments are well-positioned to work with insurers due to comparative ease in information sharing. Health departments also had the best clinical success in the work with diabetes when compared with other health system partners. Hopewell will supply the clinical support for the CHWs who work in the field.

Program Description

Past work by PACS members has demonstrated strong clinical evidence that peers have remarkable influence on the self-management habits of individuals suffering from chronic illness. While work is ongoing in other areas of Appalachia in demonstrating the cost savings to insurers using peers with diabetes, the model has likely implications for other high cost chronic illnesses, such as COPD, heart disease, recovery from addiction, childhood asthma, and more. The PACS consortium is being formed to test the peer support model on high cost conditions as identified by our insurance partners with the goal of developing reimbursement models that will support the continued employment of peers. Currently, no widespread insurance support of clinically based peers exists.

The peer support model is clinically based. Peers report to a clinical representative of Hopewell who uses current billing structures to bill for services. Case review happens weekly as do patient visits. The peer helps the patient overcome barriers to compliance and helps them stay on the road to better health. Patients are either identified by the insurance partners or identified clinically (for Behavioral Health related conditions). Insurance partners track risk reduction and cost savings.

Region Covered by Network Services

County, State	County, State
Washington County, OH	Ross County, OH
Athens County, OH	Perry County, OH
Meigs County, OH	

Network Partners

Organization	City, State	Organization Type
Washington County Health Department	Marietta, OH	Public Health
Athens City-County Health Department	Athens, OH	Public Health
Meigs County Health Department	Pomeroy, OH	Public Health
Ross County Health District	Chillicothe, OH	Public Health
Perry County Health Department	New Lexington, OH	Public Health
Community Health Improvement Associates	Marietta, OH	Public Health
Hopewell Health Centers, Inc.	Athens, OH	Federally Qualified Health Center (FQHC)
United Healthcare, Inc.	Columbus, OH	Other
Molina Healthcare of Ohio	Columbus, OH	Other
The HealthPlan of WV	Wheeling, WV	Other

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Oklahoma

Rural Health Network of Oklahoma

RHNOK

P10RH33051

Primary Project Focus Area: Network Organization/Infrastructure Development

Other Focus Areas: Behavioral Health
Substance Abuse/Addiction-Opioid
Workforce Development

Network Description

The Rural Health Network of Oklahoma's (RNHOK) mission is "better access, better health care together." That describes the impetus behind our work to join forces with other organizations with the same focus in Oklahoma. RHNOK was formally established in 2008 through a HRSA Rural Health Network Development Grant awarded to Little Dixie Community Action Agency, Inc. (LDCAA). RHNOK received non-profit status in 2012 and moved out from under the umbrella of the parent organization, LDCAA, in 2017. RHNOK is a vertically integrated rural health network with members that include primary care physicians, rural hospitals, a Quality Improvement Organization, a state university, home health agencies, behavioral health providers, community organizations, and Native American tribes. RHNOK provides technical assistance, HIT services, group purchasing of hardware and software, bandwidth consortium, and advocacy with local, state, and federal agencies for our membership. The RHNOK is a founding member of the Oklahoma Primary Health Care Extension System (OPHES) and serves as one regional technical assistance provider for rural counties in Oklahoma. Based on the successes of the RHNOK and the growth of rural health improvement efforts, there has been an expressed interest among multi-sector stakeholders to grow the rural health infrastructure, improve care coordination, and increase the participation of primary health care providers in community-based health care coalitions.

For purposes of this Planning grant, the partners are the Public Health Institute of Oklahoma, The University of Tulsa, Rural Health Projects, and Texas County Community Coalition which, together, are committed to developing and expanding rural health networks in order to support communities in their quest for better health and better health care for their residents. We intent to expand the network via the existing County Health Improvement Organization (CHIO) infrastructure in Southeast, Northwest, and the Panhandle of Oklahoma. CHIO certified county-level Coalitions are intended to support the expansion of RHNOK and the overarching Oklahoma Primary Health Care Extension System. All identified partners for the network expansion are nonprofit organizations with a successful history of rural health care development initiatives.

Program Description

The primary focus areas of the Oklahoma Rural Health Development Initiative (ORHDI) are improving efficiencies through coordinating essential health care services, achieving efficiencies through participation with primary care and ancillary care providers for community-based health improvement activities, and developing a mission and strategy among rural health network participants promoting cross-cultural collaboration. Two primary strategies are being applied to achieve the goals of the ORHDI: 1) planning and mobilization of existing partners to plan for and promote population level health projects focused on prescription opioid use, substance abuse, primary prevention, behavioral health, and maternal child healthcare services; and 2) promotion and coordination of

legislative action to support the enhancement of care coordination services in rural Oklahoma through the use of community based health workers. The goals of the project are supported by a data-driven analysis of primary health and social service needs of designated communities, including workforce needs and health system infrastructure needs.

Activities for achieving these goals and associated objectives include coordination and expansion of services, including the utilization of health information technologies, such as the proposed use of an electronic calendar and communication and collaboration platform for members. The ORHDI plans to expand the expertise and leadership of the Rural Health Network of Oklahoma, the Public Health Institute of Oklahoma, The University of Tulsa, Rural Health Projects, and Texas County Community Coalition along with other partners through strengthening dissemination and implementation channels for rural based health improvement activities. The plan includes that County-based CHIO Certified Coalitions serve as guides on behalf of the RHNOK for local communities to conduct convening and development of action plans to support improved integration of health care services across Oklahoma.

Region Covered by Network Services

County, State	County, State
Alfalfa, OK	Stephens, OK
Texas, OK	Jefferson, OK
Delaware, OK	Cherokee, OK
Grant, OK	Payne, OK
Blaine, OK	Creek, OK
Kingfisher, OK	Pottawatomie, OK
Logan, OK	Tulsa, OK
Jackson, OK	Washington, OK
Sequoyah, OK	LeFlore, OK
Latimer, OK	Pushmataha, OK
McCurtain, OK	Choctaw, OK
Bryan, OK	Marshall, OK
Atoka, OK	Coal, OK

Network Partners

Organization	City, State	Organization Type
The University of Tulsa	Tulsa, OK	College/University
The Public Health Institute of Oklahoma	OKC, OK	Public Health
Rural Health Projects of Oklahoma	Enid, OK	Area Health Education Center
Texas County Health Coalition (CHIO)	Guymon, OK	Collaborative

Grantee Contact Information

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South Dakota

Coteau Des Prairies Hospital

P10RH33041

Primary Project Focus Area: Care Coordination

Other Focus Areas:
Integrated Health Services
Network Organization/Infrastructure Development
Population Health/Social Determinants of Health

Special Populations being Served:
Children/Adolescents
Elderly
Tribal
Women

Network Description

After a reviewing the results of a Community Health Needs Assessment, Coteau Des Prairies Hospital (CDP, Critical Access Hospital) discovered a fragmented care delivery and lack of healthcare services. CDP leadership knew they needed the expertise of entities that had successfully implemented change management and have key stakes in the community health. CDP identified Sanford Research (Not-for-profit Research), Sanford Health Network (Not-for-profit rural arm of Sanford Health) and Tekakwitha Living Centers (Long Term Care Center) as partners. Once the grant was awarded, the Network was formed. The Network is currently working on establishing its structure and by-laws.

The Network members are chosen based on their commitment and leadership to serve the rural population. Sanford Research and Sanford Health Network provide project management, change management and evaluation expertise. By being a part of the largest rural not-for-profit integrated health system in the nation, Sanford Research and Sanford Health Network, have extensive resources and personnel to contribute. The Tekakwitha Living Center expertise lies in long term care management and has been a longstanding organization in the Sisseton community. The Network shares a common commitment of improving the lives of the rural residents they serve.

Program Description

The primary focus of the grant is to form a rural health network and develop strategies for improving health care delivery services in Sisseton, SD and the surrounding communities. The approach includes three phases.

During Phase 1, the Network will develop the infrastructure to include the development of the Rural Health Network Governance & Operating Structure. The infrastructure will result in a creation of a Clinical Transformation Committee. In Phase 2, the Committee will work alongside an external entity to conduct a gap analysis and resource assessment. Lastly, in Phase 3, the Network will develop a Comprehensive Network Project Plan(s) based on the outcomes of the assessment and gap analysis.

Region Covered by Network Services

County, State	County, State
Roberts County, SD	
Day County, SD	
Marshall County, SD	
Traverse County, MN	
Richland County, ND	

Network Partners

Organization	City, State	Organization Type
Coteau Des Prairies Hospital	Sisseton, SD	Critical Access Hospital (CAH)
Tekakwitha Living Center	Sisseton, SD	Skilled Nursing Facility
Sanford Research	Sioux Falls, SD	Non-Profit
Sanford Health Network	Sioux Falls, SD	Non-Profit

Grantee Contact Information

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Washington

Adams County Public Health District
Grand Columbia Health Alliance

P10RH33035

Primary Project Focus Area: Increase Health System Efficiencies

Other Focus Areas: Integrated Health Services
Network Organizational/Infrastructure Development
Population Health/Social Determinants of Health
Workforce Development

Network Description

The Grand Columbia Health Alliance (GCHA) is an informal collaboration of six rural public hospital districts including: Columbia Basin Hospital, Samaritan Healthcare, Odessa Memorial Healthcare Center, Othello Community Hospital, Quincy Valley Medical Center, and East Adams Rural Healthcare.

In early 2017, we began meeting regularly, selected our name, conducted a high-level gap analysis and began discussing how to address certain regional program needs. Since that time, we have established joint priorities, a monthly meeting schedule, an interlocal agreement, and a joint vision:

At Grand Columbia Health Alliance, our healthcare member organizations are stronger together. Together we strive for the best health of our residents – to provide our regional better access to enhanced care at the best possible price, right here, close of home.

Where Return on Investment (ROI) is measured in lives improved, lives saved, new babies born.

Program Description

This Network Planning Grant will assist the GCHA to develop a formal regional network to allow us to collectively achieve what is increasingly challenging individually: local, efficient, accessible, high-quality, sustainable health care that drives value to residents and payers. Specifically, growing and formalizing the Network will establish the mechanisms to address the regional health care needs in a high-quality, value-based manner and provide the resources to allow us to complete the following:

- Establish and operate with a formal Network structure that supports the addition of non-public providers (such as Federally Qualified Health Centers and other community providers) including reviewing ho “best in class” rural Networks are organized;
- Jointly identify, prioritize and implement services that should appropriately be available locally, including conducting a Network-wide community health needs assessment;
- Recruit and stabilize local providers to assure that they remain open, accessible, and viable for their communities;
- Develop an evidence-based model for shared services, service line collaboration and cost savings;
- Identify a “hub and spoke” structure that assures access and quality and that financially recognizes all members.

Region Covered by Network Services

County, State	County, State
Grant County, WA	Lincoln County, WA
Adams County, WA	

Network Partners

Organization	City, State	Organization Type
Columbia Basin Hospital	Ephrata, WA	Hospital
Samaritan Healthcare	Moses Lake, WA	Hospital
Odessa Memorial Healthcare Center	Odessa, WA	Hospital
Othello Community Hospital	Othello, WA	Hospital
East Adams Rural Healthcare	Ritzville, WA	Hospital
Quincy Valley Medical Center	Quincy, WA	Hospital

Grantee Contact Information

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Washington

Columbia County
Southeast Washington Health Partnership

P10RH33040

Primary Project Focus Area: Network Organization/Infrastructure Development

Other Focus Areas: Care Coordination
Telehealth

Network Description

The Southeast Washington (SE WA) Health Partnership informally began meeting monthly in 2016 to bring together the health partners in Columbia, Garfield and Asotin Counties. Partners include but are not limited to Public Health, Hospital Administration, Behavioral Health, Hospital board Commissioners, County Commissioners, Aging, and Long-Term Care, Dental Affiliates, transportation entities and other organizations interested in improving the health of residents in the three-county region. The Partnership formally organized and became a Local Health Improvement Network in July 2017. Currently, 23 partners are participating. Examples of accomplishments of the Partnership have been bringing dental outreach programs across the three counties, as well as arranging transportation and medical insurance navigation. The partnership has met consistently throughout the three years with high attendance at each meeting.

The depth of representation of health care, government entities, transportation, mental health, and dental allow the committee to address the barriers that prevent clients from receiving health care across the three counties. The purpose of the SE WA Health Partnership is to develop short- and long-term community health priorities and objectives that generate recommendations for planning, implementing, and aligning action of healthcare providers, partners and community organizations throughout Columbia, Garfield, and Asotin Counties. The SE WA Health Partnership is not intended to replace county-level planning and action but instead to support coordination and alignment across counties and shared populations, leading to more effective programs and use of resources. The primary focus of the SE WA Health Partnership is to support community priorities focusing on improving the health of our communities. With partnership wide visions on better health outcomes, strategic alignment of resources among our partners is vital.

Program Description

The focus of our Network's grant is to assure the effective use of existing resources and coordinate planning and implementation of new resources to improve access to and coordination of health care across the region, with a focus on telehealth-based health services and care coordination. In our three rural counties, resources can be limited and difficult to access for many residents. Through care coordination and telehealth capabilities, health services will be more attainable to those in need.

The Network has completed a needs assessment in Columbia, Garfield, and Asotin counties. Each county has its own assessment. In addition, the findings were also included in a 3-county assessment. The process used to select indicators for this report was collaborative and inclusive, drawing participation from a wide variety of community organizations. Using a collaborative indicator selection process generated interest among community members and allowed for valuable discussion about the meaning of data included in this report. While the process revealed a lack of recent data for many topics, participants identified a need for more data in many areas including mental health,

physical environment, healthy aging, wait times for appointments, transportation, food choices throughout the community, civic participation, economic diversity, and accessibility. This assessment will be used to base the community's health priorities. Asotin, Columbia, and Garfield Counties will undergo extensive Community Health Improvement Planning (CHIP) processes that will involve stakeholders from throughout the community. The Network has recently hired a Project Coordinator. The grant was presented at the last Network meeting with the members with discussion afterwards. Next steps include researching Best Practices telehealth and care coordination models that have been successful and sustainable, reviewing the assessments and identifying needs and gaps in services, and build a database, cataloging providers and resources in the community, along with those services which could be utilized through telehealth and enhanced with care coordination.

Region Covered by Network Services

County, State	County, State
Asotin, WA	Columbia, WA
Pomeroy, WA	

Network Partners

Organization	City, State	Organization Type
Columbia Co. Public Health Department	Dayton, WA	Public Health
Columbia Co. Health System	Dayton, WA	Hospital
Columbia Co. Transportation	Dayton, WA	Transportation
Blue Mountain Action Council	Dayton, WA	Community Development Organization
Blue Mountain Counseling	Dayton, WA	Social Services Agency
SE WA Aging and Long Term Care	Dayton, WA	Area Agency on Aging
Columbia County Commissioners	Dayton, WA	Government
Garfield County Health District	Pomeroy, WA	Public Health
Garfield County Commissioners	Pomeroy, WA	Government
Garfield County EMS/Fire	Pomeroy, WA	Government
Garfield County Hospital District	Pomeroy, WA	Hospital
Molina Health Care	Pomeroy, WA	Medicaid Managed Care Organization
Quality Behavioral Health	Pomeroy, WA	Social Services Agency
SE WA Aging and Long-Term Care	Pomeroy, WA	Area Agency on Aging
Asotin County Health District	Clarkston, WA	Public Health
Asotin County Hospital District	Clarkston, WA	Hospital
CHAS Dental	Clarkston, WA	Oral Health
Lewis and Clark Early Childhood Ed Program	Clarkston, WA	School System
Quality Behavioral Health	Clarkston, WA	Social Service Agency
SE WA Aging and Long-Term Care	Clarkston, WA	Area Agency on Aging
Tri State Hospital	Clarkston, WA	Hospital
Greater Columbia Accountable Communities of Health	Kennewick, WA	Collaborative
Community Health Association of Spokane	Spokane, WA	Federally Qualified Health Center (FQHC)
Senator Patty Murray's Office	Olympia, WA	Government

Grantee Contact Information

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Washington

Family Health Centers
Okanogan Palliative Care Team

P10RH33043

Primary Project Focus Area: Palliative Care

Other Focus Areas:
Care Coordination
Chronic Disease Management – Other than Diabetes
Increase Health System Efficiencies
Integrated Health Services

Special Populations being Served:
Elderly
Migrant
Tribal
Women

Network Description

Our network was formed in May 2018, explicitly for exploring the possibility of developing a county-wide palliative care program for Okanogan County, WA. We initiated this as the last rural 'pilot cohort,' joining six others around the state of Washington, at the invitation of and support by the Washington State Rural Palliative Care Initiative (2017-2020). Our accomplishments now 16 months later include: 1) the initial members are still showing and engaged in monthly meetings!; 2) we have formed four Work Groups and have a designated leader of each group; 3) we have formed an initial plan around rolling out advanced care workshops across the county; 4) we have conducted some pilot community workshops since January of 2019, in the Methow Valley, Okanogan County that may be rolled out across the county; and 5) we have applied for a Robert Wood Johnson Clinical Scholars grant which would support five of our team for three years to follow the HRSA grant period and allow us to begin our clinical service work.

We have ten partner agencies and sixteen members (one new member since the original team formed) from these agencies on our team. We have included the two acute access hospitals (including inpatient and emergency departments), the two major clinic systems (caring for more than 80% of our county), a long term care facility and an adult family home, a home health and hospice agency, a 'virtual village' (membership organization assisting senior to stay in their homes), a small house-call-based palliative care practice (Methow Valley), and our local emergency medical service. We intentionally chose these agencies as they are located throughout the county we will be serving and provide the common locations where palliative care patients might enter the medical system. In addition, our team members represent the multidisciplinary specialty areas critical to a palliative care service (five physicians, one ARNP, one Physicians Assistant, four RNs, two paramedics, and one chaplain).

Program Description

The Program is divided into four Aims: 1) Development of a Clinical Care Service: the aims are to develop a screening tool and determine the number of eligible patients and determine settings and sites for the Palliative Care Service, what components the service will contain, who will deliver care; 2) Provider Training: identify the palliative care specialty providers from our Team, develop the training and train them to deliver services and

determine the role of primary care physicians in providing initial palliative care and train them; 3) Community Education and Engagement: develop a community education program (newspaper articles, community forums, other), including advanced care planning workshops, set goals and begin roll-out throughout Okanogan County; and 4) Financial Sustainability: determine costs of a palliative care program (provider time and other), explore and help develop billing mechanisms for palliative care services and search out other grant funding sources to supplement existing billing opportunities. We have chosen this strategy based on the 'BluePrint' of NW Passages Coalition, Whatcom County, WA state, another rural Palliative Care program who is about ten years ahead of us in development. They term these four aims as "pillars' of their program. Short of that, there is little published data on best practices in setting up a rural palliative care program in the US. The NW Passages Coalition has been highly successful, especially in setting up a clinical service, and have done some outstanding work in generating community conversations which are slowly changing the mindset around death and end-of-life issues. We are also using input from the other six rural palliative care sites, some of which have been doing this work in our state for several years.

Region Covered by Network Services

County, State
Okanogan County, WA

Network Partners

Organization	City, State	Organization Type
Family Health Centers	Okanogan County, WA	Federally Qualified Health Center (FQHC)
Confluence Health Clinics	Okanogan County, WA	Physicians' Clinic
Aero Methow Ambulance Company	Twisp, WA	Emergency Medical Services (EMS)
The Lookout Coalition	Methow Valley, WA	Other
Frontier Hospice and Home Care	Okanogan County, WA	Hospice
Regency Harmony House	Brewster, WA	Skilled Nursing Facility
Jamie's Place	Winthrop, WA	Non-Profit
Methow At Home	Methow Valley WA	Other
3-Rivers Hospital	Brewster, WA	Critical Access Hospital (CAH)
Mid-Valley Hospital	Omak, WA	Critical Access Hospital (CAH)

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