

Rural Health Network Development Sourcebook

July 2023



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INTRODUCTION

The Federal Office of Rural Health Policy's (FORHP's) Community-Based Division provides support to integrated rural health care networks that have combined the functions of the entities participating in the network, including skilled and experienced staff and a high functioning network board, in order to address the health care needs of the targeted rural community.

Through the Rural Health Network Development (RHND) grant program, FORHP encourages innovative solutions to local health care needs identified by local communities and supports rural communities in preparing for changes within the health care environment.

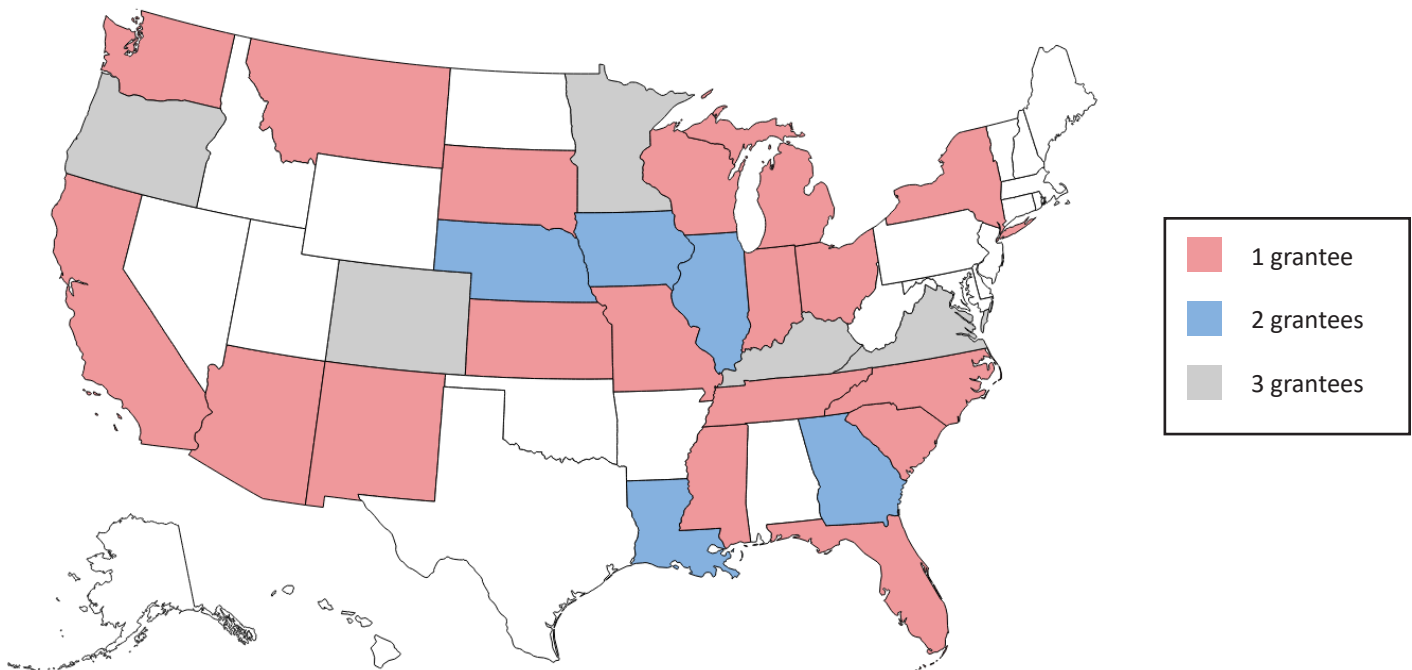
The overarching goals of the RHND program are to:

- Improve access to and quality of health care in rural areas through sustainable health care programs created as a result of network collaboration;
- Prepare rural health networks for the transition to value-based payment and population health management;
- Demonstrate improved health outcomes and community impact;
- Promote the sustainability of rural health networks through the creation of diverse products and services; and
- Utilize or adapt evidence-based or promising practice models in the delivery of health care services.

This *Sourcebook* provides brief program descriptions and overviews of the sustained impacts of the 44 rural health networks funded during the 2020-2023 grant period.

COHORT SNAPSHOT

Grantee Location Map



Grantees by State

State	Grantee Organization
Arizona	Arizona Community Health Workers Association
California	Mendonoma Health Alliance
Colorado	Bright Future Foundation for Eagle County Eastern Plains Healthcare Consortium Tri-County Health Network
Florida	St. Johns River Rural Health Network
Georgia	Dublin City Schools Rural Health Works
Illinois	HSHS Good Shepherd Hospital, Inc. Katherine Shaw Bethea Hospital
Indiana	Indiana University Health Bedford
Iowa	Mercy Medical Center - Newton Unity Healthcare
Kansas	Kansas Clinical Improvement Collaborative
Kentucky	Big Sandy Health Care Purchase District Health Department St. Claire Medical Center
Louisiana	Louisiana Rural Ambulance Alliance Winn Community Health Center
Michigan	Huron County
Minnesota	Well Being Development Wilderness Health
Mississippi	Delta Health Alliance
Missouri	Randolph County Caring Community
Montana	Montana State University
Nebraska	Community Access to Coordinated Healthcare Northeast Nebraska Public Health Department
New Mexico	Union County Health and Wellness Network
New York	Westchester-Ellenville Hospital
North Carolina	Heritage Hospital
Ohio	Hopewell Health Centers
Oregon	Northeast Oregon Network Oregon Washington Health Network Sky Lakes Medical Center Foundation

State	Grantee Organization
South Carolina	Palmetto Care Connections
South Dakota	Sacred Heart Health Services
Tennessee	Paris-Henry County Health Care Foundation
Virginia	Bay Rivers Telehealth Alliance Strength in Peers Virginia Rural Health Association
Washington	Critical Access Hospital Network
Wisconsin	Fort HealthCare Rural Wisconsin Health Cooperative Thedacare Medical Center - Shawano

Grantee Organization Type

Grantee Organization	County Government	Federally Qualified Health Center	Hospital	Local Health Department	Nonprofit Network Organization	Nonprofit Organization	Public Health Department	School Board
Arizona Community Health Workers Association					•			
Bay Rivers Telehealth Alliance						•		
Big Sandy Health Care		•						
Bright Future Foundation for Eagle County						•		
Community Access to Coordinated Healthcare					•			
Critical Access Hospital Network					•			
Delta Health Alliance						•		
Dublin City Schools								•
Eastern Plains Healthcare Consortium					•			
Fort HealthCare			•					
Heritage Hospital			•					
Hopewell Health Centers		•						
HSHS Good Shepherd Hospital			•					
Huron County		•						
Indiana University Health Bedford			•					
Kansas Clinical Improvement Collaborative					•			
Katherine Shaw Bethea Hospital			•					
Louisiana Rural Ambulance Alliance						•		
Mendonoma Health Alliance					•			
Mercy Medical Center - Newton			•					
Montana State University						•		
Northeast Nebraska Public Health Department							•	

Grantee Organization	County Government	Federally Qualified Health Center	Hospital	Local Health Department	Nonprofit Network Organization	Nonprofit Organization	Public Health Department	School Board
Northeast Oregon Network						•		
Oregon Washington Health Network						•		
Palmetto Care Connections					•			
Paris-Henry County Health Care Foundation						•		
Purchase District Health Department				•				
Randolph County Caring Community						•		
Rural Health Works						•		
Rural Wisconsin Health Cooperative					•			
Sacred Heart Health Services						•		
Sky Lakes Medical Center Foundation			•					
St. Claire Medical Center			•			•		
St. Johns River Rural Health Network						•		
Strength in Peers						•		
Thedacare Medical Center - Shawano			•					
Tri-County Health Network					•			
Union County Health and Wellness Network						•		
Unity Healthcare							•	
Virginia Rural Health Association						•		
Well Being Development						•		
Westchester-Ellenville Hospital			•					
Wilderness Health					•			
Winn Community Health Center		•						

Grantee Primary Focus Area

Grantee Organization	Alternative Payment Models	Behavioral Health/Mental Health — General	Behavioral Health/Mental Health — Substance Use Disorder	Care Coordination	Chronic Disease	Community Health Workers	Obesity Prevention	School-based Health	Social Determinants of Health	Telehealth	Workforce Development
Arizona Community Health Workers Association						•					
Bay Rivers Telehealth Alliance										•	
Big Sandy Health Care						•					
Bright Future Foundation for Eagle County											•
Community Access to Coordinated Healthcare				•							
Critical Access Hospital Network										•	
Delta Health Alliance					•						
Dublin City Schools								•			
Eastern Plains Healthcare Consortium											•
Fort HealthCare	•										
Heritage Hospital				•							
Hopewell Health Centers						•					
HSHS Good Shepherd Hospital										•	
Huron County		•									
Indiana University Health Bedford				•							
Kansas Clinical Improvement Collaborative										•	
Katherine Shaw Bethea Hospital				•							
Louisiana Rural Ambulance Alliance			•								
Mendonoma Health Alliance				•							
Mercy Medical Center - Newton								•			
Montana State University											•
Northeast Nebraska Public Health Department								•			

Grantee Organization	Alternative Payment Models	Behavioral Health/Mental Health — General	Behavioral Health/Mental Health — Substance Use Disorder	Care Coordination	Chronic Disease	Community Health Workers	Obesity Prevention	School-based Health	Social Determinants of Health	Telehealth	Workforce Development
Northeast Oregon Network						•					
Oregon Washington Health Network					•						
Palmetto Care Connections										•	
Paris-Henry County Health Care Foundation										•	
Purchase District Health Department	•					•					
Randolph County Caring Community						•					
Rural Health Works								•			
Rural Wisconsin Health Cooperative				•							
Sacred Heart Health Services											•
Sky Lakes Medical Center Foundation						•					
St. Claire Medical Center			•								
St. Johns River Rural Health Network											
Strength in Peers			•								
Thedacare Medical Center - Shawano			•								
Tri-County Health Network		•									
Union County Health and Wellness Network							•				
Unity Healthcare									•		
Virginia Rural Health Association		•									
Well Being Development		•									
Westchester-Ellenville Hospital					•						
Wilderness Health										•	
Winn Community Health Center					•						

Arizona Community Health Worker Association

Rural Arizona CHW Workforce Development Network

D06RH37493

Project focus area:
Community Health Workers

Other focus areas:
Workforce Development

Network History and Members

The Rural Arizona CHW Workforce Development Network (RAzCHOW) formed in 2018. It received a one-year HRSA Rural Health Care Network Planning grant in 2018 and a three-year HRSA Rural Health Care Network Development grant in 2020. RAzCHOW's 14 partners advocate for effective engagement of all types of community health workers (CHWs), promotores de salud, and community health representatives (CHRs) in rural Arizona. RAzCHOW enjoys the support of statewide partners and universities.

Member Organization	Location	Organizational Type
Arizona Community Health Worker Association	Douglas, Cochise County, AZ	Nonprofit Statewide Association
Chiricahua Community Health Centers, Inc.	Douglas, Cochise County, AZ	Federally Qualified Health Center
Cochise County Health and Social Services	Bisbee, Cochise County, AZ	Public Health Department
Mariposa Community Health Center	Nogales, Santa Cruz County, AZ	Federally Qualified Health Center
Graham County Health Department	Safford, Graham County, AZ	Public Health Department
Canyonlands Healthcare	Page, Coconino County, AZ	Federally Qualified Health Center
Southeast Arizona Health Education Center	Nogales, Santa Cruz County, AZ	Nonprofit Organization
Circles of Peace	Nogales, Santa Cruz County, AZ	Nonprofit Organization
Desert Senita Community Health Center	Ajo, Pima County, AZ	Federally Qualified Health Center

Member Organization	Location	Organizational Type
Winchester Heights Health Organization	Willcox, Cochise County, AZ	Nonprofit Organization
Campeños Sin Fronteras	Somerton, Yuma County, AZ	Nonprofit Organization
Pinal Hispanic Council	Eloy, Pinal County, AZ	Behavioral Health Organization
Arizona Advisory Council on Indian Health Care	Phoenix, Maricopa County, AZ	State Advisory Organization
Arizona Department of Health Services	Phoenix, Maricopa County, AZ	Public Health Department

Community Characteristics

Area

RAzCHOW is a statewide, vertical network serving residents in six of Arizona’s eight fully rural counties (Santa Cruz, Gila, Mojave, Navajo, Graham, and Greenlee), plus 11 rural census tracts in five nonrural counties (Cochise, Coconino, Pinal, Pima, and Yuma).

Target Population

The target population in these rural areas of Arizona is largely low-income, Hispanic/Latin, and Native American. Many residents in the target service area speak a language other than English, with limited access to preventive care, primary care, specialty services, inpatient care, and behavioral health services. Within that target population, RAzCHOW focuses on CHWs and the organizations that employ them to build their capacity to meet local health and social needs in order to reduce health disparities and promote health equity.

Need

The residents of the service area face many health disparities in an environment with limited availability of health care services. RAzCHOW ensures that rural health care organizations have the resources and technical assistance to create, grow, and enhance CHW services as a culturally informed and language-appropriate model that increases health care access, improves health outcomes, and reduces costs in order to reduce health disparities and increase health equity.

Program Services

Description

Network members joined forces to create momentum for CHW capacity building, utilization, and program sustainability in rural Arizona. RAzCHOW promotes CHW core competency training and promotes voluntary certification of the rural CHW workforce per Arizona law. RAzCHOW provides technical assistance to rural organizations to become approved to train CHWs. RAzCHOW works with health system providers — both clinical and community-based — to assess needs and build capacity to incorporate CHWs in health promotion, primary care, care coordination and integrated behavioral health. Finally, the network pursues long-term sustainability strategies for effective integration of CHWs into the rural health care system in Arizona.

Role of Network Partners

Network members participate in the elected leadership team, decision-making, financial oversight, and evaluation oversight. Members meet monthly (virtually) and quarterly (in-person). RAZCHOW provides members with the opportunity to learn and share at regional, state, and national levels. CHWs are important network members, actively participating in planning and implementation.

Outcomes

Program Outcomes

Major outcomes include increased network capacity, increased trainings for rural CHWs, and increased utilization of CHWs in rural areas. A major strength of RAZCHOW has been the space that it creates for rural CHWs and their employers for recognition, skill development, peer learning, and leadership opportunities. Together, RAZCHOW members produced social media materials, a strategic plan, a marketing plan, a business plan, and a sustainability plan.

Network Collaboration

The collaboration among RAZCHOW members has moved the needle for rural CHWs and rural health organizations in Arizona. Several members joined because they had little to no experience utilizing CHWs or promotores de salud and wanted to learn from peers. Now they are improving their services through the integration of CHWs into their teams. RAZCHOW has supported the CHR movement in Arizona among tribal communities. Tribal governments and American Indian organizations have generated considerable resources in the past two years to strengthen the CHR workforce through intertribal collaboration. RAZCHOW is now focusing on new rural areas of Arizona where the CHW workforce still needs to be planted, grown, and expanded.

Sustainability

RAZCHOW's services have evolved in response to two state policies that support the Arizona CHW workforce, namely CHW voluntary certification (licensing) and Medicaid (the Arizona Health Care Cost Containment System) reimbursement for certified CHW services. The network's evolution increases the likelihood that RAZCHOW services will be sustained because rural organizations value their impact on effective CHW utilization in a changing rural health landscape. RAZCHOW is pivoting to maximize rural Arizona's ability to take advantage of the potential that these two state policy changes pose for the long-term sustainability of the diverse CHW workforce in Arizona's rural communities.

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Mendonoma Health Alliance

MHA Rural Health Network

D0637511

Project focus area:

Chronic Disease

Other focus areas:

Community Health Workers

Network History and Members

The Mendonoma Health Alliance (MHA) is a rural health network consisting of three founding members: Redwood Coast Medical Services (RCMS), Coast Life Support District (CLSD), and Santa Rosa Memorial Hospital (SRMH). In 2016 the organizations formalized their long-standing relationships by executing a memorandum of understanding to establish the Mendonoma Health Alliance Rural Health Network. MHA was awarded 501(c)(3) status in May 2019. MHA's mission is to improve local access to wellness education, prevention services, and quality health care through creative solutions in collaboration with the community. MHA serves as the lead entity on community grant-funded projects and provides direct services that support the work of the partner organizations while improving health outcomes and access to health resources. MHA has been the recipient of six HRSA grants and nine local foundation grants that have all increased local capacity to improve health.

Member Organization	Location	Organizational Type
Santa Rosa Memorial Hospital	Santa Rosa, Sonoma County, CA	Hospital
Coast Life Support District	Gualala, Mendocino County, CA	EMS/Ambulance
Redwood Coast Medical Services	Gualala, Mendocino County, CA	Federally Qualified Health Center
Mendonoma Health Alliance	Gualala, Mendocino County, CA	Nonprofit Organization

Community Characteristics

Area

The project service area encompasses a 60-mile stretch of the north coast of Sonoma County and the south coast of Mendocino County. More specifically, areas served include Irish Beach and Manchester (95459), Point Arena (95468) and Gualala (95445) in Mendocino County and the Sea Ranch (95497), Stewarts Point (95480), Timber Cove (95450), and parts of Cazadero (95421) in Sonoma County. The service area is federally designated as "Frontier" and designated as a Medical Professional Shortage Area and a Medically Underserved Population. This community has the longest ambulance transports times in the state of California and is two hours away from vital services, such as pharmacies and hospitals.

Target Population

The target population is all residents in the “Mendonoma” community, which is roughly 8,500 full-time and part-time residents. The specific focus is on individuals with uncontrolled chronic conditions, Spanish-speaking residents, low-income individuals and families, and individuals discharging back home from the hospital.

Need

This project was intended to achieve three overarching goals: (1) improve population health by implementing evidence-based practices; (2) improve the quality of health care services which are accessible locally; and (3) expand the use of innovative strategies to reach patients in distant and remote locations.

Program Services

Description

The network uses a variety of evidence-based programs and practices to improve access to care and health outcomes. Those approaches include free health screenings for blood pressure, A1c, cholesterol, and COVID-19; the Healthy Living Class, which uses the Stanford Self-Management Model to offer chronic care management support that gives clients the opportunity to share information and gain accountability for incorporating healthier habits into their daily lives; free care coordination that helps people understand and navigate the health care system with a goal of improving health outcomes for individuals with chronic conditions; care transitions services, which provide one-on-one support to clients in their transition from hospital to home; community outreach to increase awareness of local resources and identifying the needs of the community by conducting a triannual community health needs assessment and various other needs assessments to plan for programs and infrastructure; and the Matter of Balance program, which is a fall-prevention program focused on home safety, strength, balance, and cognitive restructuring, intended to reduce the volume of preventable emergency dispatches, transports, and hospital admissions.

Role of Network Partners

MHA is governed by a board of directors that comprises two members holding leadership positions at each partner organization and three community representatives selected by those members, for a total of nine voting members. All partners provide joint consultation, collaboration, and coordination regarding the services rendered to residents of the designated service area to improve internal capacity and efficiency, while reducing gaps in access to care.

Outcomes

Program Outcomes

Care Coordination

- 12% increase in number of clients served, from 164 to 183, between Year 2 and Year 3 of the project
- 23.5% of clients are Spanish-speaking; 35.3% of clients are Hispanic/Latino and 6.7% of clients are Native American, which is reflective of the population profile of the entire service area
- 14% increase in number of services provided to clients, from 2,357 services to 2,686, between Year 2 and Year 3
- 209 blood pressure cuffs and health education provided to community representatives, representing 20.4% of all patients diagnosed with hypertension at the FQHC

Care Transitions

- 21 clients served in the first three quarters of Year 3 (equivalent to the total count for all of Year 2)
- 10% readmission rate in Year 2 and 6% readmission rate through three quarters in Year 3, which is significantly lower than the county readmission average of 14.3%, resulting in more than \$292,000 in cost savings to date in Year 3

Health Living Class

- 19 graduates — 100% of graduates report not being admitted to the hospital due to a chronic condition at the 30-day post-class check-in; 100% of respondents reported that the class was effective in improving health

Matter of Balance

- 20 graduates — 75% of respondents reported not experiencing any falls in the 30-day post-class check-in; 95% of respondents reported no hospitalizations due to falling in the 30-day post-class check-in

Network Collaboration

The MHA Rural Health Network holds monthly board meetings to share relevant health care information and to provide program updates. Executives of each entity meet regularly throughout the month in formal and informal settings to support each other, work on reaching common goals, and discuss barriers to achieving these goals. Every entity has internal teams that come together monthly to formalize and perfect workflows and the coordination of health information between agencies. Annual retreats are held with a specific focus on strategic planning and relationship development.

Sustainability

The MHA network has been the recipient of six HRSA grants that have helped build capacity and increase access to health resources in the community since 2016. This most recent grant award for the 2020-2023 project period has allowed the network to establish deeper connections that are more focused on meeting social determinants of health and increasing health equity. The community has access to over a dozen programs and services as a direct result of this funding. The funding has supported sustainability through connections with peers, consultants, and evidence-based practices. The required deliverables have enhanced the network's ability to plan for the future, which led to improved service models; increased capacity in local systems; and a positive shift in the knowledge, attitudes, and behaviors of all partners, staff, and the board of directors.

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Bright Future Foundation for Eagle County

The Colorado Psychology Internship Consortium

D06RH37496

Project focus area:
Workforce Development

Other focus areas:
Behavioral Health/Mental Health

Network History and Members

The Colorado Psychology Internship Consortium (CO-PIC) was originally developed in 2015 as a behavioral health workforce initiative and training network funded by a one-year HRSA Rural Health Network Development (RHND) Planning Grant. CO-PIC has evolved into an American Psychological Association (APA)–accredited doctoral psychology internship consortium with five sites. The initial network included Bright Future Foundation, STRIDE Community Health Center, and Eagle Valley Behavioral Health. Your Hope Center of Eagle River Valley joined the network in 2021, and Code-4 Counseling joined in 2022.

Member Organization	Location	Organizational Type
Bright Future Foundation (BFF)	Avon, Eagle County, CO	Nonprofit Organization
STRIDE Community Health Center	Denver, Denver Metro, CO	Federally Qualified Health Center
Eagle Valley Behavioral Health	Vail, Avon, Edwards, and Eagle, Eagle County, CO	Nonprofit Organization
Your Hope Center of Eagle River Valley	Eagle, Eagle County, CO	Nonprofit Organization
Code-4 Counseling	Lone Tree, statewide, CO	Private Practice Specialty Care

Community Characteristics

Area

Three of CO-PIC’s sites are in Colorado’s rural mountain community in Eagle County, which spans approximately 1,700 square miles of mountainous terrain within the central Rocky Mountains and includes 12 towns. Two additional sites are in the Denver metro area, with one site providing services across Colorado. Counties served by CO-PIC are highly underserved and designated as Health Professional Shortage Areas by HRSA.

Target Population

CO-PIC provides a range of clinical and training experiences to psychology interns and site faculty that represent the necessary depth and breadth required for clinical licensure and professional practice with rural and underserved populations in Colorado. CO-PIC's rural service area includes 310,307 Coloradoans. CO-PIC sites vary in populations served and include crisis response, trauma-focused care, integrated primary care, school-based programs, sports psychology programs, and services for first responders.

Need

Although the need for behavioral health services in Colorado is great, the behavioral health workforce in the state continues to be inadequate. Colorado does not have the capacity to provide opportunities for more than 40% of its doctoral students in psychology to complete their training in state, and most of the current internship positions in Colorado are in metropolitan areas. Behavioral health access challenges that rural Colorado faces are not only related to workforce shortages but also to the inability to train providers to serve the needs of rural communities specifically. CO-PIC is the only APA-accredited doctoral psychology internship program based in rural Eagle County focused on increasing the behavioral health workforce in Colorado's rural regions.

Program Services

Description

CO-PIC aims to prepare and retain psychologists to provide high-quality behavioral health care for under-resourced and rural Coloradans of all ages. To achieve this goal, CO-PIC offers a one-year, full-time doctoral internship beginning and ending in July each year. CO-PIC's goals specific to the RHND grant were to onboard two additional sites to the consortium and recruit and matriculate at least one new intern at each active site each year. CO-PIC also aimed to enhance internship and faculty training offerings to include more didactics focused on needed areas in the community (e.g., the delivery of prevention and treatment of opioid use disorder (OUD)/substance use disorder (SUD), telehealth, and culturally competent care), attendance at national conferences on OUD/SUD and suicide prevention, and additional training on evidence-based practices (e.g., acceptance and commitment therapy).

Role of Network Partners

CO-PIC is governed by a governing body known as the Training Committee, which includes representatives from each member site and the training director. The committee meets monthly to ensure the collaborative implementation of the consortium activities and to oversee the internship recruitment process each year. To assist with training CO-PIC interns, each site has at least one licensed psychologist as the primary site supervisor to provide clinical supervision to their interns. All site faculty contribute to didactics and training throughout the year as well as attend conferences or other relevant training with the interns.

Outcomes

Program Outcomes

CO-PIC's expansion from three sites to five sites has increased intern slots from three interns to eight or nine interns. Increasing the size of the intern cohort has increased cohort cohesion, peer support, and additional opportunities for interns to collaborate and foster professional relationships. During the grant term, CO-PIC trained 13 interns. These interns completed 2,000 hours of generalist training, including an average of 15 hours of didactic seminars on OUD/SUD, 2.5 hours of didactics on suicide prevention, 24 hours of didactics

on culturally competent care, training on acceptance and commitment therapy, and attendance at two conferences. All interns gained competency in nine core areas outlined by APA to provide quality care after completing their training at CO-PIC.

Network Collaboration

Onboarding new sites has expanded CO-PIC's clinical expertise in areas that were not previously available (e.g., school-based services, working with first responders, and occupational trauma). Both faculty and interns have benefited from this additional expertise through the sharing of consultation, resources, tools, and new training opportunities.

Sustainability

Through the provision of training as well as through the direct clinical services provided by doctoral intern trainees, the network serves as a key mechanism through which the state can better address the identified health care needs of the region and retain the workforce locally. At least 50% of past interns have been retained in the area following graduation and are providing interdisciplinary care services or OUD/SUD treatment services locally.

Grantee Contact Information

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Eastern Plains Healthcare Consortium

Eastern Plains Healthcare Consortium

D06RH40101

Project focus area:
Workforce Development

Other focus areas:
Workforce Development

Network History and Members

Eastern Plains Healthcare Consortium (EPHC) was conceptualized in 2015 when five hospitals on Colorado's plains recognized an opportunity to challenge the growing trend of rural hospital closures and maintain their independence through teamwork and collaboration. EPHC originally started with five Critical Access Hospitals (CAHs) but has since grown and developed to serve 11 CAHs and two health system partners. EPHC's vision statement encompasses both history and intention for the future and that is that EPHC's members will have meaningful and gainful partnerships with one another, allowing them to serve their communities for future generations. Members have consistently communicated that the relationships and partnerships they have developed through EPHC are invaluable and is the number-one reason they maintain their membership.

Member Organization	Location	Organizational Type
Haxtun Health	Haxtun, Phillips County, CO	Hospital
Lincoln Health	Hugo, Lincoln County, CO	Hospital
Melissa Memorial Hospital	Holyoke, Phillips County, CO	Hospital
Kit Carson County Memorial Hospital	Burlington, Kit Carson County, CO	Hospital
Kiowa County Hospital	Eads, Kiowa County, CO	Hospital
Yuma District Hospital and Clinics	Yuma, Yuma County, CO	Hospital
Southeast Colorado Hospital	Springfield, Baca County, CO	Hospital
Wray Community Hospital	Wray, Yuma County, CO	Hospital
Sedgwick County Memorial	Julesburg, Sedgwick County, CO	Hospital
Keefe Memorial	Cheyenne Wells, Cheyenne County, CO	Hospital
Arkansas Valley Regional Medical Center	La Junta, Otero County, CO	Hospital
Banner Health	Brush, Morgan County, CO	Health System

Community Characteristics

Area

EPHC serves the Eastern Plains region of Colorado, which includes facilities located in the counties of Phillips, Lincoln, Sedgwick, Burlington, Yuma, Kiowa, Baca, Cheyenne, Otero, and Morgan, as well as the neighboring counties in their service areas. The Eastern Plains spans a landmass greater than the state of Maryland. Most of the region is not just rural, but frontier, consisting of fewer than six residents per square mile.¹

Target Population

Nearly 20% of the Eastern Plains population identifies as Hispanic, and this is estimated to be much higher than reported by the U.S. Census metrics due to inequities related to measuring undocumented residents. English as a second language is nearly 10% higher than the state average.² Veterans make up about 7% of the population.³ Residents at either end of the spectrum often need the most care but have the greatest access issues. More than 23% of the population is under the age of 18, 7% higher than the state. People older than 65, the highest utilizers of health services, comprise 21.8% of the population, or a sizable 34% higher density than the state.³ Nearly 16% of people report a disability, and 19% of adults report fair to poor health.

Need

Provider ratios in the region show a growing concern. With an aging population as the highest density of residents, there should be more providers per person, yet this is not the case. With historical provider shortages and the impact of the pandemic, the region is at critical risk of provider burnout, which further exacerbates the issue.

Program Services

Description

1. Grow Your Own (GYO) Fellowship and Academic-Practice Partnerships — Develop relationships with local education resources and provide financial support to 12 fellows to upskill their clinical capacity.
2. Leadership Skills for a Culture of Retention Training Program — Develop leadership skills around communication and culture development with a focus on retaining high-quality staff and becoming a magnet for new talent.
3. Shared Staffing — Lower-cost option for filling shifts in times of high census or critical need while also allowing current staff the opportunity to fill their schedules at more than one facility.
4. Interprofessional Team Development Training Program — Reduce silo effect and encourage team dynamics across departments with a focus on developing a culture of retention.
5. Customized employee retention and engagement survey tools — Customized survey tools that address the unique issues and interests faced by the region to get a better picture for a new employee or for identifying culture or organization issues that may impact retention, providing an opportunity to rectify them before attrition occurs.

Role of Network Partners

Each network member holds a seat on the board of directors and is involved in decision-making, visioning, strategic planning, and the development of all network programming.

¹ <https://www.ruralhealthinfo.org/topics/frontier>

² <https://www.countyhealthrankings.org>

³ Colorado State Demography Office. (2018). 2018 Population and Percent Change Colorado Counties

Outcomes

Program Outcomes

As of the writing of this report, the program has supported 13 fellows through the GYO program on their journey to expand their clinical skills as well as provided three of four workshops in leadership and team development focused on fostering a culture of retention. Facilities that have completed these courses have reported significant improvement in employee culture survey results after one year. In the first year of the award, the project had great success with the shared staffing model — saving one facility an estimated \$10,000 in travel staff costs. This program was heavily impacted by the COVID-19 pandemic as the staffing needs changed from short-term and short-notice coverage to long-term coverage needs. Recent reports from members indicate that staffing is beginning to stabilize close to prepandemic levels, and members are returning to the staff share model to cover short-term and short-notice coverage.

Network Collaboration

EPHC's foundation is built upon trust and collaboration. Members meet regularly and are provided a safe space to share and be vulnerable. Through these relationships, additional opportunities for collaboration have been identified, further strengthening the bonds between members.

Sustainability

One of the largest impacts on the network has been the experiential confirmation that through collaboration, shared experiences, and combined resources the members can individually thrive. This foundation has resulted in growth of the network of more than 60% since the submission of the application for funding. Through identifying additional ways to partner and develop as a network there has been a positive impact on the sustainability of the member facilities, which has a profound impact on the overall sustainability of the rural communities. With several successes through this collaboration, EPHC has been identified as a valued partner with external agencies such as the Colorado Department of Healthcare Policy & Finance as well as the Colorado Hospital Association, giving our rural communities a voice in an otherwise urban-driven climate.

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Tri-County Health Network

Tri-County Health Network

D06RH37529

Project focus area:
Behavioral Health/Mental Health

Other focus areas:
Social Determinants of Health

Network History and Members

In 2008, the Telluride Foundation convened the major health care stakeholders in San Miguel, Ouray, and Montrose counties to discuss how to improve health by integrating health care services in the region. Before this time, there had been little collaboration among stakeholders. Individual network members attempted to address the needs of the region's population; however, working in isolation, they could make only incremental efforts impacting their limited patient base. Through a series of discussions, these leaders elected to create an independent organization through which they could work together to measurably improve the region's health. In 2010, the Tri-County Health Network (TCHNetwork) was established as a 501(c)(3) type I supporting organization of the Telluride Foundation. Since that time, TCHNetwork has expanded and now serves the four-county region comprising San Miguel, Ouray, Montrose, and Delta counties.

Member Organization	Location	Organizational Type
Basin Clinic	Naturita, Montrose County, CO	Rural Health Clinic
River Valley Family Health Center	Montrose, Montrose County, CO	Federally Qualified Health Center
Telluride Regional Medical Center	Telluride, San Miguel County, CO	Medical Clinic
Uncompahgre Medical Center	Norwood, San Miguel County, CO	Federally Qualified Health Center
Pediatric Associates	Montrose, Montrose County, CO	Medical Clinic
Montrose Regional Health	Montrose, Montrose County, CO	Hospital
Axis Health System	Montrose, Montrose County, CO	Federally Qualified Health Center
Telluride Foundation	Telluride, San Miguel County, CO	Nonprofit Organization

Community Characteristics

Area

TCHNetwork serves the rural area comprising of San Miguel, Ouray, Montrose, and Delta counties in southwestern Colorado.

Target Population

TCHNetwork's target populations for different services include High Fidelity Wraparound Care Coordination (HFWCC) services were targeted to high-risk patients who do not have access to care coordination services served by clinics in Delta and the West End of Montrose counties; Mental Health First Aid (MHFA) and SafeTALK workshops were targeted to Delta County community members and businesses or organizations that wanted to offer courses to staff; Spanish-language MHFA courses were targeted to community members in the four-county region who speak Spanish; teletherapy services were targeted to community members in Delta County who had a diagnosed mental health condition or were looking to support their mental well-being; and teletherapy with a clinical addiction counselor (CAC) was targeted to anyone in the four-county region with a substance use disorder who was ready to get treatment.

Need

TCHNetwork's four-county service region is designated as a Health Professional Shortage Area for primary care and mental health and is a Medically Underserved Area. Key issues impacting the health of these residents include significant behavioral health needs coupled with a lack of providers, high rates of poverty in two of the counties, community members lacking health care coverage, cultural and linguistically diverse community members and few providers who can speak Spanish or identify as Latin, and transportation barriers.

Program Services

Description

The activities offered included adapting High Fidelity Wraparound to provide care coordination to high- and rising-risk adults, launching substance use treatment teletherapy services with CACs throughout the region, offering Mental Health First Aid and Youth Mental Health First Aid training workshops in Spanish in the four counties and in English in Delta County, offering the SafeTALK suicide prevention program in Delta County, and expanding mental health teletherapy in Delta County. Through this project, TCHNetwork worked to intentionally expand its presence and partnerships in Delta County.

Role of Network Partners

The program required a network approach to be successful. Network members with an existing presence in Delta County championed the expansion into Delta County and connected team members to potential partners and stakeholders. Basin Clinic in Naturita and Axis Health System in Delta played a key role in HFWCC by working with TCHNetwork to develop a risk-stratification process, screen and refer patients to HFWCC, and participate in the HFWCC team for their patients. All network members helped to champion and promote TCHNetwork services, screen and refer patients for teletherapy, communicate program successes across the region, participate in continuous quality improvement efforts, and participate in the board of directors and clinical subcommittee meetings.

Outcomes

Program Outcomes

TCHNetwork served 300 clients through all program services. Eighty-six percent of HFWCC clients who completed services and a post-services survey reported improved ability to self-manage health, and 89% reported improved health outcomes. Of teletherapy clients who completed treatment and a post-program survey, 100% stated the program made it easier for them to get treatment, and 100% stated teletherapy improved their mental wellness. SafeTALK graduates reported being well prepared (50%) or mostly prepared

(50%) now to talk directly and openly to a person about their thoughts of suicide. MHFA graduates reported increased ability to recognize signs and symptoms of a mental health or substance use challenge when preprogram and post-program surveys were compared.

Network Collaboration

Network collaboration was key to successfully implementing programs. By sharing successes, lessons learned, challenges, and ways to address those challenges, TCHNetwork was able to successfully offer services despite the barriers presented by the COVID-19 pandemic during the program period. Perhaps the most important principle learned was how critical it was to have participation from all network members, even those who were not directly involved in some of the activities. Network members who were further away from the services provided invaluable input for quality improvement purposes. They also understand how important it was to pilot services with select network members before rolling successful services out to more members. Members helped to determine the appropriate person to speak with at each network partner organization for different purposes.

Sustainability

Sustained impacts of the program include improved health for HFWCC clients as they are empowered to work with service providers and navigate services on their own, reduced stigma around suicide and increased knowledge of behavioral health through SafeTALK and MHFA, improved service delivery at local clinics partnering on HFWCC, improved mental wellness for teletherapy patients, and improved collaboration and working relationships among service providers.

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St. Johns River Rural Health Network

St. Johns River Rural Health Network

D06RH37526

Project focus area:
Social Determinants of Health

Other focus areas:
Behavioral Health/Mental Health

Network History and Members

The St. Johns River Rural Health Network Inc. (SJRRHN) is one of nine state-certified regional rural health networks established in 1994 as independent 501(c)(3) nonprofit organizations. It upholds the mission (per Florida state statute 381.0406) to work to ensure that quality health care is available and efficiently delivered to all persons in rural areas within the region. With the loss of low-income pool funding in 2016, SJRRHN was able to redefine its role within the community to focus on its mission. In 2019-2020, with funding from HRSA's one-year Rural Health Network Development Planning grant, the network partnered with the Health Planning Council of Northeast Florida Inc. (HPCNEF) and SMA Healthcare to develop the Putnam County Care Connect (PC3) project to address behavioral health care disparities and improve population health in Putnam County. The 2020-2023 HRSA Rural Health Network Development Program funding allowed for redefining SJRRHN's role in supporting population health in the rural counties.

Member Organization	Location	Organizational Type
Health Planning Council of Northeast Florida	Jacksonville, Duval County, FL	Nonprofit Organization
SMA Healthcare	Daytona Beach; Flagler, Marion, Putnam, St. Johns, and Volusia counties; FL	Health Service Provider
Putnam County Behavioral Health Forum	Putnam County, Nassau County, FL	Nonprofit Network Organization

Community Characteristics

Area

The Rural Health Network Development grant allowed SJRRHN and its partners to focus efforts on Putnam County, Fla., an 827-square-mile area designated by the Federal Office of Rural Health Policy as entirely rural.

Target Population

Over the course of the project, the target of PC3 activities shifted away from individual Putnam residents to target nonprofit organizations; clinical providers; city, county, and state governmental agencies (such as law enforcement, department of corrections, and county health departments); hospital systems; and private businesses that serve Putnam County residents. Those implementing the project were able to adapt to community needs by supporting existing community services that provided direct care.

Need

The 2019 County Health Rankings & Roadmaps, published by the Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute, ranked Putnam County as 66th out of 67 counties in Florida in overall health and 49th in clinical care. When there is a lack of physicians, residents have a harder time receiving timely medical care. SJRRHN noticed a need for increased medical care options in Putnam County, particularly a lack of services that could be provided using telehealth. Additionally, progress in the area of behavioral health was limited in rural counties like Putnam compared to the progress of their urban counterparts due to a persistent lack of available funding and resources. One of the most highly visible challenges in the county has been widespread opioid abuse, which the Putnam County Sheriff's Office described as "off the charts."

Program Services

Description

The PC3 project activities explored telehealth options and implementation methods that utilized technology for Putnam County providers. Additionally, SJRRHN offered grant application development, project planning, implementation, management, and sustainability services to support organizations that directly serve Putnam. Network partners also informed local organizations of available education, outreach, and grant opportunities via emails and newsletters. When service providers outside of Putnam County were informed of project activities (through the implementation of the communications and marketing plan), SJRRHN expanded activities to the seven-county region to meet demand.

Role of Network Partners

SJRRHN and HPCNEF developed an annual mental health report and a consumer telehealth satisfaction report, shared opportunities for continuing education and professional-development programs to Putnam County service providers, and developed a website for PC3 project communications. SMA implemented telehealth service delivery and contributed data for a project data dashboard. Through monthly meetings, the Putnam County Behavioral Health Forum served as an in-person platform for understanding the needs, objectives, and desires of Putnam County service providers. All partners collaborated to identify five new organizations in Putnam County to become PC3 members; engage organizations to partner with the network; increase public awareness and outreach of the network's health improvement efforts; and develop the PC3 marketing plan, strategic plan, and evaluation plan.

Outcomes

Program Outcomes

As a result of network development efforts, the SJRRHN board of directors grew from three to 11 members, three of which are in Putnam County. The PC3 project also generated interest and partnerships with providers outside of Putnam County. By scaling the PC3 project up to a regional level, SJRRHN annual revenue from grants with those partners increased from \$63,555 in 2018 to \$422,841 in 2022. The project allowed partners to develop disparity impact statement reports as an in-demand product, as outsourcing to SJRRHN

gave providers more time to focus on direct services instead of report writing. With reinvestment back into the project, SJRRHN was able to add on network support personnel from half of a full-time equivalent (FTE) position to 3.5 FTEs. The PC3 project provided an opportunity to improve internal protocols for the memoranda of agreement (MOAs) that clearly define roles and responsibilities of partners.

Network Collaboration

Managing both internal and external expectations was key to successful partnerships in PC3. Maintaining open communication enabled partners to navigate challenges and determine how best to use resources. As is the case with many other rural communities, the use of in-person meetings over virtual ones fostered trust and cooperation between entities. Utilizing all available resources, such as the technical assistance, helped guide how working partnerships were created.

Sustainability

Though the PC3 project was not able to advance telehealth on a wide scale in Putnam County as originally intended, network-development efforts resulted in increased collaboration opportunities in other counties in the SJRRHN service area. Network partners were able to successfully pivot the direction of the project to adapt to community changes and the COVID-19 pandemic, which ultimately resulted in stabilizing the network. Through the PC3 project, SJRRHN established a regional reputation as a collaborative partner to rural providers instead of a competitor. Sustained impacts within SJRRHN include internal staff restructuring and strategically redefined roles based on individual strengths; new partnerships inside and outside of Putnam County; a more efficient grant research, development, and writing process; and an improved protocol for drafting MOAs between network partners to ensure long-term sustainability. SJRRHN continues to offer a robust menu of services — with a heavy focus on cultural competency support and report writing — to Putnam County and the six other counties in the service area. The strong relationships it developed in Putnam County and beyond will help sustain the organization over the long term.

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Dublin City Board of Education

Dublin City School Health Network

D06RH3750

Project focus area:
School-based Health

Other focus areas:
Behavioral Health/Mental Health

Network History and Members

The network partners have been working together for the last several decades to address unmet student health and social service needs in the Dublin City School System. In July 2020, a federal Rural Health Network Development grant award was funded to support the Dublin City School Health Network, expand school nursing services, and implement behavioral and mental health services in the school system. In May 2021, a federal Rural Health Outreach Services grant award was funded to provide dental education, outreach services, and school-based education related to substance abuse and life skills (including a mentoring program). In August 2022, a federal Small Healthcare Provider Quality Improvement grant was funded to enhance health services through the use of telehealth technology and connectivity, provide effective communication and coordination of care, promote the wide use of best practices to enable healthy living, and develop the necessary capacity and ability to obtain funding from other sources.

Member Organization	Location	Organizational Type
Dublin City Board of Education	Dublin, Laurens County, GA	School Board
South Central Health District	Dublin, Laurens County, GA	Public Health Department
Community Service Board of Middle Georgia	Dublin, Laurens County, GA	Nonprofit Organization
Fairview Park Hospital	Dublin, Laurens County, GA	Hospital
Laurens County Family Connection	Dublin, Laurens County, GA	Nonprofit Organization

Community Characteristics

Area

The service area is the city of Dublin in Laurens County, Ga.

Target Population

All 2,296 students, prekindergarten–12th grade, enrolled in the Dublin City School District and their parents/guardians.

Need

The city of Dublin has demographics similar to those of many poor, rural, and underserved areas of the nation. The poverty and other socioeconomic statistics are among the worst in the nation. Much of the poverty and dysfunctional family situations in the service area are due to issues such as substance abuse, families started when the parents were teenagers, and other at-risk behaviors. Many of the local students and their families have inadequate access to health care services other than those available through the emergency department of the local hospital. Furthermore, many students and their families have inadequate access to essential mental and behavioral health services.

Program Services

Description

Through this funding, the project implementation team is providing school nursing services; providing a depression screening or assessment for all enrolled students; providing behavioral and mental health services; providing support group services (regarding mental and behavioral health issues); developing and implementing standardized clinical protocols; developing and implementing an ongoing quality-improvement process; providing ongoing training opportunities for parents and guardians, school nurses, counselors, other school system staff members, and community collaborative members regarding relevant physical and mental and behavioral health issues; and developing a sustainability plan that will generate at least \$300,000 per year to sustain network-related activities.

Role of Network Partners

All of these members serve on the board of the network, attend relevant meetings, promote network related activities, and provide input and expertise to the network. In addition, they provide unique services as noted. The Dublin City Board of Education serves as the fiscal agent for the grant and provides overhead resources and services for the network and project directors, school nurses, and mental health coordinators; the services of existing school nurses, counselors, and educators to support school-based health; support for administration of surveys; and relevant data regarding student health and wellness. The South Central Health District provides annual flu clinics for students and staff, CPR training, scoliosis screening for students, diabetes training for students who have been diagnosed with diabetes, and relevant data regarding student health and wellness. The Community Service Board of Middle Georgia provides ongoing social/emotional and mental health services for students and relevant data regarding student health and wellness. Fairview Park Hospital provides relevant data regarding student health and wellness, and training for students, parents, and staff regarding relevant health issues. Laurens County Family Connection assists with the network's ongoing needs assessment and community awareness activities.

Outcomes

Program Outcomes

The most significant accomplishment has been the establishment of the behavioral health department in the school system. Working together to serve students and their families, the team has worked hard to establish cordial and working relationships with the other school system staff, community partners, parents, and students. One of the most visible outcomes is the "shamrock button" on the school system's webpage. When a student, parent, staff member, or community agency needs assistance from the behavioral health department, they can click on the button and describe their need, eliciting immediate and targeted assistance. During the 2021-2022 school year, there were 651 requests for assistance and related responses. Each of these requests was immediately assigned a staff member (e.g., mental health coordinator, school system

social worker, or school guidance counselor) for a response. This online referral system has been successful in mainstreaming the request process and reducing the time that would be required for a paper-driven, formal referral for services. Essentially, the student, parent, or school system staff member can refer himself or herself for assistance and receive that assistance on the same day it was requested. This streamlined referral process was made possible through the department's close working relationship with the directors of technology and publications in the school system. The mental health coordinators provided intensive ongoing in-person counseling for 76 students during a total of 218 contacts during the year. The school nurses provided school nursing-related services including, but not limited to, 8,860 in-person illness and injury visits and 11,795 medication-related visits during the first semester of the 2021-2022 school year. They also made 1,628 parent contacts and 38 referrals to local health providers. In addition, they provided hearing/vision screenings; checked all students' immunization records; conducted scoliosis screenings for all sixth- and eighth-grade students and conducted COVID-19 vaccination clinics for both students and staff. They also made 15 presentations to students, parents, and faculty during the year with an average of 63 individuals attending per session. Training opportunities for parents and guardians regarding relevant physical, mental, and behavioral health issues were provided, with the posted educational videos receiving more than 26,176 views.

Network Collaboration

The network effectively collaborated to achieve the goals of the program as demonstrated by the noted outcomes. The principles that guided the network were effective communication, established partnerships built upon trust, steadfast determination, and a commitment to serving the children (and their families) in the community using all available resources.

Sustainability

In addition to the outcomes noted above, the following sustained impacts have been achieved: (1) standardized clinical protocols were provided for use in all of the schools in the school system, (2) an ongoing quality-improvement process provided a mechanism for monitoring clinical services and evaluating grant-funded goals, (3) a comprehensive, ongoing evaluation process was implemented, (4) an ongoing community awareness campaign is visible via social media, and (5) an additional \$1.6 million in resources has been received for network services and programs.

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Rural Health Works

Southeast Georgia Obesity
Prevention Network

D06RH37521

Project focus area:
Obesity Prevention

Other focus areas:
None

Network History and Members

This network started with the local health care system and further developed by expansion to include local, nonprofit, community-based organizations and the local school systems. In 2018, the network established the Southeast Georgia Obesity Prevention Network to collaborate and develop solutions for this growing epidemic. The network is determined to combat childhood and adult obesity through a family-focused initiative and, using a multistakeholder strategy, to work together to reduce disease by reducing obesity.

Member Organization	Location	Organizational Type
Memorial Health Meadows Hospital	Vidalia, Toombs County, GA	Hospital
Vidalia City Schools	Vidalia, Toombs County, GA	School Board
Toombs County School System	Lyons, Toombs County, GA	School Board
Montgomery County School System	Mount Vernon, Montgomery County, GA	School Board
Wheeler County School System	Alamo, Wheeler County, GA	School Board
Treutlen County School System	Soperton, Treutlen County, GA	School Board
Toombs County Family Connection	Vidalia, Toombs County, GA	Nonprofit Organization
Tri-County Family Connection	Mount Vernon, Montgomery County, GA Soperton, Treutlen County, GA Alamo, Wheeler County, GA	Nonprofit Organization
Mercer University School of Medicine	Macon, Bibb County, GA	University

Community Characteristics

Area

Toombs County, Montgomery County, Wheeler County, and Treutlen County.

Target Population

The target population in the service area is children aged 9-12 years and their families. Additionally, children who utilize the local health system and are enrolled in the service area school systems are included in the target population.

Need

The network made several relevant discoveries: the region is devoid of programs that could support residents in behavioral change, none of the school systems offer regular after-school programs, organized sports and physical activities are few and far between, health promotion is not part of the school's established curriculum, community opportunities for physical activity are lacking, and several hospital-based wellness programs were discontinued due to low utilization.

Program Services

Description

The network brought together a diverse set of community stakeholders to pursue novel approaches to combat childhood obesity within the region. The network ultimately developed a pilot program to test family behavioral health counseling as an approach to address underlying causes of childhood obesity.

Role of Network Partners

Input was gathered from each of the network members to explore approaches and ultimately develop the pilot program. Pediatricians identified at-risk youth, explained the concept of family behavioral health counseling to parents, and referred families to the project. Mercer University School of Medicine's Marriage and Family Therapy program offered a practical schedule of virtual family counseling sessions with youth and their families. Rural Health Works administered and facilitated the handoff between pediatricians and behavioral health counselors. Family Connections partners, as well as school system partners, assisted in the facilitation of developing a family peer champion program so that families who have successfully completed the behavioral health counseling program can support families newly entering the program.

Outcomes

Program Outcomes

The network was able to identify novel approaches and ultimately settle upon the family behavioral health counseling model to develop a pilot project. School systems were supported with technical assistance to increase better health-focused capacity as well as several systemic policy changes at the school system level. Health care providers learned more effective approaches to weight counseling for children and youth than they had previously been utilizing. Clinical outcomes are expected in mid to late 2023.

Network Collaboration

The combination of such a diverse group of network members and stakeholders was necessary to fully explore the challenges and options concerning childhood obesity within the region. This diversity also created several challenges. After initial governance and structural work, the network ultimately identified the need

to implement the project in a two-track system. This allows community groups and school system partners to implement in one track while the health care providers, health systems, and related partners implement in another, with the two tracks converging twice per year for planning and analysis. This type of collaboration is of particular note because the network found it to provide benefits for such a diverse group of members while minimizing the challenges of working with a group that has differing areas of focus. The network was also faced with the challenge of working with the health system and provider group that changed ownership from a nonprofit to a for-profit organization midway through the program. Open-mindedness and flexibility by all members were essential for navigating this collaboration, with a key member that essentially inherited a “host” position within the network and who now had a greater focus on profit. By a constant exchange of information, patience, and pausing to assess landscape changes, the network was able to adjust to the change and continue with minimal disruption to activities.

Sustainability

Beyond developing new processes and methods of collaboration, the focus of sustainability was not to develop a project that would stand alone with the new infrastructure and overhead, but rather to develop a project that could be easily integrated into the scope of one or more network members and be profitably operated in the future, while the network remains an overarching structure to continue to identify and address community health challenges and for the future.

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HSHS Good Shepherd Hospital

Illinois Telehealth Network

D06RH3705

Project focus area:
Telehealth

Other focus areas:
School-based Health

Network History and Members

The Illinois Telehealth Network (ITN) is a member-based, voluntary network of independent organizations working together to address widespread medical provider and care shortages in rural, underserved, and disadvantaged areas in Illinois. The ITN began in 2017 and currently consists of 28 members collaborating to help eliminate barriers to health care access. Funded by more than \$5 million in federal and foundation grants, the ITN is managed by an elected board of directors that is supported by a five-person staff team helping members to advance telehealth initiatives throughout the state.

Member Organization	Location	Organizational Type
Shelbyville Community School District	Shelbyville, Shelby County, IL	School District
Sav Mor Pharmacy	Louisville, Clay County, IL	Pharmacy
Salem Township Hospital	Salem, Marion County, IL	Hospital
Locust Street Regional Center	Carlinville, Macoupin County, IL	Behavioral Health Resource Center
HSHS Good Shepherd Hospital	Shelbyville, Shelby County, IL	Hospital
HSHS St. Joseph’s Hospital Breese	Breese, Clinton County, IL	Hospital
Carlinville Area Hospital	Carlinville, Macoupin County, IL	Hospital
Thomas Boyd Memorial Hospital	Carlinville, Greene County, IL	Hospital
Memorial Hospital	Carthage, Hancock County, IL	Hospital
Warner Hospital and Health Services	Clinton, DeWitt County, IL	Hospital
HSHS St. Mary’s Hospital	Decatur, Macon County, IL	Hospital
HSHS St. Antony’s Hospital	Effingham, Effingham County, IL	Hospital
HSHS Holy Family Hospital	Greenville, Bond County, IL	Hospital
Mason District Hospital	Havana, Mason County, IL	Hospital
HSHS St. Joseph’s Hospital Highland	Highland, Madison County, IL	Hospital

Hillsboro Area Hospital	Hillsboro, Montgomery County, IL	Hospital
Jersey Community Hospital	Jerseyville, Jersey County, IL	Hospital
HSHS St. Francis Hospital	Litchfield, Montgomery County, IL	Hospital
Kirby Medical Center	Monticello, Piatt County, IL	Hospital
HSHS St. Elizabeth’s Hospital	O’Fallon, St. Clair County, IL	Hospital
Pana Community Hospital	Pana, Christian County, IL	Hospital
Sarah D. Culbertson	Rushville, Schuyler County, IL	Hospital
Southern Illinois Healthcare Foundation	Sauget, St. Clair County, IL	Federally Qualified Health Center
HSHS ACO, LLC	Springfield, Sangamon County, IL	Accountable Care Org.
HSHS St. John’s Hospital	Springfield, Sangamon County, IL	Physician Group
HSHS Medical Group	Springfield, Sangamon County, IL	Physician Group
Prairie Cardiovascular Consultants	Springfield, Sangamon County, IL	Physician Group
HSHS Physician Clinical Integration Network	Springfield, Sangamon County, IL	Physician Group

Community Characteristics

Area

These counties in Illinois: Marion, Shelby, Clay, Hancock, Dewitt, Macon, Effingham, Bond, Sangamon, Christian, Piatt, Montgomery, Mason, Macoupin, Clinton, Schuyler, St. Clair, Jersey, Madison, and Greene.

Target Population

The ITN serves all ages of rural and urban patients in central and southern Illinois, regardless of gender, race, ethnicity, or ability to pay.

Need

More than 1.7 million rural dwellers and patients in disadvantaged and underserved shortage areas of central and southern Illinois have limited or no access to essential health care services, and many of their providers have limited capacity. To address this need, the nonprofit ITN was formed with an elected board, bylaws, and mission “to promote the capacity of members to improve access to health care, in rural, underserved and disadvantaged communities, through the application of telehealth and telemedicine solutions,” and a vision to “connect and share resources, strengthen rural health care and save lives.”

Program Services

Description

This 2020-2023 Rural Health Network Development (RHND) project proposed three telehealth activities to (1) expand current services, (2) develop three new focus area services, and (3) support program sustainability. The three new focus area services are opioid/substance use disorder telemedicine, school-based telehealth, and tele-cardiology.

Role of Network Partners

ITN members participate in needs assessments and voluntarily plan and collaborate on initiatives to drive change in health care delivery by evaluating, choosing and implementing telemedicine solutions that support

their organizational business model and serve their patients. ITN members are highly engaged, motivated, and committed to increasing access to quality patient care in rural and underserved areas. Members contribute annual member dues and participate in committees and member meetings to advance ITN's mission and vision through practical collaborations and pilots.

Outcomes

Program Outcomes

The ITN expanded services in the tele-stroke, tele–neonatal intensive care unit, and tele–emergency department crisis assessment programs to additional sites and connecting with 2,000 patients per calendar year. The school-based telehealth pilot has started and is at full capacity and would benefit from additional tele-behavioral health providers. In the first semester of operation, it has saved families \$1,500 in mileage and 80 hours of driving time, in addition to avoidance of a six-week or more waiting list for services. It is receiving positive feedback from school staff, patients, and parents.

Network Collaboration

ITN members are very receptive to collaboration and utilizing resources to best suit the needs of patients, providers, and their business models. A lesson learned through pilots and operations is to keep the workgroup small and bring in key stakeholders when necessary.

Sustainability

This RHND project continues to improve the access to and the coordination, quality, and delivery of telemedicine services for patients in rural underserved Illinois shortage areas to increase access to essential health care. Four new members were added to the Illinois Telehealth Network including a behavioral health resource center, a rural township hospital, a rural school district, and a rural pharmacy, resulting in an expansion to the rural population being served through the network. The ITN has witnessed a positive shift in attitudes and behaviors around telehealth in the past few years and expects to see continued growth and adoptions from providers and patients, along with new and innovative ways to provide health care services to underserved populations.

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Katherine Shaw Bethea Hospital

Northwest Illinois Rural Health Network

D06RH37509

Project focus area:
Care Coordination

Other focus areas:
Social Determinants of Health

Network History and Members

Katherine Shaw Bethea (KSB) Hospital, Kreider Services Inc., and Sinnissippi Center Inc. have worked together for over a decade. Collaboration resulted in the creation of Florissa, a pediatric development center with a holistic approach to diagnosis and treatment of children birth to 18 years old. In 2017, the network received a Rural Health Network Development grant to transform KSB’s pediatric practice to the first patient-centered medical home (PCMH) recognized by the National Committee for Quality Assurance (NCQA) in our area. This launched a variety of new services including integrated behavioral health services, a new virtual care platform, and care coordination activities. The network expanded this initiative to two family medicine practices located in Lee County (KSB Family Health Center) and Ogle County (KSB Oregon Clinic). In 2021, KSB committed in their three-year strategic plan to expand the PCMH model to all KSB primary care practices. The broadened focus of the network and the medical homes toward cradle-to-grave care opened new services, including a population health management–platform, disease registries, chronic care management services, and social determinants of health (SDOH) screening and referral pathways. Other stakeholders involved in the network include health departments, rural office of education, schools, and other service providers.

Member Organization	Location	Organizational Type
Kreider Services Inc.	Dixon, Lee County, IL	Nonprofit Organization
Sinnissippi Centers	Dixon, Lee County, IL	Nonprofit Organization
KSB Hospital	Dixon, Lee County, IL	Hospital

Community Characteristics

Area

The PCMHs are physically located in Dixon, Ill., (Lee County) and Oregon Ill., (Ogle County). However, patients reside in Lee, Ogle, and Whiteside counties.

Target Population

This project serves the northwest Illinois counties of Lee, Ogle, and Whiteside. From a program perspective, the two medical homes serve people of all ages, genders, races, and insurance status within the primary

service area, which comprises 15 ZIP codes surrounding the cities of Dixon and Oregon, Ill., (46,000 total population). Specific attention is given to those impacted by special health care needs or who hold other risks for compromised health and wellness. This includes adults and children who exhibit chronic medical, developmental, or behavioral conditions.

Need

Lee, Ogle, and Whiteside counties are recognized as Health Professional Shortage Areas with shortages in primary care, dental, and mental health services. As expected, this target population lags state and national benchmarks when it comes to common wellness and preventive exams and services including wellness exams, mammograms, and colonoscopies (County Health Ranking data, “Quick Facts: CRC Screening in Illinois,” Centers for Disease Control and Prevention, 2016). Prevalence of diabetes and other chronic conditions exceeds national benchmarks. Diabetes, obesity, physical inactivity, and food insecurity consistently rank as top health concerns in community health needs assessments. There is a need to identify and help address social determinants of health with a lack of coordination and resources to do so.

Program Services

Description

The major activities conducted through this program include (1) the transformation of two family medicine practices (Dixon and Oregon) into PCMHs following the NCQA model, (2) implementation of a fully integrated behavioral health service at each medical home based on the Primary Care Behavioral Health (PCBH) model, (3) the development and implementation of a digital population health platform (Cerner HealtheRegistries) that leverages electronic health record data, claims data, disease registries, and evidence-based recommendations to identify gaps in preventive care services, (4) expansion of a chronic care management program, and (5) development and implementation of a screening program for social determinants of health utilizing the Protocol for Responding to & Assessing Patients’ Assets, Risks & Experiences (PRAPARE) screening tool and supporting referral pathways.

Role of Network Partners

The three formal partners are KSB Hospital and Medical Group, Kreider Services Inc. (developmental disability provider), and Sinnissippi Centers (mental health provider). KSB serves as the fiscal agent, employs the project director, and operates the medical practices. Kreider Services employs the network director, and Florissa assists with building capacity for complex pediatric diagnostics. Sinnissippi and KSB are currently piloting a digital community referral platform called Community Wellbeing through the medical home integrated behavioral health service with the goal of improving coordination and data sharing between the two organizations. Several other network participating agencies have been involved in helping build the SDOH screening and referral program.

Outcomes

Program Outcomes

Outcomes achieved as a result of this project include the implementation of new care delivery models at two family medicine practices and the PCMH and PCBH models. In addition to implementing new care delivery models and corresponding services and workflows, the network also developed and implemented a digital population health platform that provides a real-time view of all recommended preventive services and screenings for each empaneled patient, allowing for execution of a robust preventive care strategy for the community. As a result of these new models, services, and technology, there has been a decrease in

readmission rates from baseline, an improvement in several preventive care measures including breast and colorectal cancer screening rates, an increase in well visits for children 0–6 years of age, increased enrollment in chronic care management services, screening for and identification of social determinants of health using the PRAPARE tool, and improved care coordination between agencies.

Network Collaboration

Developing relationships and becoming familiar with available services in the region has been critical to sustainably and efficiently serving patients, especially with the launch of SDOH screening and supporting referral pathways. Collaborating with network partners to come up with creative solutions to address service gaps was important. In one example, members worked with a local transportation agency to reserve certain appointments in the schedule, which allows a shorter round trip for patients who utilize that service. Collaboration resulted in another network partner’s pilot of a digital community referral platform to assist with referrals and improve information sharing for behavioral health services.

Sustainability

New service models introduced as a result of the grant include the medical home and integrated behavioral health model. The implementation of these models has increased capacity to treat more conditions within the practices while improving access to medical and behavioral health care. The medical home model emphasizes continuous quality improvement (QI), which has resulted in improved systems such as QI huddles and visual boards that engage teams in quality, access, and patient experience improvement efforts. Investments made in technology, like the digital population health platform for preventive care and disease management/registries, have provided real-time decision support to care teams leading to sustainable improvements in various preventive care and wellness gaps within the target population. This technology has also allowed the project team to conduct wellness outreach campaigns to proactively educate and remind patients of overdue services. Finally, this project launched the exploration among network partners of utilizing a standardized evidence-based screening tool for the identification of SDOH. The medical homes were the first sites to implement the PRAPARE screening tool and referral process within the network.

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University Health Bedford Hospital

Rural Dementia Network

D06RH37507

Project focus area:
Dementia

Other focus areas:
Community Health Workers

Network History and Members

The Rural Dementia Network of Southern Indiana (RDN) was established because of the Rural Health Network Development (RHND) grant awarded in July 2020, building on the success of and in collaboration with the Alzheimer’s and Dementia Resource Service (ADRS) at Indiana University (IU) Health Bloomington Hospital. The RDN has brought a concentrated focus to the underserved rural populations of Lawrence and Orange counties in Indiana by developing a network of support, education, awareness, and stigma reduction. The services provided by both the RDN and ADRS are at no cost to the community. An added benefit to the community has been a greater focus on brain health, cognitive decline risk reduction, and an implementation of best practices in care along with an increase in health care literacy surrounding brain health and dementia. The network addresses all phases of the dementia trajectory, from diagnosis through the end of life, both for people living with dementia (PLWD) and their care partners.

Member Organization	Location	Organizational Type
Indiana University Health Bedford Hospital	Bedford, Lawrence County, IN	Hospital
Indiana University Health Bloomington Hospital	Bloomington, Monroe County, IN	Hospital
Indiana University Health Paoli Hospital	Paoli, Orange County, IN	Hospital
The Solutions Center	Mitchell, Lawrence County, IN	Nonprofit Organization
Hoosier Uplands	Bedford, Lawrence County, IN	Area Agency on Aging

Community Characteristics

Area

The target area for the RDN is rural Lawrence and Orange counties, Ind. Residents of Lawrence and Orange counties experience the typical sociocultural health disparities of rural counties across the country. The area is home to approximately 65,000 people.

Target Population

The targeted population of the project are PLWD, care partners (both private and professional), as well as the overall general population. A more narrowed target population was persons 45 years and older for brain health assessment, however, as health care literacy is an area of concern that spans all age groups. Considerable attention to risk reduction and stigma reduction is targeted to the entire community population. Within this service area, the percentages of racial and ethnic minority subpopulations is very small.

Need

The aging population and needs of seniors were identified as an area of focus in regional community health needs assessments (CHNAs) conducted by IU Health hospitals that serve Lawrence and Orange counties, Ind. The population of individuals aged 65 years and older is projected to increase in each of the targeted counties between 2020 and 2025. The increase in population of this age group will contribute to a growing need for health services. The regional CHNAs identified significant needs among older adults, particularly related to resources to age in place as well as cognitive issues among seniors.

Program Services

Description

The RDN addresses all phases of the dementia trajectory, from diagnosis through the end of life, both for PLWD and their care partners. The following services are provided at no cost to the target populations:

- Community education and outreach to promote awareness of brain health and combat stigmas regarding cognitive decline
- Specialized training for hospital, long-term care, and other health care staff in dementia care practices
- Training for current and upcoming certified nursing assistants and home health aides to better relate to PLWD through the Dementia Friendly Care Partner Development Program
- Coalition-building, including leading local “dementia-friendly” efforts
- Resource connections and referrals to health care and social service providers
- Individualized family consultation, including home visits
- Care partner support groups and respite assistance
- Scholarships for PLWD and their care partners for training and educational opportunities related to dementia and brain health

Role of Network Partners

All formal network partners provided valuable feedback to the project and network directors on local needs and resources and advised on necessary services in the area. They served on an advisory board, which held quarterly meetings and worked together on relevant projects and workgroups. Both formal and informal partners were key in successful implementation of the objective of a robust network of support for people living with dementia and their care partners. They also served as advocates of the educational opportunities and activities of the network and promoted and participated in various projects.

Outcomes

Program Outcomes

Through the efforts and outreach of the RDN, more than 500 people attended at least one training, conference, presentation, or educational opportunity in Lawrence and Orange County. More than 90

professional caregivers and future professional caregivers were trained in Dementia Friendly Care Partner Certification classes. More than 100 people living with dementia or their caregivers were individually connected with resources and services through private consultation. Every department of the Bedford City Government in Lawrence County, Ind., was certified dementia-friendly, as were more than 30 other businesses and organizations in Lawrence and Orange County, including the entire IU Health Bedford and IU Health Paoli Hospital. Efforts spread to other counties due to increased interest and requests for services. A medical model inflatable brain was purchased to help teach people about dementia and brain health. The RDN brought key stakeholders together to address these needs through a formal, comprehensive, and collaborative approach.

Network Collaboration

The network partners collaborated on strategic planning and evaluation planning projects, as well as on completing objectives and activities throughout the project. Despite partners' attention at times being focused on addressing the pressing health care issues presented by the COVID-19 pandemic, progress and participation was consistent and the strength of the network is good. The RDN partners, both formal and informal, continue to collaborate on ways to work together to reach the targeted populations through creative strategies and address isolation, health outcomes, and quality of care. Many partners have become trainers in dementia-friendly practices to advance the efforts and impact of the RDN.

Sustainability

Formal network partners have developed a strong relationship that will likely continue well beyond the scope of this project. The impact in the community by both formal and informal network partners in proactively addressing the unique needs of PLWD and their care partners helped create an environment where they are more able to navigate resources within this rural community with a sense of dignity and inclusion. Support and education, where there was essentially none prior to the project, have improved the access to and awareness of resources and impacted health care literacy and support. There are now people in the health care workforce who have more specific dementia care training.

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MercyOne Newton Medical Center

Rural Health Integration Network

D06RH37512

Project focus area:
Community Health Workers

Other focus areas:
Social Determinants of Health

Network History and Members

The MercyOne Population Health Services Organization (PHSO) was instrumental in utilizing grant funding to initiate a community health worker (CHW) program in urban areas across central Iowa. Learning of the success of this program, MercyOne Newton reached out to the PHSO to partner and apply for HRSA funding to implement a CHW program in the emergency department of their rural medical center. Based on prior working relationships and awareness of the needs in the communities, the MercyOne affiliate organizations of Dallas County Hospital and Family Medicine Clinic, and Knoxville Hospital and Clinics, were invited to be part of this project. The desire of the leadership in these additional rural health facilities to implement a CHW program led to the initiation of the Rural Community Health Integration Network.

Member Organization	Location	Organizational Type
MercyOne Newton Medical Center	Newton, Jasper County, IA	Hospital
Dallas County Hospital and clinics	Perry, Dallas County, IA	Hospital
Knoxville Hospital & Clinics	Knoxville, Marion County, IA	Hospital
MercyOne PHSO	Clive, Polk County, IA	Hospital

Community Characteristics

Area

MercyOne Newton serves the rural community of Newton and residents of Jasper County. Dallas County Hospital is located in a rural tract of an urban county and serves the rural community of Perry, Iowa, and the surrounding area. Knoxville Hospital and Clinics, located in Marion County, serves the residents of Knoxville, Pleasantville, and Pella.

Target Population

The target population is adults served by network member organizations. Dallas County and Knoxville target those seen in the hospital and rural health clinics. Newton serves patients treated in the emergency department.

Need

Studies indicate the health of a person is most influenced by socioeconomic factors and health behaviors. The medical care a patient receives from his or her provider contributes to only 20% of the overall health of the person. The Rural Community Health Integration Network was developed to impact the health of patient populations by reducing socioeconomic burdens, improving the care delivery systems within the rural health care facilities and communities, and to expand and strengthen community partnerships within the network.

Program Services

Description

A CHW was hired for each rural community. Social needs screening was implemented at each site, and patients who identified an unmet social need, through screening or during an encounter with a member of the health care team, were asked if they would like to work with a CHW. The CHW partners with each person to prioritize needs and identify appropriate community resources to help meet their social needs. CHWs also developed relationships with community-based organizations to better understand the resources available, help improve the referral process, and identify opportunities for growth and partnership.

Role of Network Partners

The MercyOne PHSO is responsible for grant administration. Both the project director and the grant project manager are employed by the PHSO. The grant project manager organizes network meetings, trains and mentors the CHWs, and collaborates with the leadership at each network site. MercyOne Newton (grant awardee) and the PHSO grant team work closely with the MercyOne director of social and clinical care integration to model the grant project after the established CHW program already in place in urban communities. The network partners in each rural community hire and employ the CHWs at their facilities. While the grant application and work plan provide the framework for this project, each network member determines how to incorporate the CHW into the care team and how the process will be implemented in their organization. CHWs and leadership from each network site participate in network meetings and work together to move the grant project forward and plan for sustainability of the program after the grant is complete.

Outcomes

Program Outcomes

During the grant project period to date of this report, 15,700 patients were screened for social needs. Of these, 3,700 patients identified they had one social need or more, over half of them requested assistance from a CHW, and 30% of those same patients indicated their needs were “urgent.” Of patients with whom CHWs were able to follow up after being given resources, 42% indicated that their needs were full or partially met.

Network Collaboration

CHW collaboration was invaluable to this program. While this program was modeled after the urban MercyOne CHW program, the rural CHWs were able to discuss and troubleshoot challenges specific to rural areas. The network also collaborated to create marketing and educational materials, making this more cost-effective and efficient than having each member create their own resources. One of the most beneficial tactics was the collection of detailed data. Grant funding enabled each site to connect with, and chart in, the MercyOne care management platform. This allowed the collection of detailed data from each site as well as aggregated data. Leaders appreciated this detailed information that has been used in reports, in applications for additional funding, and even for a physician process-improvement project. The data has also been shared with

community organizations, at least one of which used the data to pursue additional funding. The combination of patient progress stories and detailed data each month has engaged stakeholders both within and outside of the network.

Sustainability

The sustained impact of this program includes improved awareness of the influence of social determinants of health on the health of a person as demonstrated by a pre- and post-survey of health care staff at each network site. The project has increased capacity at the local network sites by improving the data feed from the local electronic health record to the MercyOne care management platform, providing better access to data. Educational opportunities, including staff trainings, motivational interviewing training for the CHWs, and CHW manager training, have increased the capacity of the network sites to provide a high-quality, evidence-based CHW program. Marketing and education materials are available to each site to order or print as needed and are utilized in staff orientation and training. A combination survey and community organization focus group was conducted at each network site to evaluate the strengths and barriers in coordinating patient care. The information and data generated from the survey and discussion will be invaluable moving forward to address challenges each community faces.

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Unity Healthcare

Fueling the Future Rural Health Network

D06RH37531

Project focus area:
Workforce Development

Other focus areas:
Social Determinants of Health

Network History and Members

The Fueling the Future Rural Health Network is an existing informal group of health care providers that were part of the Future Ready Iowa pilot project ideation. The initial collaborative partners were the UnityPoint Health–Trinity, Muscatine public health director, Community Foundation of Greater Muscatine president, city of Muscatine Community Development and Housing director, Muscatine Center for Social Action director, and Muscatine Community College president. At the time of application to the Future Ready Iowa grant, the United Way of Muscatine director and Aligned Impact Muscatine director were added to the network. At the time of application to HRSA, the network was more fully formed and added a representative from the Muscatine Community School District and Robert Young Behavioral Health. These additions provided a more actionable team with robust expertise. The leadership of each partner organization is highly credentialed and trained and holds seats on various regional and state agency boards and councils, ensuring best practice utilization.

Member Organization	Location	Organizational Type
Community Foundation	Muscatine, Muscatine County, IA	Nonprofit Organization
Muscatine County for Social Action	Muscatine, Muscatine County, IA	Nonprofit Organization
Trinity Muscatine	Muscatine, Muscatine County, IA	Hospital
Align Impact Muscatine	Muscatine, Muscatine County, IA	Nonprofit Organization
City Housing	Muscatine, Muscatine County, IA	City Government
United Way of Muscatine	Muscatine, Muscatine County, IA	Nonprofit Organization
Muscatine School System	Muscatine, Muscatine County, IA	School Board
Muscatine Community College	Muscatine, Muscatine County, IA	Community College
Eastern Iowa Mental Health/ Disability Services	Muscatine, Muscatine County, IA	Hospital

Community Characteristics

Area

The following Iowa counties reached by the project included Muscatine and a portion of Northern Louisa County. The communities covered included Muscatine, West Liberty, and Wilton.

Target Population

Fueling the Future targeted Muscatine County and northern Louisa County adults in low-income families of school-age children who demonstrated food insecurity.

Need

The goal of the program was to provide a holistic approach of support to the family during the course of the programming, through the process of seeking and securing employment, and for up to six months post-employment in order to assist families with reaching the goal of no longer being food insecure, thereby providing children with the means to be successful throughout their educational career.

Program Services

Description

The program identified families who qualified for free and reduced lunch within the school systems, or were able to demonstrate a food insecurity, and connected them with an economic navigator, who would assist adults in the family with enrolling in a six-week upskill program. The educational programs identified at the time were computer numerical control machining, welding, certified nursing assistant (CAN), and pharmacy tech programs. Families were provided with support via child care referrals, rental support and utility assistance, a monthly food stipend, and ongoing case management throughout their experience in the program. Case management services utilized the social determinants of health (SDOH) tool in order to identify and work toward eliminating the barriers families experiencing poverty often encounter.

Role of Network Partners

Network board members participated in several cross-collaborative projects, which has increased trust, created shared purpose, and strengthened mutual respect for decision-making and vision. Through the collective expertise of the network board, Fueling the Future has an interconnected impact on optimal health outcomes for the households they are called to care for in the community. Network meetings provided consensus and direction on activities. Meetings were held monthly, minutes were compiled, and agendas established by prioritized focus areas. Metrics, outcome tracking, timing targets, and other measurement mechanisms were sent out with the upcoming agendas and minutes prior to the meeting to allow study by the network partners to create informed dialogue and decision-making.

Outcomes

Program Outcomes

Seventy percent of participants who successfully completed the program showed an increase in income. A program graduate stated that her two children, aged 13 and 4, are inspired by her drive to continue her education and have since made education one of their priorities. The participant reported that she has made the decision to move beyond her CAN certification and seek out her licensed practical nurse (LPN) credential.

Network Collaboration

Fueling the Future programming has allowed agencies to implement new procedures for coordinating services across agencies. Resource navigators with the school system developed a working relationship with housing navigators with homeless service agencies to address needs of families. Local public health officials gained connections with schools, homeless service agencies, higher education, and community agencies such as the Community Foundation, United Way, and Align Impact, to seek out resources for families in need.

Sustainability

Ninety-five percent of Fueling the Future participants have maintained employment since graduating from the program. Interviews gathered from participants have shown that involvement in programming has resulted in an increase in valuing education, for themselves and their children. Participants have indicated that the support they received has allowed families to be connected to resources they normally wouldn't be aware of, thus lessening the risk of crisis.

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Clinical Improvement Collaborative

Kansas Clinical Improvement Collaborative

D06RH37508

Project focus area:
Care Coordination

Other focus areas:
Chronic Disease

Network History and Members

In 2014, the University of Kansas Health System received a four-year \$12.5 million Center for Medicare and Medicaid Innovation Health Care Innovation Award to establish a rural clinically integrated network. Initially, the network focused on implementation of evidence-based standards of care for treatment of heart attack and stroke in rural communities and on delivery of ambulatory care management services for rural residents with chronic conditions. The network, now known as the Kansas Clinical Improvement Collaborative, LLC (KCIC), has expanded its membership, the conditions for which it supports implementation of evidence-based practices, and the scope of its care management services. KCIC also supports its providers in participating in value-based contracts.

Member Organization	Location	Organizational Type
Kansas Clinical Improvement Collaborative	Ellis County, KS	Clinically Integrated Network
Citizens Medical Center	Thomas County, KS	Hospital
Hays Medical Center	Ellis County, KS	Hospital
Ellsworth County Medical Center	Ellsworth County, KS	Hospital
First Care Clinic	Ellis County, KS	Federally Qualified Health Center
Norton County Hospital	Norton County, KS	Hospital

Community Characteristics

Area

The following counties in Kansas are included in the project: Atchison, Barton, Cheyenne, Clark, Clay, Decatur, Dickinson, Edwards, Ellis,* Ellsworth,* Finney, Greeley, Jefferson, Kearny, Labette, Lincoln, Logan, Mitchell, Morton, Ness, Norton,* Pawnee, Rawlins, Republic, Russell, Scott, Sherman, Smith, Stanton, Thomas,* Wallace, and Wichita.

Target Population

The primary target population is residents of the counties served by the initial cohort of providers participating in the initiative (marked with * above) who suffer from chronic conditions and who would benefit from remote patient monitoring (RPM) services. The secondary target population is residents of counties served by other KCIC-participating providers.

Need

The following table lists the rate of chronic disease in the Medicare population in the four counties served by the initial cohort of providers participating in the initiative as compared to the statewide rate.¹

	Population (2021)	Asthma	Atrial Fibrillation	Cancer	Chronic Kidney Disease	COPD	Diabetes	Heart Failure	Hyperlipidemia	Hypertension	Ischemic Heart Disease
Kansas	2,934,582	4%	9%	9%	22%	11%	24%	13%	46%	57%	27%
Ellis	28,790	3%	10%	10%	28%	12%	23%	15%	49%	61%	25%
Ellsworth	6,336	3%	9%	9%	17%	15%	26%	11%	27%	53%	21%
Norton	5,342	3%	12%	8%	22%	9%	23%	14%	31%	49%	27%
Thomas	7,877	2%	10%	9%	24%	13%	23%	17%	53%	64%	20%

Program Services

Description

In collaboration with the initial cohort of providers, KCIC has engaged in the following activities: (1) evaluated and selected RPM devices, (2) developed criteria for patients to be monitored, (3) designed and executed processes for patient education and device deployment, (4) educated practitioners on the use of RPM in patient management, (5) developed and executed monitoring protocols, (6) recruited and trained clinical staff to serve as monitors, (7) developed and implemented processes for the submission of claims for reimbursement, and (8) monitored and evaluated performance.

¹ <http://www.kansashealthmatters.org/indicators>

Role of Network Partners

Due to COVID-19 pandemic, the participation of the initial cohort of providers was limited during the early phases of the initiative. Initially, these providers furnished lists of patients at highest risk during the pandemic. KCIC then reached out to these patients regarding RPM services. More recently, the network partners have furnished feedback regarding monitoring processes, educated practitioners regarding RPM services, continued to facilitate the identification and enrollment of patients in RPM services, participated in program evaluation, and promoted RPM services to other KCIC participants.

Outcomes

Program Outcomes

In Year 1, KCIC provided RPM services to 200 patients, of which 87% continued receiving services through Year 2. In total, KCIC served 273 patients in Year 2. At present, KCIC is providing services to more than 300 patients, exceeding its projections. Anecdotal reports indicate patients receiving RPM services experience improved health outcomes.

Network Collaboration

Most rural providers lack the resources to provide RPM services in their local communities. Through the network, participants have worked collaboratively to develop, implement, and maintain a program that serves multiple communities. The initial cohort of providers now promote RPM services to other KCIC participants. KCIC has developed a formal contracting process to engage local physicians more fully in RPM services by compensating them appropriately for their work relating to RPM services. These arrangements are increasing the use of RPM services and improving the use of data in ongoing patient management.

Sustainability

Sustainability of RPM services requires provider engagement, patient engagement, and generation of sufficient revenue or other demonstrable return on investment. Regarding provider engagement, KCIC has developed the formal contracting process as described. KCIC also has refined the manner by which monitoring data is presented to providers to make it more useful in ongoing patient management. To engage patients, KCIC has worked with participating providers to identify and recruit appropriate patients. KCIC has made several refinements to its processes to overcome technological challenges, including education and in-person delivery regarding devices. To generate sufficient revenue to sustain services following the award period, KCIC has developed and implemented processes for the submission of claims for reimbursement in compliance with all applicable billing rules. KCIC continues to advocate for Medicare reimbursement to rural health clinics for RPM services, as well as Medicaid and commercial payer reimbursement. Through ongoing program evaluation, KCIC intends to demonstrate the impact of RPM services on total cost of care for providers participating in value-based arrangements.

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Big Sandy Health Care

ReachEKY Health Care Access Network

D06RH37495

Project focus area:
Chronic Disease

Other focus areas:
Community Health Workers

Network History and Members

The ReachEKY Health Care Access Network was formed in 2020 to reduce the burden of chronic disease in a low-income, underserved population in a five-county region of eastern Kentucky. The network consists of seven traditional and nontraditional health care organizations.

Member Organization	Location	Organizational Type
Big Sandy Health Care Inc.	Prestonsburg, Floyd County, KY	Federally Qualified Health Center
Floyd County Health Department	Prestonsburg, Floyd County, KY	Public Health Department
Johnson County Health Department	Paintsville, Johnson County, KY	Public Health Department
Magoffin County Cooperative Extension	Salyersville, Magoffin County, KY	Extension
Pike County Cooperative Extension	Pikeville, Pike County, KY	Extension
Lakefront Church of God	Salyersville, Magoffin County, KY	Faith-based Organization
Sandy Valley Transportation Services	Prestonsburg, Floyd County, KY	Nonprofit Organization

Community Characteristics

Area

The following are included in the project service area: Prestonsburg, Floyd County; Paintsville, Johnson County; Salyersville, Magoffin County; Inez, Martin County; and Pikeville, Pike County.

Target Population

The network targeted adult patients with complex chronic conditions, multiple comorbidities, and social determinants of health issues including food and housing insecurity, lack of transportation, low levels of education, and social isolation. A special emphasis was placed on patients who were dual-eligible for Medicaid and Medicare as well as the uninsured.

Need

People in the service area suffer from disproportionate rates of chronic disease including diabetes, heart disease, chronic obstructive pulmonary disease (COPD), and cancer. High rates of poverty and unemployment, as well as a shortage of medical providers, prevent patients from accessing quality health care. Due to the mountainous terrain, as well as the lack of major highways and public transportation in eastern Kentucky, patients are isolated and live a great distance from health care, including specialty providers, hospitals, and Level 1 trauma centers. Hunger is prevalent in eastern Kentucky. The state has the highest rate of food insecurity in the nation among children and among 50- to 59-year-olds.

Program Services

Description

The network provided health education, navigation services, and linkages to resources for more than 500 patients during the three-year grant period. Community health workers (CHWs) conducted more than 8,000 home visits and provided food and medication deliveries, transportation, and assistance obtaining social services, child care, employment, educational opportunities, and other resources as needed. Most of these services were provided over the past three years, during which time BSHC employed nine CHWs. CHWs also responded to crises such as the COVID-19 pandemic, catastrophic flooding, and ice storms that occurred in the service area. CHWs assisted patients in replacing basic needs such as clothing, food, and household supplies as well as assisting with paperwork required for government assistance. During the grant period, the network also implemented a successful mechanism for billing for services provided by CHWs.

Role of Network Partners

Each network partner played a critical role in the planning and implementation of the grant activities. Each member provided staff, space, and services needed to fulfill the network's mission. Big Sandy Health Care employed and housed all project staff including CHWs. The health departments provided health education and public health services as well as guidance through the COVID-19 pandemic. The cooperative extension services provided farmers markets that facilitated the provision of the FarmRx program, a voucher program to assist with food insecurity and nutrition education efforts. Sandy Valley Transportation provided medical transportation to patients, and Lakefront Church of God provided monthly food boxes and emergency food.

Outcomes

Program Outcomes

Project outcomes included the development of a sustainable, effective health network that provided more than 8,000 home visits to nearly 500 patients. Among patients with diabetes, 62% of patients reduced their A1c by an average of 2.5 points. Through the FarmRx program, more than 400 patients used vouchers for healthy foods. Among the patients participating in the FarmRx program, 48% with diabetes lowered their A1c, 51% with hypertension lowered their blood pressure, and 60.4% reduced their weight.

Network Collaboration

The network collaborated effectively due to developing a shared mission, vision, and strategic plan as well as developing innovative communication strategies that were successful even during a global pandemic. These included using the Zoom platform for monthly meetings, email, patient portals, and Facebook to communicate with each other, patients, and the public.

Sustainability

The impact of the project includes the implementation of a sustainable and replicable model of chronic care management that uses CHWs to reduce the burden of chronic disease. There are also implications for impact resulting from revenue generated by the provision of chronic care management services. This will allow the network to continue operations and to expand and enhance services as needs change. This impact has implications for improved population health outcomes in the region as well as economic benefits realized due to reduced emergency department visits and hospitalizations.

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Purchase District Health Department

Purchase Area Health Connections

D06RH37519

Project focus area:
Community Health Workers

Other focus areas:
Chronic Disease

Network History and Members

Purchase Area Health Connections (PAHC) is a rural health network in western Kentucky with an eight-county service area. PAHC was originally formed by large health care providers realizing they needed to join forces to positively affect population health in the area. This collaborative combines the expertise of members from hospitals, health department, federally qualified health centers, behavioral health, economic development agency, county extension offices, the area health education center, higher education, and the United Way. PAHC sought funding for this grant (1) to continue to strengthen the network and its members, (2) to gain a better understanding of policies and trends in health care and explore their impact on rural health, and (3) to improve population health and reduce hospital readmissions with a system of transitional care that is augmented by technology supporting interagency communication. Through a prior HRSA grant to reduce hospital readmissions at Mercy Health Lourdes and Baptist Health Paducah Hospitals, network members have successfully piloted a transitional care program that was designed to improve population health by reducing hospital readmissions. With this project, the network sought to expand and replicate efforts with two additional hospitals, specifically Jackson Purchase Medical Center and Marshall County Hospital.

Member Organization	Location	Organizational Type
Jackson Purchase Medical Center	Mayfield, Graves County, KY	Hospital
Marshall County Hospital	Benton, Marshall County, KY	Hospital
Baptist Health Paducah	Paducah, McCracken County, KY	Hospital
Mercy Health Lourdes	Paducah, McCracken County, KY	Hospital
Kentucky Hospital Association	Headquartered in Louisville, KY	Nonprofit Network Organization

Community Characteristics

Area

The PAHC network serves the Purchase District (PD) in western Kentucky, which includes the following counties: Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Marshall, and McCracken. PD counties are either in part or entirely Medically Underserved Areas and Health Professional Shortage Areas designated by HRSA.

Target Population

Based on the need below, the specific target population is all individuals admitted to Marshall County and Jackson Purchase hospitals with a target diagnosis (congestive heart failure, sepsis, chronic obstructive pulmonary disease (COPD), pneumonia, total joint replacement — hip or knee, coronary artery bypass grafting, acute myocardial infarction, and stroke) and at risk for later readmission.

Need

According to 2022 data from the Centers for Disease Control and Prevention (CDC), the leading causes of death in Kentucky are heart disease, COPD, stroke, and sepsis. Heart disease in Kentucky occurs at an incidence that is nearly twice the national rate. A community health needs assessment by a hospital in the Purchase Area found that 28% of residents in the service area were smokers. Data from four project partner hospitals in the Purchase Area suggests that individuals with index admissions for heart failure were 20% more likely to be readmitted. As such, the community health worker (CHW) project was developed to reduce the high readmission rates and to improve health outcomes.

Program Services

Description

Case managers CHWs of admitted clients, and CHWs approached clients about enrolling in the program. Clients who enrolled in the program were supported by the CHW for 31 days. The CHW provided clarity about discharge orders and their diagnosis, encouraged and tracked adherence, completed a medication inventory, and aided in connecting patients to resources to help alleviate social determinant barriers to health. Development of the CHW program was guided by four promising/evidence-based practices offered by the Rural Health Information Hub: (1) Community Health Coaches for Successful Care Transitions, (2) MI-Connect Community Health Worker Program, (3) Abbeville County's Community Paramedicine Program, and (4) the CDC's evidence-based Community Health Worker Toolkit. The procedural aspects of the program include (1) an introduction to the program through a meet and greet in the hospital, (2) an enrollment phone call, (3) three home visits, (4) one follow-up phone call, and (5) additional meetings as necessary. During the COVID-19 pandemic, many aspects of the program were transitioned to telehealth.

Role of Network Partners

Network partners attended meetings to drive the project forward, took part in strategic and sustainability planning, and evaluated the services provided. Network partners referred patients to CHWs and worked together to provide coordinated care across their differing agencies and the spectrum of health. Network partners worked together to address population health in the Purchase Area in addition to CHW patient responsibilities.

Outcomes

Program Outcomes

- Patient acuity is a primary driver of patient readmission, with 40% of program participants having a score of 10 or greater on the LACE Index Scoring Tool for Risk Assessment of Hospital Readmission. Nonetheless, there were increases in the program enrollees who did not readmit between project Year 1 (40%) and Year 2 (46%).
- Between project years 1 and 2 there was a decrease in hospitalwide all-cause, all-payer readmission rates from 10.36% to 9.91%, respectively.

- Considering patient self-efficacy and satisfaction, all patients/caregivers (100%) reported increased confidence and understanding of patient care and condition, all (100%) were satisfied, and close to nine in 10 (88%) felt the program had a positive health impact.
- Each participant received five social determinant of health services, which included durable medical equipment (e.g., blood pressure monitor, grab bar) and connection to food pantries, on average (5.1).

Network Collaboration

PAHC has established relationships with case managers at the two grant hospitals for the purposes of fostering the flow of patients into the CHW program and serving as a champion for the CHW program to hospital leadership. Toward these ends, a transitional care task force was established to coordinate efforts through monthly meetings. The network collaborates on population health goals and education including championing CHW programs as a solution to social determinants of health needs in rural areas.

Sustainability

- Online resource guide was compiled that provides CHWs and other health care providers with information about available medical resources and services in place to assist with meeting social determinants of health.
- Training was provided to local hospital leadership, case manager directors, and other hospital staff on value-based care, including how the CHW program is an application of value-based care.
- CHWs participated in multiple skills-based trainings.
- The network developed understanding of the health care IT behind sharing information between hospitals and CHWs.
- The network provided information for managed care organization reimbursement for CHWs (extends funding for CHWs beyond the grant statewide).

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St. Claire Medical Center

Northeast Kentucky Substance
Use Response Coalition

D06RH37525

Project focus area:

Behavioral Health/Mental Health –
Substance Use Disorder

Other focus areas:

Youth Opioid Prevention

Network History and Members

In 2018, the Northeast Kentucky Opioid Crisis Response Network was established as a part of a one-year, Rural Health Network Development (RHND) Planning Grant. This original coalition consisted of five partner organizations that served a seven-county area in the region. In 2019, the number of partners increased to nine and the name was changed to the Northeast Kentucky Substance Use Response Coalition. Currently, the coalition has seven partner organizations that serve an 18-county region in northeast Kentucky.

Member Organization	Location	Organizational Type
Tri-State Primary Care	Grayson, Carter County, KY	Private Primary Health Clinic
Gateway District Health Department	Owingsville, Bath County, KY	Public Health Department
Clark County Health Department	Winchester, Clark County, KY	Public Health Department
Kentucky Rural Healthcare Information Organization	West Liberty, Morgan County, KY	Nonprofit Organization
Pathways Inc.	Ashland, Boyd County, KY	Community Mental Health Center
Comprehend Inc.	Maysville, Mason County, KY	Community Mental Health Center
Northeast Kentucky AHEC/St. Claire HealthCare	Morehead, Rowan, KY	Hospital AHEC

Community Characteristics

Area

The counties the coalition serves through this RHND-funded program are Bath, Carter, Clark, Elliott, Fleming, Greenup, Lawrence, Lewis, Magoffin, Mason, Menifee, Montgomery, Morgan, Nicholas, Powell, Robertson, Rowan, and Wolfe.

Target Population

The grant program served northeastern Kentucky. Historically, this area has experienced low income, poor health outcomes, and higher rates of substance use disorder (SUD) than state and national averages. The target populations included middle and high school students, health care providers, and the community at large.

Need

The network was designed to address the SUD crisis in northeastern Kentucky. All of Kentucky has felt the effects of SUD, but northeastern Kentucky has been particularly overwhelmed. Many of the counties the coalition serves experience overdose rates that exceed the Kentucky state rates. The network wanted to make a difference in the community on these issues through provider and community education and youth addiction prevention. The region also experienced a lack of medication-assisted treatment (MAT)–trained providers. The region’s SUD crisis also led to more hepatitis diagnoses.

Program Services

Description

The coalition undertook a number of projects and activities to reach targeted service delivery goals. First, was the creation of a MAT Training Resource Center with graduated programming that included a MAT 101 course, MAT Waiver Course, and a MAT Boot Camp to familiarize the providers with the basics of MAT. The training resource center developed a mentorship program in which trained providers could shadow an experienced MAT provider in person and then meet with the mentor virtually or via telephone if or when other issues arose. The training resource center includes a series of MAT-related, continuing medical education–accredited videos designed to give providers confidence in administering MAT as part of their practice. Second, the coalition partnered with the Kentucky Rural Health Association to provide the Kentucky Hepatitis Academic Mentorship Program (KHAMP), designed to train primary care providers to address hepatitis C in the rural, primary care setting. Finally, the coalition oversaw the provision of prevention education to middle and high school students through the Prescription Education for Appalachian Kentucky Students (PEAKS) program. For this program, the Generation Rx curriculum developed by Ohio State University and the Cardinal Health Foundation was chosen to educate youth on prescription drug misuse. These middle school assemblies were paired with reflections from a peer support specialist who could share personal experiences with substance use with the students.

Role of Network Partners

Each coalition member contributed to the planning and implementation of network activities. Through quarterly meetings and other communication, members were able to help generate ideas and work out issues as programs were implemented. Each network member has been vested in the success of the program and demonstrated commitment through continuous response to the needs of the program. Members contributed to the coalition’s strategic planning and evaluation of the coalition’s programs and projects, and helped promote and deliver the coalition’s services. The coalition’s governing board members felt a sense of ownership and were heavily involved in both the day-to-day activities and the long-range planning of the coalition.

Outcomes

Program Outcomes

(1) The coalition developed a MAT video curriculum based on frequently asked questions that medical professionals had concerning MAT. Through the coalition’s efforts, 294 health care providers, clinical support

staff, medical residents, and health professions students were trained through the MAT Training Resource Center's MAT 101, MAT Boot Camp, and MAT Waiver courses. Because of this, these providers were able to offer MAT as a resource to patients in the coalition's service region. The MAT Mentorship program had 17 mentees and three mentors. (2) The coalition partnered with the Kentucky Rural Health Association to provide the KHAMP program. This program gave education to providers to enable them to treat hepatitis C better in the coalition's service region. (3) The PEAKS program was presented in all counties in the service region, with more than 1,000 students receiving prevention education. (4) The growth and success of the coalition led to it being recognized as a leader in the region in the SUD field. This recognition was leveraged to form new partnerships in the coalition's various projects.

Network Collaboration

Each member brought a specific area of expertise to the network and was willing to share insights with the whole group. Shared goals, open communication, and mutual support allowed the group to effectively work together. Specifically, the governing board representative for the Gateway District Health Department came up with the idea for the MAT Training Resource Center. Pathways Inc. and Comprehend Inc. provided the peer support specialists for the PEAKS presentations and First Day Forward jail reentry program. St. Claire HealthCare and the Northeast Kentucky AHEC provided project staffing and grant management support for all projects. In addition, each member of the coalition regularly attended quarterly meetings and contributed feedback and ideas that influenced coalition programming.

Sustainability

Sustained impacts of the coalition's work include:

- **New access to MAT treatment in rural communities:** As a direct result of the MAT Training Resource Center and mentorship program, more providers are now practicing MAT in rural health care settings.
- **Better care for those who have hepatitis C.** The KHAMP content received by providers will outlast the grant period.
- **Increased knowledge among local students:** The PEAKS presentations have increased teenagers' knowledge about the dangers of misusing medications and substances. This knowledge will remain with the students beyond the grant period.

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Rural Ambulance Alliance

End the Epidemic Louisiana

D06RH37510

Project focus area:
Youth Opioid Prevention

Other focus areas:
Workforce Development

Network History and Members

End the Epidemic LA (EELA) was launched in November 2016 and is an initiative of a network composed of the members as noted in the preceding section. It is governed by a governing board with each member represented. During 2016–2020, the majority of the network’s effort had been related to collecting information about the impact of the opioid epidemic on rural residents as well as local activities in place to respond to the epidemic. Simply, even if local rural communities collectively have the resources to address the opioid epidemic, they lack the organizational structure to do so. Resources are being duplicated, and in some circumstances, wasted. To that end, EELA has worked to establish local networks to address the opioid epidemic in rural Louisiana.

Member Organization	Location	Organizational Type
Louisiana Rural Ambulance Alliance	St. Gabriel, Iberville Parish, LA	Nonprofit Organization
Louisiana Attorney General’s Office	Baton Rouge, East Baton Rouge Parish, LA	Attorney General
Louisiana Association for Behavioral Health	Baton Rouge, East Baton Rouge Parish, LA	Nonprofit Organization
Louisiana Department of Health, Bureau of Primary Care and Rural Health	Baton Rouge, East Baton Rouge Parish, LA	State Government
Pafford Emergency Medical Services	Ruston, Lincoln Parish, LA	EMS Agency
Jackson Parish Emergency Medical Services	Jonesboro, Jackson Parish, LA	EMS Agency
Acadian Ambulance Service	Lafayette, Lafayette Parish, LA	EMS Agency

Community Characteristics

Area

Seven of the Louisiana Departments of Health's nine rural regions were chosen for network activities.

Target Population

According to the Centers for Disease Control and Prevention (CDC), death rates for unintentional injuries like drug overdoses are about 50% higher in rural areas than in urban areas. Louisiana has the seventh-highest opioid pain reliever prescription rate in the United States. Louisiana also has the fifth-highest rate of past-year nonmedical prescription opioid pain reliever use and has the 24th-highest drug overdose death rate. The Louisiana Commission on Preventing Opioid Abuse reported in its findings, "Rural areas have pronounced opioid dependent persons and these areas have few resources to provide to them. One of Louisiana's significant health challenges is to provide healthcare services to underserved rural populations."

Need

Upon presentation of the summary data from the local listening sessions, surveys, and incidents such as the one described above, the governing board determined that local End the Epidemic networks should be established and supported by the larger End the Epidemic LA Network. The governing board recognizes that local networks dedicated to addressing the opioid epidemic with local resources and local support will have a more substantial and lasting impact. They also recognized that local coordination of activities would avoid duplication of services and leverage already-existing programs. Therefore, the target population for grant activities is local rural leaders from all aspects of the community.

Program Services

Description

Activities for the network included (1) completing locally driven and realistic sustainability plans for each local network; (2) developing quantifiable metrics to assess the impact of local network activities; and (3) training and developing training curricula for rural substance use, mental health, and primary care practitioners on relevant topics including but not limited to opioid use disorder (OUD), screening for mental health and substance use disorder conditions, recognizing potential cases of OUD, and opioid overdose prevention.

Role of Network Partners

Network partners collaborated to (1) strengthen the existing End the Epidemic LA Network; (2) strengthen the rural health care system as a whole through support and development of rural community-based End the Epidemic networks; (3) achieve efficiencies through identification of opportunities to leverage federal, state, and local resources specific to the opioid epidemic; (4) achieve efficiencies through identification and adoption of process to avoid duplication of services and resources in rural communities; and (5) develop and adopt End the Epidemic LA Network Sustainability Plan, and support the development and adoption of End the Epidemic Network Sustainability Plans at the local level.

Outcomes

Program Outcomes

Outcomes for the funded project included these: (1) local rural networks achieved efficiencies by integrating opioid prevention, response, and treatment services in rural communities through local End the Epidemic networks; (2) the local rural networks focused on network activities directly related to combating and

addressing the opioid epidemic, an ever-increasing component of the rural health environment; and (3) local rural health networks implemented and expanded access to evidence-based practices for opioid addiction/ OUD treatment, such as medicated assisted treatment, including developing strategies to eliminate or reduce treatment cost to uninsured and underinsured patients.

Network Collaboration

Each network member brought its expertise and added value. Their physical locations were diverse, and more than half are rural. The collaboration of these members is valuable. For example, using incident addresses in the emergency medical services (EMS) records, the End the Epidemic network could produce hot spot maps to detect areas where high numbers of overdoses were occurring. These maps were shared with the Louisiana Association for Behavioral Health as well as local public health organizations through the State Office of Rural Health, which provided education on substance abuse and addiction, allowing them to target certain rural sections of the state and efficiently use resources.

Sustainability

The most remarkable and measurable working relationships that will continue beyond grant funding are those between the local rural EMS providers and the local representatives at the Louisiana Department of Health. Synergy related to delivery of tangible benefits including but not limited to Detera Bag distribution (drug disposal kits) and free Narcan to providers. Narcan distribution will remain a viable network product after grant funds are exhausted as the Louisiana attorney general's office has resources to continue to provide that necessary medication. Additionally, local networks will continue to operate after grant funds are exhausted in the local community as an activity related to their own specific company functions. Through the statewide network and local networks, rural residents have been trained to recognize and address cardiac events related to opioid events. Also, many rural residents and network members have taken advantage of mental health resiliency training programs offered through or paid for by the End the Epidemic network. There was a specific focus on ensuring training to address the opioid epidemic included "train the trainer" events so that local residents could continue to train other rural residents on response and recognition of OUD. Those served have demonstrated measurable changes in knowledge about opioid use and abuse through presentations and educational events. Attitudinal changes are subjective and difficult to measure; the network predicts that some of the stigma associated with opioid use and abuse has lessened through these grant-funded efforts. While the behaviors of opioid users and abusers has not been measured through the grant, behaviors of pharmacists and opioid prescribers has been. There has been an increase in provision of drug disposal bags in both the rural pharmacy and rural prescriber community through the local and statewide networks.

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Winn Community Health Center

Cen-LA Healthcare Improvement Partnership

D06RH37510

Project focus area:
Youth Opioid Prevention

Other focus areas:
Workforce Development

Network History and Members

In the face of the changing health care environment and in an effort to strengthen health care services within the region, the four partners, Winn Community Health Center (WCHC), Winn Parish Medical Center (WPMC), Louisiana Primary Care Association (LPCA), and Winn Parish School Board (WPSB), leveraged previous informal working relationships and formed Cen-LA Healthcare Improvement Partnership (CHIP). The city of Winnfield was added to the membership during the project period. The network members have worked together since 2017 to identify health care needs in the community and improve the health of patients with chronic conditions, assisting them through education on health promotion and disease prevention. In recent years, there has been leadership turnover at the medical center, and additional effort has been made to orient and engage new leaders with each period of transition.

Member Organization	Location	Organizational Type
Winn Parish Medical Center	Winnfield, Winn Parish, LA	Hospital
Winn Parish School Board	Winnfield, Winn Parish, LA	School Board
City of Winnfield	Winnfield, Winn Parish, LA	County Government
Louisiana Primary Care Association	Louisiana	Nonprofit Network Organization
Winn Community Health Center	Winnfield, Winn Parish, LA	Federally Qualified Health Center

Community Characteristics

Area

Winn Parish community.

Target Population

The target population includes adult patients living at or below the poverty line who have chronic conditions such as chronic obstructive pulmonary disease (COPD), high blood pressure, congestive heart failure, and diabetes.

Need

According to findings from a 2018 community health needs assessment conducted by Professional Research Consultants Inc., “39% of Winn Parish residents characterize their overall health as ‘fair’ or ‘poor.’” The findings note, “A total of 22.9% of Winn Parish adults have been diagnosed with diabetes” and “Winn Parish exhibits a significantly high proportion of adults reporting high blood pressure (50.7% versus 37.0% across the US).” It continues noting that “cardiovascular disease (heart disease and stroke) and cancers are the leading causes of death in Winn Parish.”

Program Services

Description

Through this project, patients in the local community are provided with health education through a one-on-one relationship with a registered nurse assigned to contact each patient monthly. The pharmacist checks in with the patient regarding medication. The monthly contacts focus on prevention with reminders of yearly preventive measures and a wellness visit. Labs and medications are discussed during each monthly call. The long-term goal is to improve quality of life for those with chronic disease complications in rural Louisiana and reduce the disease burden. The pharmacy aspect provides more medication management so the physician can devote more time to performing the diagnostic and procedural responsibilities. Health coaching is provided to patients, and this has been proven to engage patients in self-management of health conditions and encourage health behavior change.

Role of Network Partners

WCHC served as fiscal agent and ensured the project was adequately staffed and managed. In addition, WCHC provided patients access to primary care at two primary care sites and a school-based health center (SBHC), coordinated care with other providers, and participated in regular network meetings, providing feedback and data as needed. WPMC provided access to its electronic health record to project staff to retrieve emergency department and discharge summaries. WPSB worked with the project and SBHC staff in obtaining parental consent for students as needed as well as ensuring the continued cooperation of teachers and school nurses in the program. In addition, WPSB participated in regular network meetings, providing feedback and data as needed. LPCA’s role in the network was to collect data and provide statewide and nationwide comparisons for chronic disease measures. LPCA also participated in regular network meetings, providing feedback and data as needed. Winnfield participated in the regular network meeting, providing feedback as needed.

Outcomes

Program Outcomes

Clinical measure data has shown improvements with the targeted population:

- Comprehensive diabetes care received — 20.37%
- Body mass index screening and follow-up provided — 77.01%
- Closing the referral loop — 69.27%
- Medication reconciliation post discharge — 91.67%
- Controlling high blood pressure — 55%
- COPD care — 85.19%
- Breast cancer screening — 80%

Network Collaboration

The ways CHIP effectively collaborated to achieve the goals of the program include referral relationships, information sharing, and open and honest communication. CHIP recommends the following principles of a successful partnership to other networks: have comparable reputations, focus on shared goals, and keep the door open to newcomers when leadership changes occur.

Sustainability

The long-term effect on the community as a result of this grant-funded program includes improved health outcomes from coordination of care and clinical pharmacist intervention. The program also resulted in changed attitudes, since patients became more accustomed to sharing responsibility for their health. In addition, in the primary care environment, providing care coordination decreased unnecessary visits by patients to their providers, resulting in an increase in access to care for others.

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Huron County

Thumb Community Health Partnership

D06RH37506

Project focus area:
Behavioral Health/Mental Health

Other focus areas:
Chronic Disease

Network History and Members

In 2018, organizations from multiple sectors recognized the need for a cross-sector, regional collaborative that could leverage collective resources. The mission of the Thumb Community Health Partnership is to provide an integrated approach to identifying key issues and establish a coordinated response to regional community needs. Following a comprehensive needs assessment in 2019, partners identified chronic diseases and behavioral health as significant health disparities for the region. Additional system and community challenges were identified including workforce shortages and social determinants of health.

Member Organization	Location	Organizational Type
Deckerville Community Hospital	Deckerville, Sanilac County, MI	Hospital
Harbor Beach Community Hospital	Harbor Beach, Huron County, MI	Hospital
Hills and Dales Community Hospital	Cass City, Tuscola County, MI	Hospital
Marlette Regional Hospital	Marlette, Sanilac County, MI	Hospital
McKenzie Health System	Sandusky, Sanilac County, MI	Hospital
McLaren Hospital–Caro	Caro, Tuscola County, MI	Hospital
McLaren Hospital–Lapeer	Lapeer, Lapeer County, MI	Hospital
McLaren Hospital–Thumb	Bad Axe, Huron County, MI	Hospital
Scheurer Hospital	Pigeon, Huron County, MI	Hospital
Huron County Health Department	Bad Axe, Huron County, MI	Public Health Department
Lapeer County Health Department	Lapeer, Lapeer County, MI	Public Health Department
Sanilac County Health Department	Sandusky, Sanilac County, MI	Public Health Department
Tuscola County Health Department	Caro, Tuscola County, MI	Public Health Department
Great Lakes Bay Health Centers	Bad Axe, Huron County, MI	Public Health Department
Huron Behavioral Health	Bad Axe, Huron County, MI	County Mental Health Authority
Lapeer County Community Mental Health	Lapeer, Lapeer County, MI	County Mental Health Authority

Member Organization	Location	Organizational Type
Sanilac County Community Mental Health	Sandusky, Sanilac County, MI	County Mental Health Authority
Tuscola Behavioral Health Systems	Caro, Tuscola County, MI	County Mental Health Authority
Human Development Commission	Caro, Tuscola County, MI	Communtiy Action Agency
List Psychological Services	Caro, Tuscola County, MI	Private Mental Health Agency
Northeast Michigan 2-1-1	Midland, Midland County, MI	Information and Referral Agency
Great Start Collaborative–Huron	Bad Axe, Huron County, MI	Education
Great Start Collaborative–Sanilac	Sandusky, Sanilac County, MI	Education
Great Start Collaborative–Tuscola	Caro, Tuscola County, MI	Education
Sanilac County Community Foundation	Sandusky, Sanilac County, MI	Community Foundation
Michigan Department of Health and Human Services–Huron	Bad Axe, Huron County, MI	Human Service Agency
Michigan Department of Health and Human Services–Lapeer	Lapeer, Lapeer County, MI	Human Service Agency
Michigan Department of Health and Human Services–Sanilac	Sandusky, Sanilac County, MI	Human Service Agency
Michigan Department of Health and Human Services–Tuscola	Caro, Tuscola County, MI	Human Service Agency

Community Characteristics

Area

Huron, Lapeer, Sanilac, and Tuscola counties in Michigan.

Target Population

This project is in the mitten-shaped area of Michigan commonly referred to as the “thumb.” The four-county region includes 40 rural municipalities. There are 152,000 rural residents in the region, 96% of the population in the region is white, and less than 4% is Hispanic. Huron County has the highest percentage of residents older than 65 at 25.9%. The region has a high number of people that are veterans and people with disabilities. Thirteen percent of households are in poverty, and children are more likely to have a family income under 200% of the federal poverty level. Residents in the region are more likely to be uninsured (8%) and unemployment rates are above the state average. Evidence of health disparities includes higher rates of years of potential life lost for eight of the top 10 leading causes of death and elevated risk factors related to obesity, physical activity, and behavioral health issues.

Need

The partnership provides a more coordinated community health approach, increases capacity, and strengthens the health system as a whole in the area of Michigan commonly referred to as the Thumb — Huron, Lapeer, Sanilac, and Tuscola counties.

Program Services

Description

Early in the development of the network, partners expressed a strong commitment to improving community health. Community programs include consistent messaging campaigns; Man Therapy, a suicide prevention program for men; Women 2 Women, a virtual chronic disease self-management program; health insurance navigator services; and a social determinants of health planning project. Additional activities include youth health and human service career programs, an employer-led collaborative, a health and human service job bulletin, and the development of recruitment and retention projects to reduce workforce challenges. The partnerships have continued to evolve with a strong focus on community health needs assessments and a regional assessment every three years.

Role of Network Partners

Network partners make decisions through attendance at partnership meetings, email, or electronic feedback. A three-person executive committee provides additional feedback and guidance between meetings. Partners send a representative to two standing workgroups. A data workgroup plans and conducts community health needs assessment and analysis. A priority workgroup designs, coordinates, and implements community projects. Human resources staff are engaged in workforce-development activities and participate in an employer-led collaborative that includes external stakeholders such as education institutions, state agencies, and health care providers. Marketing and communications staff assist with consistent messaging campaigns. The Communities and Residents Empowered (CARE) Connect Task Force was formed to increase input from marginalized populations and grassroots organizations.

Outcomes

Program Outcomes

The project achieved increased efficiencies related to conducting health assessments, which included county-level, organizational, and regional health assessments. The effectiveness of a regional response to prioritized health needs was achieved through a priority workgroup and included multiple collaborative pilot projects. Through a cross-sector approach the health care system as a whole was strengthened. The network structure was defined and expanded through a strategic plan, marketing plan, and business plan.

Network Collaboration

Three frameworks were used to advance the goals of the project. Mobilizing Action through Planning and Partnership provided guidance for need assessment activities, the Sustainable Network Model—Adaptive Networks was used to learn from existing activities and ensure application of best practices. System change efforts provided support for the long-term goal of developing a coordinated regional effort to identify, plan for, and provide interventions that lead to a healthier community.

Sustainability

As a result of this grant program (1) there is data-driven regional planning that includes cross-sector engagement; (2) collaboration has increased understanding of services across sectors, strengthened referral networks, and improved access to services; (3) evaluation for pilot projects has shown a direct impact on program participants and established new ways of providing outreach for behavioral health, chronic disease management for women, and ensuring access to health insurance; (4) members are especially excited about

developing community information exchange and community clinical linkages to address social determinants of health and increase access to social supports; (5) immediate and long-term workforce strategies will strengthen the system through embedded recruitment and retention programs; and (6) workforce training programs will ensure a more skilled and culturally and linguistically competent workforce well into the future.

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Well Being Development

Ely Behavioral Health Network

D06RH37510

Project focus area:
Behavioral Health/Mental Health –
Substance Use Disorder

Other focus areas:
Community Health Workers

Network History and Members

In 2008 a small group of professionals met to explore collaboration to address the void of services for youth with mental illness in the Ely area. In response, a group of providers representing diverse organizations (health care, social services, nonprofits, etc.) and consumers developed the Ely Community Care Team (CCT) in 2011 to address poor health outcomes of people living in the rural northeast Minnesota Iron Range. Multiple CCT surveys, community health surveys, provider surveys, and the like, as well as feedback from consumers, consistently identified gaps in behavioral health care and a lack of continuity of care between physical and behavioral health services. To address these needs, a small group of five organizations formed the Ely Behavioral Health Network (Ely BHN). These initial agencies were the ones connected most to behavioral health services and populations and had leaders committed to action-based collaboration. Ely BHN has since grown to nine organizations and addresses gaps and barriers in behavioral health services through integration in primary care, a hub-and-spoke model of care facilitation (Pathways to Wellness), and a robust education and stigma-reduction effort.

Member Organization	Location	Organizational Type
Ely-Bloomenson Community Hospital	Ely, St. Louis County, MN	Hospital
Ely Community Health Center	Ely, St. Louis County, MN	Free Clinic
Ely Community Resource	Ely, St. Louis County, MN	Nonprofit Organization
Ely Housing and Rehabilitation Authority	Ely, St. Louis County, MN	Public Housing
Essentia Health Ely Clinic	Ely, St. Louis County, MN	Clinic
NHS Northstar	Chisholm, St. Louis County, MN	Nonprofit Organization
Range Mental Health Center	Virginia, St. Louis County, MN	Nonprofit Organization
St. Louis County Public Health and Human Services	Virginia, St. Louis County, MN	Public Health Department
Well Being Development – Fiscal Agent	Ely, St. Louis County, MN	Nonprofit Organization

Community Characteristics

Area

This grant project serves northern St. Louis County (SLC) in northeast Minnesota, including Ely, Babbitt, Tower, Virginia, and Hibbing. Rural, northern St. Louis County, Minn., is in both a designated mental health and primary care HPSA and a medically underserved community/medically underserved population.

Target Population

The target population of northern SLC includes 51,101 people, a population with slightly more males, a higher median age, and a higher percentage of people older than 65 than in the state and nation. Residents are less likely to have a college degree or higher. The percentage of residents who are Native American is higher than the state and national levels. The percentage of SLC residents living below poverty level is higher than in the state, and because of fluctuations in the mining and tourism sectors, the unemployment rate varies.

Need

This grant-funded project focuses specifically on trauma and expanding the network's capacity to improve health behaviors and outcomes of residents by reducing the prevalence and impact of adverse childhood experiences and increasing resilience across the age spectrum. SLC's ranking on health behaviors, including adult smoking, adult obesity, excessive drinking, motor vehicle crash death rate, sexually transmitted infections, and teen birth rate, is 76th of the 87 counties ranked in Minnesota. Minnesota Student Survey data found high rates of long-term mental and behavioral health challenges, self-harm, suicidal ideation, and substance use among 6th-grade through 12th-grade students.

Program Services

Description

Ely BHN identified three goals to guide its development project: (1) to expand evidence-based screening and intervention strategies in the Ely area to reduce trauma and build resilience across the age spectrum, (2) to develop a behavioral health community network in Virginia, Minn., based on lessons learned in the Ely project, and (3) to successfully manage the grant-funded project, expanding the Ely model to another neighboring community. Activities employed to achieve changes in behavioral health outcomes include growing Ely BHN; expanding the network to the neighboring community of Virginia, Minn., (with a surrounding service area population of about 18,000); and developing and integrating trauma-informed and skill-building programs in health care, care coordination, school, and community organization settings.

Role of Network Partners

BHN member agencies were chosen based on ability to identify behavioral needs and provide services to a high-risk population. The governance structure involves equal representation and power of all BHN members, and decision-making is by consensus of all members. BHN member agencies commit to monthly meeting attendance and participation in annual strategic planning. BHN member organizations also commit to interagency collaboration, internal and external communication to achieve BHN goals and objectives, and compliance with confidentiality policies. Partners share their data to both assess needs and evaluate progress toward goals, development of the network, and outcomes. All BHN agencies (1) are part of Pathways to Wellness (care facilitation) referral and service model; (2) participate in education and stigma-reduction programs by incorporating content in their websites and social media and by other activities such as health fairs and agency events; and (3) participate in trauma-informed trainings and incorporate behavioral health literacy into client services.

Outcomes

Program Outcomes

The following outcomes have resulted from this project: (1) piloted a grades 6-12 mental health literacy curriculum from the Mental Health Collaborative, and pre- and post-surveys showed increases in knowledge of mental illnesses and health efficacy strategies and reductions in stigma; (2) provided trauma-informed training for all care facilitators as well as Suicide Safe Care, Motivational Interviewing; (3) professional referrals and self-referrals for care facilitation services, serving 547 individuals with behavioral health and social determinants of health needs last year; and (4) Mesabi BHN is growing and has developed mission, vision, bylaws, and has completed strategic planning.

Network Collaboration

Key lessons related to collaboration came from the development of the new Mesabi BHN. Utilizing a “neutral” party as the convener — in this case the county public health department — added to the level of trust and eliminated competition. Ensuring all sectors were included in the planning and development, including community members with lived experience, provided a thorough assessment of needs and resources. Developing memoranda of understanding early allowed organizations to understand their role and responsibilities from the start.

Sustainability

Ely BHN has helped bring about (1) stronger relationships and improved communication between service providers in the Virginia area, and Ely Schools and Ely Community Resource (ECR) are working more closely to deliver behavioral health support to students, (2) stronger coordination of care between Ely-Bloomenson Community Hospital and Essentia Health Ely Clinic, (3) community prevention coalitions collaborating on countywide projects, (4) Essentia Health adding seven care facilitators in seven clinics and care facilitation to Ely-Bloomenson Community Hospital’s emergency department, (5) improved crisis coordination between agencies, and (6) stigma reduction among patients related to seeking behavioral health treatment and non-network agencies holding or attending behavioral health events.

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Wilderness Health

Wilderness Health

D06RH37535

Project focus area:
Telehealth

Other focus areas:
Behavioral Health/Mental Health

Network History and Members

Wilderness Health (WH) was established in 2013 as a 501(c)(3) nonprofit, operating as a network of nine independent health care organizations across northeast Minnesota. The WH network tagline is “Partners Advancing Rural Health.” WH’s mission is to advance patient and community health outcomes, including health disparities experienced by rural populations, improve the patient experience, and lower the costs of providing health care services by working together with members to explore ways to provide services more effectively and efficiently to the public and the health care community. The network’s strategic plan focuses on three primary priorities: advancing value-based care, cultivating the health care talent pool, and developing a comprehensive telehealth program.

Member Organization	Location	Organizational Type
Bigfork Valley Hospital	Bigfork, Itasca County, MN	Hospital
Community Memorial Hospital	Cloquet, Carlton County, MN	Hospital
Cook Hospital	Cook, St. Louis County, MN	Hospital
Ely-Bloomenson Community Hospital	Ely, St. Louis County, MN	Hospital
Fairview Range/Range Regional Health Services	Hibbing, St. Louis County, MN	Hospital
Grand Itasca Clinic & Hospital	Grand Rapids, Itasca County, MN	Hospital
Lake View Hospital	Two Harbors, Lake County, MN	Hospital
North Shore Health	Grand Marais, Cook County, MN	Hospital
St. Luke’s	Duluth, St. Louis County, MN	Hospital

Community Characteristics

Area

Counties served: Lake, St. Louis, Cook, and Carlton.

Target Population

WH's target population included patients with mental or behavioral health care needs in rural northeast Minnesota. Pilot programs specifically addressed patients presenting with attention deficit hyperactivity disorder (ADHD) or anxiety, and emergency room and ambulatory patients needing psychiatric services. All patients and community members with mental or behavioral health needs were targeted by a marketing awareness campaign.

Need

The primary factors driving the addressed need included accessibility barriers, lack of providers, and stigma. The network's geographic region is predominantly rural, resulting in barriers to accessing services due to travel time and inclement weather. The network resides in a Mental Health Professional Shortage area exacerbated by inadequate access to services and long wait times for care. Finally, the network found that stigma is a significant barrier to receiving mental and behavioral health care.

Program Services

Description

WH designed and implemented two tele-mental health pilot programs and a marketing awareness and supportive resources strategy. The first pilot program was a diagnostic evaluation and referral system to screen for ADHD and anxiety, with room to expand to other conditions. The second pilot program was a tele-psychiatry program to bring psychiatric services to remote member hospitals. The marketing awareness strategy included messaging for stigma reduction based on community perspectives through a "Let Us Help" campaign.

Role of Network Partners

Each member had representation across various network committees and roundtables to support and monitor the work plan progress. A member site was designated as a pilot site for process improvement, community building, programming, and pilot development. Several member sites participated in the ADHD and anxiety mental health assessment pilot and were key in designing the service for patients. A Critical Access Hospital trialed the tele-psychiatry pilot and helped develop a working model. All sites continue to monitor their respective pilots.

Outcomes

Program Outcomes

Through this grant an integrated system was designed in which wait times for ADHD and anxiety diagnostic testing were reduced significantly, and psychiatric services were brought to patients who would otherwise receive no psychiatric care or wait exorbitant lengths of time to receive care. Sites with comprehensive access to tele-behavioral health increased. Technological and telehealth literacy have improved among providers and patients, and patient satisfaction with telehealth services rose. Stigma began to be addressed across the region and communities were engaged in important conversations to reduce barriers to seeking mental health care. Depression screening and scores improved at the pilot site. The network of members has improved the health care outcomes through an increase in transitional care management accountability.

Network Collaboration

Network members collaborated through committees and roundtables, which allowed different groups to come together and discuss ideas and outcomes across the network and brainstorm new ways to address networkwide problems. The telehealth committee connected the network to many community and nonprofit

groups that offered support to the members and projects. By partnering with organizations outside of the network and offering a space for collaboration, a more comprehensive set of programs was created. Scope-of-work agreements between WH and participating sites were instrumental in ensuring shared goals and accountability.

Sustainability

The targeted communities now have telehealth and tele-mental health as viable options for care. Member facilities have gained access to resources and information sharing through a committee structure and community networking that will carry into the future. Providers and care team members have been able to provide input into telehealth processes to improve services going forward and strengthen buy-in. Educational experiences have extended knowledge about the implementation of telehealth into clinical and business settings for a variety of students. The model of provider communication and referral that has been built will ensure continuity of care.

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Delta Health Alliance

Delta Diabetes BLUES Network

D06RH37500

Project focus area:
Chronic Disease

Other focus areas:
None

Network History and Members

The original partners of the network consisted of Leland Medical Clinic (LMC), Leflore County Health Center (LCHC), and The Endocrine Clinic (TEC) of Memphis. With this original partnership, the grant was launched with the ECHO model of delivering endocrine care via telehealth. As Coahoma County was within the project service area, a partnership was formed with Urgent and Primary Care of Clarksdale who referred patients to the endocrine care telehealth program. LMC was able to deliver this care by deploying their mobile medical clinic to both LCHC and Clarksdale, thus bringing the care to the patient and eliminating the barrier of transportation.

Member Organization	Location	Organizational Type
Leland Medical Clinic	Leland, Washington County, MS	Federally Qualified Health Center
Leflore County Health Center	Greenwood, Leflore County, MS	Nonprofit Organization
Urgent and Primary Care of Clarksdale	Clarksdale, Coahoma County, MS	Clinic
The Endocrine Clinic	Memphis, Shelby County, TN	Clinic

Community Characteristics

Area

Washington, Leflore, Coahoma, Tallahatchie, and Quitman counties in Mississippi.

Target Population

The total population of the target area is 124,500, and 70.3% of the population are Black/African American. Only 77.2% of adults have a high school degree, 35.4% of adults live below the poverty level, 41.7% of adults are obese, and 15.3% of adults have been diagnosed with diabetes. The mortality from diabetes is more than double the national average with 54.4 deaths per 100,000 compared to the U.S. average of 24.2 deaths per 100,000.

Need

The network's purpose is to reduce the morbidity and mortality of diabetes in rural, low-income, minority communities. Based on the statistics above, the need to control diabetes in these areas is vital, and glycemic control, blood pressure control, lowering cholesterol, and reducing hospitalizations of the targeted patients were the program's overall goals.

Program Services

Description

Participants in the grant were monitored every three months, and clinical measures including HbA1c, blood pressure, and cholesterol (ABC) were obtained and tracked over the three-year period. Those participants with an HbA1c greater than 9% were referred to the endocrinology telehealth program in conjunction with the network partner, TEC. More than one-third of the total number of participants in the program went through the telehealth program to lower their HbA1c. Success stories include the participant with an HbA1c of more than 15 dropping their HbA1c to 5.6 (prediabetic range). By deploying the LMC Mobile Medical Clinic, participants were seen in both Leflore and Coahoma counties with participants coming in from Quitman and Tallahatchie counties. The program served participants in all five of the service area counties. Participants met with or were called by the program manager monthly to assess their health status and needs. All participants became patients of LMC so clinical data could be stored in one electronic health record, and data was collected and stored in the Delta Health Alliance (DHA) Efforts to Outcomes (ETO) database for analysis and evaluation monthly.

Role of Network Partners

LMC, a federally qualified health center look-alike (FQHC-LAL) operated by DHA, served as the repository for all data, and the program utilized the LMC electronic health record and mobile medical clinic for telehealth. The network director and program director were both housed at LMC. Leflore County Health Center served as a referral source for telehealth patients and is a community health clinic. TEC of Memphis provided telehealth endocrinology services and educational services to LMC staff on diabetes and the treatment of types I and II diabetes. Urgent and Primary Care of Clarksdale served as a referral source and partner to the telehealth endocrine services and worked closely with grants management in care of their patients.

Outcomes

Program Outcomes

The program followed participants' ABCs for the life of the grant. To summarize the program's outcomes, the program saw a drop of approximately 2% in participants' HbA1c. On average participants' dropped blood pressure by 27 points, with cholesterol dropping by 29 points. The program had 111 participants meet their cholesterol goal of lower than 200. The largest drops in HbA1c were seen by the program's telehealth participants as they were the most chronic patients. After 36 participants were followed for two years, 25 participants dropped their HbA1c by an average of 3.22%. Twenty-four of these 25 participants dropped their HbA1c below 9%. Five participants reported no change in HbA1c, and six participants increased HbA1c by an average of 1.47%.

Network Collaboration

The network partners worked in tandem to assist participants in meeting their ABC goals for the grant. LMC and Urgent and Primary Care followed participants every three months to monitor blood work by checking participants' ABC numbers. TEC provided much-needed endocrine services to the most chronic patients. This service included patient education and medication management and referrals to nutrition, social, and

psychological services as needed. LCHC provided support by allowing the LMC mobile medical clinic to utilize their facility to set up and see patients and was a consistent referral source. TEC served as the hub of the program's evidenced-based Project ECHO hub-and-spoke approach to the network collaboration and delivery of telehealth endocrine care. Information and education to both providers and clinical partners was disseminated from TEC to the other partners for the management of diabetes and setting standards of care for the treatment of diabetes. Information flowed back to TEC in the form patient status, care plans, and questions with regard to the treatment of diabetes. TEC served as the primary source of knowledge for education of staff and providers on all aspects of diabetes. LCHC worked as the community advocate and in the areas health equity and eliminating health disparities. The network director spearheaded the project, ensuring the resources of LMC were at the disposal of the project.

Sustainability

The long-term effects on the community are numerous. A benefit of having LMC patients as participants was that those participants with diabetes in the Washington County area could meet with the LMC nutritionist and learn about healthy eating related to diabetes. All program participants were given literature addressing portion control, diabetic cookbooks, as well as measuring cups and spoons. Participants were provided with glucometers, strips, and lancets to monitor their blood sugars daily and logbooks to record their blood sugars before and after meals. These efforts promoted feelings of self-efficacy for the participant. These tools increased patient knowledge and changes in attitudes toward personal management of the participant's disease. With this came a change in behavior that can be quantified by the program's outcomes. As providers learned more about the management and treatment of diabetes through the grant, this knowledge impacted the target population as they received improved care as evidenced by the overall drop in HbA1c in participants and patients treated for diabetes. Another impact on the community was the communication of grant outcomes to the patient advisory board every quarter. This information was provided to the board at their quarterly meetings held at LMC, and the continued improving outcomes were addressed. The patient advisory board then reported back to the respective agency they represented repeating the information they gleaned from the meeting. This information was spread to community organizations, faith-based organizations, and social clubs in Washington County. Regarding capacity, with the aid of the program, LMC saw an increase in capacity as all participants were required to be a patient of LMC. If a participant wished to enroll in the program, the participant was first required to see an LMC provider and have baseline labs drawn. Per the stipulations of the grant, the participants were to be followed for a total of 30 months. The LMC patient base grew as patients transferred care from other primary care providers to LMC for enrollment in the program.

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Randolph County Caring Community Partnership

Rural Mental Health

D06RH37520

Project focus area:
Behavioral Health/Mental Health

Other focus areas:
Social Determinants of Health

Network History and Members

The Randolph County Caring Community Partnership (RCCCP), now in its 22nd year, was established in 1999 with a mission to serve as the foundation to engage the community action toward enhancing the quality of life for all residents. RCCCP is focused on initiating programs and services that positively impact and influence the social, economic, and health-related needs of residents in Northeast Missouri, with the intent to improve outcomes for children, families, and residents of all ages. Through HRSA's Rural Health Network Planning Development Grant (RHND) in 2011, the Rural Mental Health Network (RMHN) was created. The RMHN received additional funding from HRSA in 2017 and 2020 to formalize through the network. In 2012, RCCCP received funding from the Missouri Foundation for Health to implement the Health Information Systems Integration Project, a collaborative effort of members of the Mental Health Action Team, which expanded identification of health information needs, development of an information technology strategic plan, identification of an electronic health information system, and integration of health information to support care coordination.

Member Organization	Location	Organizational Type
Oak Hill Behavioral Health Solutions	Moberly, Randolph County, MO	Behavioral Health
Randolph County Health Department	Moberly, Randolph County, MO	Public Health Department
Monroe County Health Department	Moberly, Randolph County, MO	Public Health Department
Schultz Psychological Services	Moberly, Randolph County, MO	Mental Health
Family Health Center	Moberly, Randolph County, MO	Federally Qualified Health Center
Sam's Health Mart	Moberly, Randolph County, MO	Pharmacy
Timberlake Christian Counseling	Moberly, Randolph County, MO	Behavioral Health
Lighthouse Counseling Services	Moberly, Randolph County, MO	Behavioral Health
Olive Tree Counseling Services	Moberly, Randolph County, MO	Mental Health
Crossroads Counseling Services	Moberly, Randolph County, MO	Mental Health

Member Organization	Location	Organizational Type
Randolph County Ambulance	Moberly, Randolph County, MO	Emergency Care
Primrose Hill	Moberly, Randolph County, MO	Recovery Support
Moberly Regional Medical Center	Moberly, Randolph County, MO	Hospital
University of Missouri Health Management and Informatics Group	Columbia, Boone County, MO	Hospital
Moberly Area Community College	Moberly, Randolph County, MO	Education
Big tree medical home	Columbia, Boone County, MO	Primary Care
Compass Health Network	Moberly, Randolph County, MO	Primary Care

Community Characteristics

Area

Randolph, Howard, Chariton, and Monroe.

Target Population

The target population comprises residents over the age of 18 and their affected family and community members with the following characteristics: unemployed, uninsured, history of mental illness or substance abuse, acute or chronic pain, chronic illness, or lack of social support networks and connections.

Need

In northeast Missouri, there are many children, related family, and community members who experience a myriad of risk factors related to physical, mental, and behavioral health who are faced with a lack of access to the full array of needed services and resources to meet their needs. This called for a focus on coordination of primary medical care, dental, and mental health professionals and responsiveness to persistent community health-related needs that affect overall health. Expanding access to specific, mental health services and fusing services that address community, social, and health-related needs represents a more holistic approach to treatment than the traditional consultative and referral models.

Program Services

Description

The program focused on expanding the RMHN by bringing in diverse professional expertise and establishing a matrix of mental health providers, providing high-touch and a value-based approach. The community outreach, education and behavioral health care systems integration was possible by empowering certified community health workers (CHWs). The CHWs were placed on-site at the service area health department to conduct community outreach. They are trained in community health assessment and understand the health needs of the service area. A referral process is set in place, and referrals are made through the state-run Community Connections MO information-sharing system to navigate the clients to the needed services. Collaborative care teams were formed to bring a more holistic approach to meeting the needs of the clients. These teams of experts in client-centered approach are now well established. Community services resource mapping was put together by the RCCCP Innovative Strategies team, and a spreadsheet of all the mental health, primary care, and many ancillary and social determinants of health-related providers in the service has been established and mapped to support referrals. The ongoing resource mapping encourages the providers to participate in the network meetings to make connections and grow the relationships.

Role of Network Partners

The network itself is a formal partnership between members that focuses on exchanging information, altering activities, sharing resources, and enhancing the capacity of each member for mutual benefit and to achieve a common purpose. Further, the RMHN enables opportunities through coordination and cooperation between provider members for a more value-based system. Key members of the RMHN are at the collaboration level of the Collaboration Continuum tool, agreeing to accept full sharing of resources, risks, rewards, and responsibilities.

Outcomes

Program Outcomes

Outcomes include a strengthened rural health care system, improved mental health outcomes for the targeted populations, economic savings and healthy communities, identification of sustainable network components, and development of a dashboard of program outcomes for dissemination among key stakeholders.

Network Collaboration

The partners work together on infrastructure development for the integration of the care coordination model and collaborative care team, professional development, resource mapping, and direct clinical services for uninsured. Monthly meetings are held, keeping the network members informed about the current activities with the projects, and regular collaborative care team meetings are held to discuss services for clients.

Sustainability

The network partners will continue to sustain the mission. Sustained impacts include increased number of service providers, with increased knowledge of community resources, that will be sustained beyond the grant funding. The capability for collaborating entities to request services through the website, which increases the number of client referrals, will continue to create value after the grant. The reinforcement of the CHWs in the community outreach activities has encouraged partners to implement CHWs roles within their practices. With the successful graduation through the CHW certification course offered by Central Christian College, it has increased the workforce of CHWs in the area. The ongoing assessments in the rural subpopulation of minorities will have a positive impact in the community. Computer programs like LYFT learning, which comprises various modules that will help the client to develop skills, such as how to open a bank account and how to prepare a resume, will continue to support capacity in local systems.

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Montana State University — Montana Area Health Education Center

Montana Behavioral Health
Workforce Network

D06RH37513

Project focus area:
Workforce Development

Other focus areas:
Behavioral Health/Mental Health

Network History and Members

Montana is a big state with a small population. The combination of the vast geography and low population mass presents challenges and opportunities. Some of the challenges include access to care and access to education and training. To address these issues, health care organizations, higher education, state agencies, community-based organizations, and health care foundations have worked together to create solutions to address the behavioral health and other health care issues in our state. A key strategy has been to bring together existing health care networks in a “network of networks.” These networks bring the collective experience and knowledge of their members (more than 100 stakeholder organizations) to the table to create strategies that work in the most rural communities. The “network of networks” has worked at a high level of collaboration to tackle complex issues for over 15 years.

These health care leaders that make up the “network of networks” are rebuilding frameworks around the existing workforce and resources instead of recruiting a new workforce. Workforce development is the biggest challenge identified by the network for rural Montana. The Montana Healthcare Workforce Strategic Plan was updated in 2019 to address workforce shortages in rural Montana within these structures. The top strategies include the “Growing Your Own” approach, focusing on developing health care workforce skills of people living and working in local communities; delivering education in place and via distance education to people in rural communities; and developing stackable credentials that can lead to a career ladder.

Member Organization	Location	Organizational Type
Montana Health Research Education Foundation	Helena, Lewis and Clark County, MT	Nonprofit Organization
Rocky Mountain Tribal Leaders Council	Billings, Yellowstone County, MT	Nonprofit Network Organization
Montana Primary Care Association	Helena, Lewis and Clark County, MT	Nonprofit Organization
Mountain Pacific Quality Health	Missoula, Missoula County, MT	Nonprofit Organization

Community Characteristics

Area

The Montana Behavioral Health Workforce Network (MBHWN) serves the entire state of Montana.

Target Population

The network is focusing on the health care workforce providing substance use, mental health, and behavioral health services to rural, frontier, underserved, and tribal communities throughout Montana.

Need

Montana is a large state with a small population. The combination of the vast geography and low population mass presents challenges, including access to care and access to education and training. Montana has a critical shortage of mental and behavioral health professionals while battling a mental and behavioral health crisis in the state.

Program Services

Description

The project focused on strengthening collaborative, strategic approaches through partnerships to address the severe shortage of mental health, behavioral health, and substance use disorder services in rural Montana. Comprehensive assessments of the needs of rural and underserved communities for behavioral health workforce development were completed. A coordinated plan was created for training, recruiting, and supporting the behavioral health workforce via distance education, Project ECHO, regional training, and ongoing professional development. A collaborative, cross-organizational network model was developed, utilizing the expertise and leadership among the partners, to create a sustainable system to support the most vulnerable communities in addressing identified needs for mental health, substance abuse, and behavioral health workforce development. And, finally, continuous monitoring and evaluation of project quality, improvement strategies, and outcomes has been maintained.

Role of Network Partners

Network members participate in meetings, programmatic activities, and decision-making.

Outcomes

Program Outcomes

Long term, MBHWN expects to impact health outcomes for Montana's rural, frontier, and underserved communities. MBHWN has created the following trainings: Pathway to a Messenger (Crow Tribe and community health worker (CHW) curriculum blend), Health Equity in Montana, Historical Trauma, and Introduction to Montana Tribes. New trainings to be rolled out this year are Spanish-language CHW training and CHW guide to palliative care. To date, the network has trained more than 6,500 Montanans in behavioral health-related trainings across the state.

Network Collaboration

The network has an extensive history of collaborating on a number of projects. The network provides a coordinated and expert role in improving the quality of the health care services in rural, tribal, and frontier Montana through a thoughtful and strategic approach to community health support workforce development.

Sustainability

MTBHWN has increased collaboration, provided support across the state, and positively impacted the workforce needs and health outcomes for Montana’s rural, frontier, and underserved populations.

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Community Access to Coordinated Healthcare

CATCH Network

D06RH37497

Project focus area:
Care Coordination

Other focus areas:
Social Determinants of Health

Network History and Members

Since its inception in 1994, the Community Access to Coordinated Healthcare Inc. (CATCH) Network has received a variety of grants including 2016 and 2018 HRSA Rural Health Network Development Planning grants which enabled CATCH to initiate a comprehensive needs assessment and discussions around implementation. Based on this assessment, it was determined that an integrated care coordination network (ICCN) of local health departments (LHDs) and primary care clinics was necessary to address the prevalence of chronic disease in rural Nebraska. CATCH is utilizing the ICCN model of LHDs, clinics, and Critical Access Hospitals to link public health and primary care.

Member Organization	Location	Organizational Type
Four Corners Health Department	York; Butler, Polk, Seward, and York counties; NE	Public Health Department
North Central District Health Department	O'Neill; Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Perce, and Rock counties; NE	Public Health Department
Elkhorn, Logan Valley Health Department	Wisner; Burt, Cuming, Madison, and Stanton counties; NE	Public Health Department
Public Health Solutions Health Department	Crete; Fillmore, Gage, Jefferson, Saline, and Thayer counties; NE	Public Health Department
Southeast District Health Department	Auburn; Johnson, Nemaha, Otoe, Pawnee, and Richardson counties; NE	Public Health Department
Three Rivers Public Health Department	Fremont; Dodge, Saunders, and Washington counties; NE	Public Health Department
Blue Valley Community Action	Fremont; Butler, Fillmore, Gage, Jefferson, Polk, Saline, Seward, Thayer, and York counties; NE	Nonprofit Organization

Midtown Health Center	Norfolk, Cuming and Madison counties, NE	Federally Qualified Health Center
Brown County Hospital	Ainsworth, Brown County, Nebraska	Hospital
Methodist Health	Fremont, Dodge County, Nebraska	Hospital
Niobrara Valley Hospital	Lynch, Boyd County, Nebraska	Hospital
Osmond General Hospital	Osmond, Pierce County, Nebraska	Hospital
York General Hospital	York, York County, Nebraska	Hospital
York Medical Clinic	York, York County, Nebraska	Clinic

Community Characteristics

Area

The CATCH Network covers 30 rural counties in north, central, and eastern Nebraska, all of which are rural and have a low population density, posing unique challenges. From the farthest points, it is approximately 120 miles to the nearest urban city. The large geographic area with a sparse population of 317,040 people, many who are older and lower-income, makes health care access difficult.

Target Population

The target population is high-risk individuals with heart failure, hypertension, diabetes, chronic obstructive pulmonary disease (COPD), and depression. These individuals are likely to have comorbidities and associated behavioral and social risk factors.

Need

Identified needs reflect the demographic and socioeconomic characteristics (an older population) of the area, significant access barriers (shortage of health professionals and lower levels of insurance coverage) contributing to health disparities, risky lifestyle behaviors, and adverse social determinants (e.g., food insecurity and poverty). In the past, patients were treated only during physician visits with the main focus on provision of clinical services. In a care coordination model, prevention and treatment receive an equal emphasis and related plans for high-risk patients are comprehensive, addressing physical and behavioral health clinical needs, lifestyle risk factors, and social needs.

Program Services

Description

CATCH provides technical assistance to network members on care coordination processes as well as data collection and management. In this model, the patient is screened for clinical needs, personal risk factors, and social determinants of health needs where high-risk individuals are identified and referred for recommended services. Clinical and LHD staff are responsible for developing action or care plans to encourage patients to initiate goals and act on their health goals with guidance from the clinic care coordinator.

Role of Network Partners

Collaboration among network partners is essential for this care coordination model to be successful. Physician clinics are responsible for screening high-risk patients and working with a care team to meet the patient's clinical needs, as well as address lifestyle risks and social and behavioral needs. LHDs are responsible for providing a variety of public health programs and activities that focus on changing adverse lifestyle habits, such as physical inactivity and poor nutrition. LHD staff link patients with other community services to address some

of their major social needs, such as connecting a patient to a local food bank to address a food insecurity issue. Last, CATCH is responsible for financial management of the project, providing technical assistance support and ensuring that the project is meeting deadlines and goals.

Outcomes

Program Outcomes

Outcomes include the identification of rural patients who need health intervention and education. These patients are primarily obese and most often are diagnosed with hypertension (41.7%), depression (33.8%), diabetes (19.8%), and COPD (1.4%). Many of the identified patients experience comorbidities (22.1%). Referrals to the LHD have increased through the progression of the network's care coordination efforts. Most referrals are sent to the LHDs (97%), and individuals are enrolled in one of their programs or connected to local resources. This project has demonstrated that effective care coordination of physician clinics and LHDs can enhance chronic disease outcomes, patient self-management, and preventive health.

Network Collaboration

The network provides the foundation and has been the catalyst for bringing partners together to discuss common problems, identify best practices, and develop workable solutions. The network is better able to identify and support the technical assistance activities that are needed to mitigate the challenges of care coordination in rural health systems. The network also creates a more efficient mechanism to collect and share data among partners. Implementing a care coordination model across a large geographic region creates many similar challenges that can be addressed more effectively by working collectively in a network where resources, lessons learned, and shared interventions work to improve quality and outcomes.

Sustainability

As a result of these continued care coordination efforts, primary care clinics and LHDs are working together to build trust and expand the capacity for integrating public health and primary care services, and patients are now receiving comprehensive and less fragmented care. These relationships and services will be sustained because of enhanced patient satisfaction, better access to comprehensive health care, and improved health outcomes. Partners have expanded their capacity to address mental health, including the onboarding of licensed behavioral health professionals to treat patients and one LHD billing third-party payers for behavioral health services. As a result, some clinics have revised their policies and procedures to ensure they are offering more comprehensive and patient-centered care for their patients. For example, adopting new practices for identifying which patients would benefit from an external referral and which patients' needs may be met internally. Attitudes in LHDs and clinics have shifted from a primary care focus to a more preventive mindset, which is essential to addressing social determinants of health and improving management of chronic diseases. This project has helped providers find ways to improve behavioral health care integration, use community health workers, and expand the use of existing health resources such as telehealth services.

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Northeast Nebraska Public Health Department

Northeast Nebraska Rural Health Network

D06RH37514

Project focus area:
Obesity Prevention

Other focus areas:
Alternative Payment Models

Network History and Members

The Northeast Nebraska Rural Health Network (NNRHN) members have a shared interest in assessing their community's health needs and working together to improve the health of the service area. They began to meet to discuss completing a new joint community health needs assessment (CHNA) that would describe the current health status of the four counties of focus: Cedar, Dixon, Thurston, and Wayne. The CHNA would provide the foundation for an increased understanding of the factors impacting the health outcomes in this service area. As part of this process, a core team was formed using a memorandum of agreement to oversee the data-gathering process and manage the work. Through the Health Resources and Services Administration (HRSA) Rural Health Network Development Program grant, the NNRHN has successfully completed the CHNA and community health improvement plan (CHIP), created two community coalitions to address the concerns of mental health and health promotion, assisted with development of an area health equity advisory council, and is developing a weight loss management program for early 2023. Continued development of a rural health network during the pandemic was challenging, but partners continued to see the importance of network partnerships in the service area.

Member Organization	Location	Organizational Type
Northeast Nebraska Public Health Department	Wayne, Wayne County, NE	Public Health Development
Providence Medical Center	Wayne, Wayne County, NE	Hospital
Pender Community Hospital	Pender, Thurston County, NE	Hospital
Midtown Health Center	Norfolk, Madison County, NE	Federally Qualified Health Center
Faith Regional Health Services	Wayne, Wayne County, NE	Family Medical Clinic
Winnebago Public Health Department	Winnebago, Thurston County, NE	Public Health Department
University Nebraska Medical Center	Norfolk, Madison County, NE	University

Community Characteristics

Area

NNRHN serves the northeast Nebraska area, which includes Wayne, Thurston, Cedar, and Dixon counties and two Native American reservations.

Target Population

The target population is 30,861 people living in four Nebraska counties, in an area encompassing 2,053 square miles. The target population includes two sovereign American Indian tribes, the Winnebago and the Omaha, as well as a growing Latin population.

Need

The CHNA is intended to serve as the foundation for setting health priorities with a shared goal of ultimately reducing health disparities and improving the health status of the district by strengthening the health system's coordination of resources and quality of life of all.

Program Services

Description

NNRHN developed three goals: (1) Improve access to and quality of health care in rural areas through sustainable community health needs assessment and community health improvement planning to create effective health care programs as a result of network collaboration. This was addressed through the completion of the CHNA and CHIP, which identified several priority areas: mental health, cancer, access to health care, chronic disease management, barriers to weight management including lack of access to resources including healthy food, and infectious diseases such as COVID-19. The two priority areas selected for focus from this process were behavioral health and health promotion. These priorities are being addressed through community coalitions. The coalitions have created vision statements, goals, objectives, and action plans to achieve those goals. (2) Reduce the levels of overweight and obesity found in the 18- to 74-year-old population within the service area by implementation of a communitywide weight loss intervention program based on evidence-based practices (EBPs). EBPs include self-monitoring mobile technology combined with health coaches. This goal addresses a third area of priority from a previous CHNA and CHIP, obesity. A weight-management committee has worked to develop a program that includes a work plan, goals, procedures, and technology and is scheduled to launch early in 2023. (3) Prepare NNRHN for the transition to value-based payment and population health management. This is being addressed by the network manager and program coordinator through educational opportunities to learn about value-based payment, such as speeches and webinars. The weight-management work will serve as the pilot to help move this process forward.

Role of Network Partners

Northeast Nebraska Public Health Department did take the lead on the application of the grant; however, all partners were equal and active partners to strengthen the local health infrastructure to improve access to and quality of health care. Network partners participate in monthly board meetings that include discussion of current events that may affect the work of the network, learning and training opportunities, technical requirements of the grant, services the network provides, and direction of the network. Partners attend and contribute to the mental health and health-promotion coalitions. Four of the partners are active in the weight loss management program. This includes planning and design of program, referrals to the program, and directly providing the weight loss management services.

Outcomes

Program Outcomes

The NNRHN has grown from five partners when they applied for the Rural Network Health Network Development Program to the current seven. The network has completed its goal of a CHNA along with a CHIP. Coalitions for mental health and health promotion have been created along with a weight loss management program beginning early 2023.

Network Collaboration

Community partners have come together for action planning meetings to continue the work of the CHIP identified from the CHNA. A variety of sectors were represented in the work: public health departments (including tribal public health), hospital, public school, private citizen, higher education institution, behavioral health, local government, and local businesses. Some of these participants have established formal working relationships with the network and some are new, potential partners. NNRHN has made connections with another Nebraska health network, Community Access to Coordinated Healthcare Inc. (CATCH), which has met with the NNRHN board. Connections have also occurred with a national association of health networks and strategic partners. All of this is an attempt to assist network members to gain a better understanding of how networks benefit health care systems and the health of the residents of the area.

Sustainability

The network will apply insights derived from connecting with other networks to find inspiration and learning from their experiences of success and tough lessons of disappointment. Network staff are currently researching value-based payment to assist network partners in movement toward this quality-improvement approach. The community and network partners realize the value of the rural network and the power that comes from collaboration. Partners understand that more can be achieved in pursuit of the common goal of improved community health by working together rather than by working in siloes.

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Union County Network

Union County Network,
DBA Northeast Network of New Mexico

D06RH37530

Project focus area:
Chronic Disease

Other focus areas:
Community Health Workers

Network History and Members

The Northeast Network of New Mexico (NEN-NM) is a 501(c)(3) vertical rural health network with board representation from all member organizations. NEN-NM's mission is to improve the health and well-being of residents of northeast New Mexico by promoting (1) healthy behaviors, (2) access to and quality of clinical care, (3) social and economic determinants of health, and (4) a physical environment that supports health. Since its incorporation in 2011, NEN-NM's programs have included oral health access, school-based health, farm-to-table program, an allied health workforce-development program, and the current ACES 4 HEARTS program.

Member Organization	Location	Organizational Type
Golden Spread Rural/Frontier Coalition	Clayton, Union County, NM	Nonprofit Organization
Krossroads Integrative Health and Recovery Solutions	Santa Fe, Santa Fe County, NM (with offices in Union and Colfax counties)	Nonprofit Organization Behavioral Health Agency
Alternatives to Violence	Raton, Colfax County, NM	Nonprofit Organization
Regional Agency Intervention Network	Raton, Colfax County, NM	Nonprofit Network Organization
Miners Colfax Medical Center	Raton, Colfax County, NM	Hospital

Community Characteristics

Area

The area is the frontier counties of Union and Colfax, N.M.

Target Population

ACES 4 HEARTS targets adults (18 and over) with or at risk for cardiovascular disease or type 2 diabetes. Over the course of the project period, two additional subpopulations were prioritized, seniors and low-income population.

Need

Cardiovascular disease is the leading cause of death in Union and Colfax, with mortality rates for heart attack and stroke exceeding the New Mexico averages. Rates for diabetes mellites, a leading cause of heart disease, also are higher than the statewide rate and place a major cost burden on the local hospitals. Sparse resources, fragmented care, and few educational or preventive programs make it difficult for the regional health care system to adequately address these conditions.

Program Services

Description

At the core of this grant-funded program, and of the network itself, are two community advisory councils, one in each of the two counties served. These councils draw representation from various levels of the member organizations, partner organizations not represented on the board of directors, and community volunteers. The councils participate in the prioritization process, promote awareness of services and resources related to the target population, identify service gaps and access barriers, and address gaps and barriers through collaboration and capacity building. For this project, two evidence-based models to address chronic disease were utilized: (1) the Pathways Community HUB model, which is community-based care coordination performed by community health workers who support clients and their families in addressing risk factors and unmet health needs through established “pathways,” and (2) Chronic Disease Self-Management Program (CDSMP) and Diabetes Self-Management Program (DSMP), which are six-week educational workshop series that help people with a chronic disease and their caretakers to build skills to better manage the disease.

Role of Network Partners

The Regional Agency Intervention Network has functioned as the community advisory council for Colfax County and has provided network leadership. Golden Spread has helped facilitate the Union County Community Advisory Council and has provided network leadership. Alternatives to Violence has conducted community-focused marketing services and serves as one of the contracted care coordinating agencies — those agencies contracted through the Pathways Community HUB program to perform care-coordinating services through a community navigator. Crossroads also serves as a care coordinating agency.

Outcomes

Program Outcomes

The two community advisory councils launched almost immediately at the beginning of the grant period. The councils participated in the strategic-planning process, have helped identify resources for a community resource guide for navigators to use with clients, and now are collaborating to address food and transportation gaps. Some partners conduct shared marketing on behalf of the network. The Pathways program was delayed in large part due to COVID-19–related challenges, but is up and running. Many of the Pathways clients have overcome barriers to care, such as lack of health insurance, transportation, and the health literacy needed to complete medical forms. Others have been able to access services or resources that are helping them become healthier. During COVID-19, the network partnered with the New Mexico Department of Health to deliver the CDSMP and DSMP workshops virtually. Doing so increased the numbers of participants but didn’t reach the full target population, particularly seniors. The network is building capacity to deliver education locally.

Network Collaboration

The above examples demonstrate successful collaboration among network members. Two principles of successful partnership learned during this project are (1) that it is important to develop relationships with multiple individuals within a partner's organization (this promotes continuity in the event of leadership turnover, and it supports effective communication about the collaborative efforts throughout that organization) and (2) before engaging in a major collaborative venture, secure a formal memorandum of agreement or contract. Checklists also are helpful to highlight requirements or action steps. Spell out not only organizational responsibilities but also personnel responsibilities and a communication plan. These formalities ensure everyone is on the same page and surface any questions or concerns.

Sustainability

Sustained impacts include:

- CDSMP participants report better ability to manage their chronic conditions and communicate with their health care team.
- Pathways clients have overcome barriers to care and have increased their capacity to navigate services and resources.
- A 50-page community-health resource guide was developed, which serves as a reference for Pathways navigators and clients and is available to the community at large.
- Partners are working together in new and innovative ways — both to address identified service gaps and access barriers and to collaborate on their own programs and initiatives.

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Westchester-Ellenville Hospital

Ellenville Regional Rural Health Network

D06RH37534

Project focus area:
Obesity Prevention

Other focus areas:
Chronic Disease

Network History and Members

The Ellenville Regional Rural Health Network (ERRHN) was founded in 2017 through a partnership with the Ellenville Regional Hospital, the Institute for Family Health, and the Ulster County Department of Health and Mental Health with the original mission of promoting improved health and health equity of the rural community through increased access to services, while enhancing the local health and human services workforce. Founded with a Rural Health Network Development Planning Grant through the Health Resources and Services Administration (HRSA), the network launched its first project utilizing a HRSA Outreach grant, providing access to community health workers to all in the Wawarsing area that were at increased risk of heart disease or cardiovascular incident. Since then, the network has expanded its scope to include projects focused on seniors, families with children at risk of obesity, and adults who are managing or at risk of developing a chronic disease, in addition to a robust opioid and overdose-prevention program. All of these programs work toward the network's newly developed mission to continuously pursue healthier lives for everyone in the community.

Member Organization	Location	Organizational Type
The Institute for Family Health	Ellenville, Ulster County, NY	Federally Qualified Health Center
Ulster County Department of Health	Kingston, Ulster County, NY	Public Health Department
Ulster County Department of Mental Health	Kingston, Ulster County, NY	Public Health Department
Cornell Cooperative Extension of Ulster County	Kingston, Ulster County, NY	Nonprofit Organization
Planned Parenthood of Greater New York	Kingston, Ulster County, NY	Nonprofit Organization
Catholic Charities of Orange, Sullivan, Ulster	Goshen, Orange County, NY	Nonprofit Organization

Community Characteristics

Area

The Ellenville Regional Rural Health Network serves primarily the towns of Wawarsing, Crawford, and Mamakating. These three towns span the counties of Ulster, Orange, and Sullivan in New York and represent the main population served by Ellenville Regional Hospital.

Target Population

The population targeted by this grant project includes families with children in the home who are either obese, overweight, or at risk of developing obesity and chronic disease.

Need

In Ulster County, 30.6% of adults and 19.9% of children and adolescents are obese. These rates are both higher than the New York state rate. During a needs assessment conducted by ERRHN in 2019, it was identified that during the Ellenville Central School District 2017-2018 school year, 18% of female students in grades pre-K, kindergarten, second, and fourth were overweight or obese (12% obese), and 22% of males from the same grades were overweight or obese (15% obese). While these rates seem promising, county data indicates that as children age these outcomes worsen. A study of the Institute for Family Health's patients during the same period looking at all youth under the age of 18 indicated an alarmingly higher rate of 48% of male and 44% of female pediatric patients being overweight or obese (30% and 26% respectively obese).

Program Services

Description

Through this program, the ERRHN was able to start a family wellness program, providing the expertise of a community health worker (CHW) to anyone in the service area who had children in the home who were obese or at risk of becoming obese. The CHW is able to guide these families through goal setting, action planning, and building on successes throughout their health journey. We are also able to offer a nutritionist for one-on-one consultations and host many physical education and activity classes for the community free of charge.

Role of Network Partners

Network partners assist with the planning and evaluation of all aspects of the program, as well as host the free education classes for the community. Often, these classes are already created and in place in other areas, but through the collaboration of the ERRHN, are made available to the otherwise underserved community.

Outcomes

Program Outcomes

These programs have reached more than 1,500 people each year of this grant-funded project. Fifty families have enrolled in the health coaching program, with a total of 123 individuals among those families. At 66 events, educational information was distributed and six weekly classes were held at the hospital, including Tai Chi, yoga, strength training, Walk with Ease, cardio interval training, and senior education classes. The nutritionist routinely meets with 50 clients for one-on-one nutrition consultations.

Network Collaboration

The network has been meeting continuously throughout the course of the program, at least once each month. This has allowed for constant process evaluation and for quick workflow changes to be made when necessary. The constant communication between network partners is an integral part of keeping programs on track and making sure that the programs were continuing to be beneficial to all partners involved.

Sustainability

The program has had an effect on the community's attitudes toward and understanding of their own health issues and the resources available to them in the community. This grant funding has provided the opportunity to remodel programming. The network learned that there is a great interest in the free education classes offered to the community and that, after attending these classes, community members have a much more welcoming attitude toward meeting with the community health workers and beginning health coaching and asking for assistance with resource navigation. This has also led to a greater sense of community between the individuals who attend classes, some friendships have blossomed, and many community members take it upon themselves to start up their own exercise groups. Many of the individuals who meet with the nutritionist have reported an increase in knowledge surrounding the creation of healthier meals, meal planning for themselves, and understanding how to read health information.

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East Carolina Health-Heritage

Edgecombe County Rural Health Network

D06RH37503

Project focus area:
Sepsis Early Management

Other focus areas:
Care Coordination

Network History and Members

In 2011, the Robert Wood Johnson County Health Rankings were published. Edgecombe County was ranked the fifth most unhealthy county in the state. The hospital president and the county health director made a call to action for community stakeholders, and the catalyst program Get Healthy Edgecombe was launched in 2011. That group of stakeholders plus additional ones morphed into the Edgecombe County Rural Health Network (ECRHN) in 2019. The ECRHN supports health care delivery system reform through an effective network that addresses the social determinants of health and population health management by collaborating in delivering care, extracting and analyzing data, reducing barriers, increasing efficiency, and sharing and generating resources. The network’s mission is to provide a collaborative health care network that will improve health and wellness outcomes for Edgecombe County residents. The goals are to increase the number of residents with primary care providers and access to behavioral health care and health care coverage and to decrease emergency department (ED) visits for situations treatable by primary care.

Member Organization	Location	Organizational Type
Access East Inc.	Tarboro, Edgecombe County, NC	Nonprofit Organization
Area L AHEC	Rocky Mount, Nash County, NC	Nonprofit Organization
Carolina Family Health Centers Inc. Freedom Hill Community Health Center	Tarboro, Edgecombe County, NC	Federally Qualified Health Center
Eastpointe Human Services-LME/ MCO	Rocky Mount, Edgecombe County, NC	Managed Care Organization
ECU Health Edgecombe Hospital	Tarboro, Edgecombe County, NC	Hospital
Edgecombe County Emergency Medical Services (EMS)	Tarboro, Edgecombe County, NC	Emergency Medical Services
Edgecombe County Health Department	Tarboro, Edgecombe County, NC	Public Health Department
Opportunities Industrialization Center Inc.	Rocky Mount, Edgecombe County, NC	Federally Qualified Health Center
Rural Health Group Inc.	Whitakers, Edgecombe County, NC	Federally Qualified Health Center

Community Characteristics

Area

Edgecombe County is a 507 square-mile rural county located approximately one hour east of the city of Raleigh. Its municipalities include Conetoe, Leggett, Macclesfield, Pinetops, Princeville, Rocky Mount, Sharpsburg, Speed, Tarboro, and Whitakers. It includes 14 townships and two unincorporated communities and has 0.5% of North Carolina's population.

Target Population

This initiative encompasses all county members with an emphasis on medical professionals and senior citizens. The county is designated as Tier 1 by the North Carolina Department of Commerce, meaning it is a "most distressed" county based on unemployment rates, median household income, population growth, and property taxes. With a population of 54,032 people, with almost 20% of those individuals being over the age of 65.

Need

From 2014 to 2016, Edgecombe County's top 10 mortality rates were greater than those of North Carolina for all 10 categories. Of those 10 categories, all 10 were pre-existing conditions that increase vulnerability to developing sepsis. The seventh-leading cause of death was sepsis. This confirmed the immense need for this initiative.

Program Services

Description

Activities include, but are not limited to, sepsis trainings with medical professionals (MDs, PAs, RNs, CNAs, etc.), sepsis protocol implementation between clinics and the ED, community education through various outlets and data analysis to track patient care from clinic to hospital, as well as care once hospitalized. One of the identified issues within the county is the unnecessary use of the hospital ED for primary care-type issues and, often, by patients discharged from the hospital within the last 30 days. The ECRHN gathered and decided the best way to combat this issue is for the (Federally Qualified Health Centers) FQHCs to receive data pertaining to their patients post-hospitalization. The ECRHN has executed a data sharing agreement that allows the program's community health improvement coordinator to run a weekly report in the electronic health record for each FQHC in the network. This report shares basic but critical information for the primary care providers to be aware of on which patients were hospitalized, why, and when they were released. Upon receiving the report, the primary care providers (PCP) are now reaching out to their patients and scheduling a hospital follow-up visit. In addition, two of the FQHCs have enhanced their walk-in/urgent care clinic hours. The network has established a sepsis protocol for each of the primary care clinics to reduce the time to treatment for patients coming to the ED from primary care with suspected sepsis. Sepsis mortality increases by 7% for each hour that antibiotic treatment is delayed, making this protocol a potentially lifesaving action plan. The project works with the clinics to educate them on the warning signs and symptoms of sepsis, targeting the appointment secretaries and the patient care teams. If there is not an available appointment, the patient will be directed to the ED. The secretary will then call a designated phone number within the ED to alert them that a potential sepsis patient is on the way to ensure they receive prompt treatment upon arrival. If the patient is seen in the clinic and sepsis is suspected, the same protocol is followed. Community members have shown significant interest in learning more about sepsis. In addition to sponsoring senior breakfasts, the team attends community events with various marketing materials. There are ECRHN-branded handouts of daily household items that display pertinent sepsis information.

Role of Network Partners

The network members played a vital role in the strategic planning process as well as all other grant-required reports and plans. Meeting monthly, members share updates that benefit other network members. Area L AHEC has been the leading education partner to assist with providing continuing education credits to the medical professionals undergoing the sepsis training courses. FQHC partners have assisted in facilitating the education sessions with their staff as well as supported the creation and implementation of sepsis protocols.

Outcomes

Program Outcomes

Efforts included five data-supported goals: (1) increase the number of patients seeking treatment for sepsis in the primary care setting, (2) decrease the number of patients visiting the ED for suspected sepsis, (3) decrease the time to appropriate antibiotic treatment for sepsis cases, (4) decrease the number of days a sepsis patient is hospitalized, and (5) decrease the mortality rate among sepsis patients in the initiative area. As of the most recent (2022) data analysis, the project is trending in the desired direction in four of the five data measures. For goal 4, there is an increase instead of a decrease, which is attributed to the inclusion of additional ICD-10 codes for septic shock patients.

Network Collaboration

Perhaps the most beneficial collaboration tool is that at the end of each monthly meeting, each partner provides updates. In the beginning, those updates simply included any successes or pertinent information. This was extremely valuable, but partners were encouraged to take it one step further by including any challenges. While it is easy to talk about successes and share general information, by encouraging partners to verbally share any challenges they have been facing, it helps the partners “talk it out,” and, often, other partners have constructive feedback to help potentially work through the challenges and brainstorm solutions.

Sustainability

Several practices have been successfully implemented that will have a sustained impact on the community: weekly patient hospitalization reporting to the respective FQHCs, enhanced walk-in and urgent care clinic availability to reduce unnecessary ED visits, institutionalization of sepsis protocols at each primary care clinic, and increased community awareness of sepsis.

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Hopewell Health Centers

Partnership to Achieve
Compliance and Savings

D06RH37504

Project focus area:
Community Health Workers

Other focus areas:
Chronic Disease

Network History and Members

The Partnership to Achieve Compliance and Savings (PACS) was formed in 2019 with the help of a HRSA Rural Health Network Development Planning grant. Health departments, state health plans, and Hopewell Health Centers (HHC) came together to explore the use of community health workers (CHWs) to address social determinant barriers to better health. The focus has been on developing sustainable employment for CHWs. PACS membership has grown over time. Major accomplishments to date have been the formation of a Pathways Hub, in which Ohio health plans reimburse for CHW services and health plan investment in clinically based CHWs. Diabetic hemoglobin A1c reduction has averaged close to two points for high-risk patients.

Member Organization	Location	Organizational Type
Hopewell Health Centers	Regional – Athens, Perry, Hocking, Vinton, Jackson, Ross, Gallia, Meigs, and Washington counties, OH	Federally Qualified Health Center
United Healthcare Community Plan Inc.	OH	Medicaid Insurer
Molina Healthcare Inc.	OH	Medicaid Insurer
Caresource	OH	Medicaid Insurer
Athens County Health Department	Athens County, OH	Public Health Department
Washington County Health Department	Washington County, OH	Public Health Department
Vinton County Health Department	Vinton County, OH	Public Health Department
Meigs County Health Department	Meigs County, OH	Public Health Department
Ross County Health Department	Ross County, OH	Public Health Department
Corporation for Ohio Appalachian Development (COAD)	Regional – Athens, Perry, Hocking, Vinton, Jackson, Ross, Gallia, and Meigs counties, OH, plus others outside service area	Development Corp.

Member Organization	Location	Organizational Type
Ohio University (OU)	Athens, OH, plus surrounding area	University
Ohio Association of Community Health Centers	OH	Nonprofit Network Organization
Oral Health Ohio	OH	Nonprofit Organization
Community Health Improvement Associates	Athens, Perry, Hocking, Vinton, Jackson, Ross, Gallia, Meigs, and Washington counties, OH	Nonprofit Organization

Community Characteristics

Area

Athens, Perry, Hocking, Vinton, Jackson, Ross, Gallia, Meigs, and Washington counties, Ohio.

Target Population

Individuals with social determinant barriers to better health, with a focus on high-risk diabetes patients.

Need

CHWs have consistently demonstrated improved health outcomes with the high-risk individuals they serve; however, there has never been a way to sustain their efforts in southeast Ohio. Ohio health plans do not currently reimburse for CHW services except through Pathways Hubs.

Program Services

Description

The purpose of the network has been to convene partners to create system changes to support CHWs, to form and support a Pathways Hub, to work with the health plans and HHC clinic sites to identify high-risk patients, to field CHWs to meet weekly with identified high-risk patients, and to track both health improvements and cost savings.

Role of Network Partners

HHC supplied the clinic sites; health plans track data; HHC, health departments, and other partners field CHWs; the Corporation for Ohio Appalachian Development formed the Pathways Hub; and Ohio University trains and certifies CHWs and, through the Ohio Association for Innovation in Population Health, provides information for policy.

Outcomes

Program Outcomes

The formation of a Pathways Hub will help lead to CHW sustainability. Community agencies can bill the hub for CHW efforts to address social determinant barriers. Ohio health plans are interested in determining the savings generated by CHW efforts with identified high-risk individuals, which should lead to further reimbursement for CHW activities. One plan has contributed money for HHC to hire a CHW. Discovering a lack of correlation between health plan– and clinic-identified, high-risk patients has helped balance high-risk enrollment.

Network Collaboration

Network collaboration has led to the formation of a Pathways Hub and a forum to discuss CHWs. Health plan participation has helped the network understand and pilot potentially reimbursable CHW activities. The network has grown from 10 to 21 member organizations.

Sustainability

Pathways will make CHWs sustainable. These CHWs will assist individuals in overcoming social determinant barriers to better health. Demonstrating the cost-savings generated by CHWs assisting identified high-risk individuals will improve CHW sustainability but, more importantly, could also lead to widespread system changes supporting this activity and improving the health of the most fragile residents.

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Northeast Oregon Network

Northeast Oregon Network

D06RH37515

Project focus area:
Community Health Workers

Other focus areas:
Chronic Disease

Network History and Members

The Northeast Oregon Network (NEON) became a mature network in 2009 and rolled out the first iteration of the Pathways Community Hub program in 2014. Since that time, the network has grown geographically and has served diverse populations with equally diverse needs and barriers to health. This has allowed for diverse funding opportunities to support the network with grants from both governments and private foundations, each with different interests and focus areas. NEON also has a rich history of working with partners in broad sectors including health care, behavioral health, public health, and social service providers. NEON has become a cornerstone of collaborative projects in the community. Agencies that NEON has worked with value the skills and services offered by the network as evidenced by the training and consulting program, which continues to grow year after year.

Member Organization	Location	Organizational Type
Northeast Oregon Network	La Grande, Union County, OR	Nonprofit Organization
Good Shepherd Health Center	Hermiston, Umatilla County, OR	Hospital
Grande Ronde Hospital	La Grande, Union County, OR	Hospital
Lifeways Inc.	Ontario, Malheur County, OR	Behavioral Health Organization
Community Counseling Solutions	Pendleton, Umatilla County, OR	Behavioral Health Organization
Easter Oregon University Head Start	La Grande, Union County, OR	University
Chastain Consulting Services, LLC	Redmond, Deschutes County, OR	Consulting

Community Characteristics

Area

Athens, Perry, Hocking, Vinton, Jackson, Ross, Gallia, Meigs, and Washington counties, Ohio.

Target Population

Union, Baker, Wallowa, Umatilla, Malheur, Morrow, and Grant counties in northeast Oregon.

Need

This grant program allowed for an expansion of the Pathways Hub program at NEON to serve new parents and families with young children who need additional support and mental health services. An expansion in the geographical area served includes not only at-risk populations such as low-income individuals, but also migrant and seasonal farmworkers and Native American tribal families.

Program Services

Description

The Pathways Community Hub infrastructure provides tools and strategies needed to ensure that individuals with health-related social needs in a community are served in a timely, coordinated manner and utilizes a newly trained community health worker (CHW) workforce to do so. The hub ensures that persons and populations are connected to meaningful health and social services that contribute to positive health outcomes. The hub helps avoid duplication of effort in care coordination and keeps individuals from falling through the cracks. To accomplish its goals, the hub provides centralized processes, systems, and resources that allow systematic tracking of those being served and that tie incentive payments to milestones that improve the patient's health and well-being. The hub increases population health by focusing on specific target populations with poor health outcomes, thus concentrating efforts across partners and sectors for those most at risk.

Role of Network Partners

Network leadership and partners engage in collective decision-making via several different methods:

- The NEON board includes representatives from the network area and is responsible for joint decision-making over human resources, budget, finances, mission, vision, and strategic plan via meetings and an annual retreat.
- The leadership team, made up of network partners, engages in operational decision-making as it relates to the hub, including setting operational policy and procedure, accepting and confirming new hub-contracted partners, reviewing data for outcome and quality improvement needs, recommending new funding opportunities to the board, and engaging in sustainability activities.
- NEON staff act as planners and implementers of the above decisions and bring problems needing resolution to each of the entities.
- Network partners participating in the hub program are made up of CHWs, trained by NEON staff on workflow to enroll clients, provide linkages and resource connections, and receive monthly outcome reimbursements based on work submitted in an online care coordination system.

Outcomes

Program Outcomes

In the short term, the program has resulted in closer relationships between community resource agencies and CHWs. It will also increase the number of healthy babies born, increase weight and lead screenings and interventions for young children, increase the number of 2-year-olds with up-to-date vaccinations, and increase access to behavioral health services for parents experiencing depression. In the long term, the program will result in an increase in academic readiness, a decrease in the stigma surrounding behavioral health, an increase in good health and nutrition status in adolescence, and a reduction in the incidence of child

abuse and neglect. At the long-term population level, the program will result in a reduction in cost of care, a reduction in the incidence of chronic health conditions, and an increase in long-term success for children and families.

Network Collaboration

Collaborations with network partners have included board membership, collaboration on community health plans, joint training programs, in-kind provision of meeting and training space, data sharing, and partnership on a wide variety of projects and funding opportunities. The primary network work groups for management and communication consist of biweekly project staff meetings for deliverable communications, work sessions and project check-ins, quarterly hub leadership team meetings (the leadership team has operational decision-making authority within the hub project), and quarterly learning collaborative meetings that consist of home visitors across the region. These communication efforts have aided in effective collaborations and achieving program goals throughout the grant.

Sustainability

This grant has expanded the use of the Pathways Hub model in eastern Oregon, broadened the CHW service population and strengthened outreach efforts to new departments, such as women and children’s clinics and women’s centers. Many partner sites have expanded their CHW workforce, adding more positions because of the statewide shift recognizing the need for more CHW services. Additionally, NEON strengthened ties with Head Start, providing support for the onboarding and establishment of a new home visitor position to work in a self-guided behavioral health program for new mothers called MomNet, and other early childhood and behavioral health–focused partners. NEON adapted to online learning methods by providing virtual trainings across the state via Zoom, making trainings much more accessible and with a reduction in travel costs. Through this expanded training method and training opportunities provided by this grant, NEON has helped increase the knowledge of the CHW workforce, as well as other front-line community-based workers, such as social workers and home visitors statewide.

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Washington Health Network

Oregon Washington Health Network

D06RH37516

Project focus area:
Behavioral Health/Mental Health –
Substance Use Disorders

Other focus areas:
Social Determinants of Health

Network History and Members

The Oregon Washington Health Network (OWhN) was established in March 2014. During that month, Yellowhawk Tribal Health Center of Pendleton, Ore., submitted a successful Rural Health Network Development Planning grant to the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services. The network was originally formed with six members. Much of the impetus for establishing a regional health network related to the need to address critical access needs that had existed in northeast Oregon and southeast Washington for decades. The most challenging of these related to access to medical, dental, and behavioral health services and a lack of preventive care. For much of the past decade, Umatilla County ranked the lowest of all 34 Oregon counties for health-related behaviors including obesity, smoking, and lack of physical activity. High death rates for heart disease, cancer, and stroke have also existed in northeast Oregon for decades. A lack of behavioral health and substance abuse treatment services had led to high rates of suicide, increasing use of opioids and methamphetamines, and high rates of domestic violence. Thus, the creation of OWhN has been focused on integrating physical, mental, behavioral, and public health services to improve health outcomes and health equity, focusing on access, quality, and cost-effectiveness.

Member Organization	Location	Organizational Type
Umatilla County Department of Human Services (now Community Counseling Solutions)	Umatilla County, OR	Nonprofit Organization
Yellowhawk Tribal Health Center	Pendleton, Umatilla County, OR	Nonprofit Organization
CHI St. Anthony Hospital	Pendleton, Umatilla County, OR	Hospital
Blue Mountain Community College	Pendleton, Umatilla County, OR	Community College
Good Shepherd Health Care Systems	Hermiston, Umatilla County, OR	Hospital
Morrow County Health Department	Heppner, Morrow County, OR	Public Health Department
Morrow County Health District	Heppner, Morrow County, OR	Nonprofit Organization
Providence St. Mary Medical Center	Walla Walla, Walla Walla County, WA	Hospital
Walla Walla Department of Community Health Services	Walla Walla, Walla Walla County, WA	Public Health Department

Community Characteristics

Area

Counties served are Umatilla, Union, and Morrow in Oregon and Walla Walla County in Washington.

Target Population

With OWhN's mission to improve health outcomes and health equity, efforts are focused toward underserved or marginalized populations, such as houseless, Latin, tribal, migrant farm workers, veterans, and others. The majority of the programs created by OWhN offer behavioral health and substance use disorder services, which largely dictates the general population served by direct services, but the network's mission and collaborative efforts are to focus on integrated health for all, with emphasis on underserved populations.

Need

There have been critical access needs in northeast Oregon and southwest Washington for decades. This has been related to medical, dental, behavioral health, or substance use disorder services, as well as an overall lack of preventive care. The counties in the project service area remain low in County Health Rankings, with the burden of obesity, smoking, and lack of physical activity higher than the respective state averages, and with access to health care being lower than respective state averages.

Program Services

Description

Three key positions were established to help support community and network partners. A health professions recruiter has assisted networks in recruiting for health care professionals, as well as getting National Health Service Corps (NHSC) site approval to help bolster recruitment efforts. The chronic disease health educator collaborated with network partners to provide health education via prevention and maintenance efforts within the communities served. In addition, a billing specialist has been available to offer technical assistance to network partners with billing efforts to support revenue generation.

Role of Network Partners

Initial commitment was made between the network partners as part of funding for a Rural Communities Opioid Response Program and Umatilla County Human Services. The 10 member organizations remained committed for this grant to support integrated health care by collaborating toward expanding access to care, improving quality and outcomes of care, and strengthening the rural health care system as a whole. Members work together to meet and discuss gaps in service areas so that they can assist one another in improving and achieving these outcomes.

Outcomes

Program Outcomes

The overall outcome is collaboration and contribution of evidence-based practices for direct services, such as cognitive behavioral therapy for anxiety, depression, and behavior; co-occurring disorders; suicide response training; motivational interviewing; and cognitive processing therapy. During this time, a primary care facility was opened that also addressed opioid use disorder and addiction treatment and served as a crisis center and respite care. The network members worked closely with providers in the network to ensure wraparound services are being provided to clients or patients. OWhN continues to provide direct care to clients in regard to opioid use disorder and other substance use and addictions. They continue to collaborate and work with other network partners to expand these services into all primary care facilities and to increase services within jails.

Network Collaboration

Members across the network worked closely throughout the COVID-19 pandemic, especially to try to ensure that access to quality care remained possible for clients. There was an increase in overdoses and substance abuse during this period due to the many hardships created. The OWhN partners met regularly to discuss challenges they were facing as a network and how they could help, whether that was referring to another organization that had the availability to take in a client, assisting with community resources to help clients without basic needs, or assisting as a full care team to ensure that clients received wraparound care. Throughout the course of the program, it has been important to provide network members with up-to-date information and opportunities for engagement. Some key members were lost along the way, and those members who came on board later in the project had a steep learning curve to get up to speed with the goals and commitments of the network.

Sustainability

OWhN has made valuable relationships with network partners that have evolved since the initiation of this grant. Many of the original members are no longer in their positions, but that has provided “new” members with whom to work and collaborate. This has allowed for new ideas, new ways to coordinate care, and new ways to collaborate toward better serving communities. Not only did OWhN procure additional funding sources through grants to provide services within behavioral health and implementing opioid treatment services through 2026, OWhN also acquired Grand Ronde Recovery in 2021, which provides billable revenues through outpatient services. This creates a pipeline of clients in need of additional patient care, which is connected through to network partners. This has sustainability by increasing capacity and billable revenues as well as increasing involvement and engagement within communities and network partners. The network is well connected now and has many opportunities for expansion of services with the continued support of our network partners.

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Sky Lakes Medical Center Foundation

Healthy Klamath

D06RH37524

Project focus area:
Chronic Disease

Other focus areas:
Care Coordination

Network History and Members

A healthy community where all community members have the ability to thrive and live a happy, healthy, and prosperous life is the vision of the Healthy Klamath Network. Sky Lakes Medical Center (SLMC) leadership spearheaded the conversations that later formed the Healthy Klamath Coalition in 2012. As a network, Healthy Klamath has over 10 years of successful health improvement work that is rooted in collaboration. With significant work focused on evidence-based strategies to improve the built environment, address health equity issues, and establish cross-sector involvement, the Healthy Klamath Network formalized through this Rural Health Network Development grant and has evolved and expanded its work to focus on collaborative approaches for diabetes management.

Member Organization	Location	Organizational Type
Sky Lakes Medical Center (SLMC)	Klamath Falls, Klamath County, OR	Hospital
Klamath Health Partnership (KHP)	Klamath Falls, Klamath County, OR	Federally Qualified Health Center
Cascade Health Alliance (CHA)	Klamath Falls, Klamath County, OR	Care Coordinated Organization

Community Characteristics

Area

Klamath County, Ore.

Target Population

Community members living in rural Oregon that experience social, economic, and physical barriers to successfully managing or preventing diabetes. Program intervention focused on patients with Medicare who are diagnosed with diabetes and on patients with the primary language of Spanish.

Need

By strengthening the Healthy Klamath Network to reach additional vulnerable patient populations, the Healthy Klamath: Expanded Network for Diabetes Management's aim is to help patients living in rural communities overcome barriers to managing their diabetes. The target population was chosen due to the disproportion number of patients with diabetes in poor control, in addition to their lack of clinical oversight and unique patient demographics.

Program Services

Description

A diabetes management-specific network and expanded marketing and service delivery of the Diabetes Prevention Program (DPP) were developed. Through the Healthy Klamath Extended Network for Diabetes Management, the marketing, expansion, and management of community diabetes management services and deliveries was coordinated between the multiple community organizations in Klamath County. The extended network acted as a conduit for communication and problem-solving between Healthy Klamath staff and community partners. The extended network is a hub for all community health organizations to share ideas, campaigns, and data around referrals to and utilization of community diabetes management programming. The extended network provided oversight of local DPP delivery and the development of the local culturally and linguistically appropriate DPP program, Programa de Prevención de la Diabetes, which is offered by Spanish-speaking staff at the local Federally Qualified Health Center, Klamath Health Partnership.

Role of Network Partners

The network members were essential to the planning and implementation of the grant-funded work. Key players included SLMC, Klamath Health Partnership (KHP), and Cascade Health Alliance (CHA). SLMC and KHP have shown success in utilizing value-based payment agreements with local managed care entities to support community health work and wellness programs. KHP trained multiple community health workers and the community health worker team reviewed the national Centers for Disease Control and Prevention (CDC) DPP curriculum and adapted a shorter curriculum plan for individuals whose primary language is Spanish. Through this grant program, KHP worked with Sky Lakes Medical Center to determine a method for enrollment and outreach. CHA was integral in scaling up the referral program through Healthy Klamath Connect, a central social service referral and outreach platform focused in Klamath County. CHA worked with network partners to identify programs and key staff and to train on platform workflows to ensure that each agency could send, receive, and manage referrals to programs as necessary. CHA continues to work with partners to ensure all programs are identified and linked within the Healthy Klamath Connect platform.

Outcomes

Program Outcomes

During this grant period, the network worked with community partners to develop a health equity action plan, created a Hispanic health committee, and continued to drive progress in the community health improvement plan areas. The grant led to the formation of a diabetes care network that has continued to grow throughout the grant project. The Healthy Klamath Connect platform has allowed partners and patients to engage in services through referral and self-referral. In fact, the Healthy Klamath Connect platform has been adopted as a key strategy for the 2022 community health improvement plan priority area of health promotion: access to services.

Network Collaboration

The Healthy Klamath Network continues to work closely with community partners to improve the health and well-being of Klamath County. Regular partner meetings, diabetes programming meetings, and leadership team meetings drive progress with the project work. Community health progress has been shared with the larger network via a monthly newsletter, a quarterly magazine, and during monthly meetings. This diabetes network is focused on identifying community partners that either serve patients with diabetes, have resources for treatment or education, or provide case management for patients in this population. This network has already helped several agencies identify opportunities for their patients that were previously unknown to them.

Sustainability

The work with diabetes management and DPP programming will continue through support from SLMC and KHP with coordination and collaboration supported through the Healthy Klamath network. Systems and education developed throughout this grant period will be incorporated into both Healthy Klamath and KHP services, including formalizing diabetes care management–specific care plans for community health work and expanding the available chronic disease–management classes and educational offerings.

The Healthy Klamath Network will also continue to sustain and drive progress toward improving the health and well-being of Klamath County. Key partners will continue to come together to strategically identify key priority areas to focus on and improve together over time. With a formal system in place, data will be tracked and evaluated. Healthy Klamath will continue to work to expand and diversify the leadership team and membership. The network will continue to meet regularly as the expanded network for diabetes prevention and will continue to try to reach underserved populations and increase recruitment and participation among the Spanish-speaking population. Additionally, funds will be sought from local, state, and national partners to further the efforts that are defined in the community health improvement plan.

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Palmetto Care Connections

Palmetto Care Connections
Rural Health Network

D06RH37517

Project focus area:
Telehealth

Other focus areas:
Chronic Disease

Network History and Members

The South Carolina Virtual Access Telehealth Network (SC VATN) expands the existing Palmetto Care Connections (PCC) rural health network by adding rural, independent pharmacies, Medical Ministries Inc., Pine Hill Indian Community Development Initiative, community centers, Southeastern Housing and Community Development, and health care providers to the telehealth network services. The purpose of this project is to expand access to care in target rural, underserved communities by integrating the functions of the network members, staff, and the board of directors to improve population health as well as individual health outcomes.

Member Organization	Location	Organizational Type
Ehrhardt Pharmacy	Ehrhardt, Bamberg County, SC	Pharmacy
Pine Hill Indian Community Development Initiative	North, Orangeburg County, SC	Community Center
Lane Community Center	Lane, Williamsburg County, SC	Community Center
Bamberg Villas – Southeastern Housing Development	Bamberg County, SC	Community Development
Medical Ministries, Inc. – three locations	Ehrhardt, Bamberg County, SC Orangeburg County, SC St. George, Dorchester County, SC	Nonprofit Organization
Allendale Leisure Center – Senior Center	Allendale County, SC	Community Center
Generations Unlimited – Senior Center	Barnwell County, SC	Community Center
Good Hope AME Church	Cope, Orangeburg County, SC	Faith-based Organization
Bamberg Family Practice	Bamberg County, SC	Physician Practice - Primary Care
Clemson Rural Health	Clemson/Orangeburg County, SC	Rural Health Care - Primary Care

Community Characteristics

Area

The service area covers six rural counties in South Carolina: Allendale, Bamberg, Barnwell, Dorchester, Orangeburg, and Williamsburg. The project met the health care needs of the rural underserved population in the rural South Carolina communities of Allendale, Bamberg, Barnwell, Cope, Ehrhardt, Lane, North, St. George, and Orangeburg.

Target Population

The current population in the targeted counties has limited or fixed incomes. Among the top chronic diseases for this population are diabetes, obesity, and hypertension. Approximately 14% do not have health insurance, approximately 44% are not in the labor force, and about 20% live below poverty level.

Need

The need for telehealth services in these targeted rural counties is exacerbated for many reasons, such as transportation barriers, financial reasons, family support, and more. These services will improve population health, reduce care costs, and increase access to care with emphasis on chronic disease management for hypertension and diabetes.

Program Services

Description

Network project activities include implementing telehealth services, specialty and primary care integration, improving coordination of services, implementing health information technology/exchange, and implementing programs to increase primary care workforce in rural communities. Expected outcomes of the project were improvement in quality of life among chronic disease patients, an improvement in blood pressure control amongst hypertension patients and improvement in HbA1c levels in patients with diabetes, and an improvement in knowledge and skills amongst pharmacists and providers.

Role of Network Partners

All network partners are involved in program implementation and help to determine schedules that work for their SC VATN site or their practice. Partners help determine schedule blocks (if required) and telehealth requirements such as policy and procedures. There are several SC VATN sites that collaborate with a local pharmacist, that provides free health care education classes.

Outcomes

Program Outcomes

Over time, SC VATN's intended impact is coordinating primary care and specialty care, with emphasis on chronic disease with the highest prevalence in the communities served, provided via telehealth with local, supportive public health services, including chronic disease self-management education, diabetes prevention, and medication therapy management. Increasing access to care in the local community and engaging more residents in consistent care, and connecting providers, communities, and payers in care coordination, will better prepare communities for the transition to value-based care.

Network Collaboration

Service providers are working together in new ways to improve the quality of care that their patients receive through telehealth equipment and provider collaboration. It is important to keep in mind the rapid pace of change in health care and the required willingness and ability to adjust plans accordingly.

Sustainability

All collaborative efforts will continue throughout and after the grant coverage period. The biggest contributor to the success and sustainability of this program is revenue not being generated through PCC. Revenue is generated solely through the providers providing services at the SC VATN sites. This allows the providers the ability to see the full advantages of utilizing the services at the SC VATN sites. PCC will also continue to maintain the equipment as part of its mission, at no cost to the providers even after the grant coverage period has ended.

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Sacred Heart Health Services

Upper Midwest Palliative Care Education Network

D06RH37523

Project focus area:
Palliative Care

Other focus areas:
Education

Network History and Members

The Upper Midwest Palliative Care Education Network’s purpose is to [increase knowledge](#) of palliative care by collaborating with area academic institutions to develop a comprehensive, replicable curriculum model to educate students in health care–related programs; support continuing education for health care professionals; and raise awareness among patients, families, and others located in rural communities. In addition to these founding members listed in the above table, the network has grown to more than 400 individuals representing 38 organizations.

Member Organization	Location	Organizational Type
South Dakota State University	Brookings, Brookings County, SD	University
Mount Marty University	Yankton, Yankton County, SD	University
Presentation College	Aberdeen, Brown County, SD	University

Community Characteristics

Area

Through the project, more than 2,000 persons have received education on palliative care. Participants of the continuing education program were from nine states in the United States. For those within South Dakota, they represented the three urban, 14 of the 25 rural, and two of the 38 frontier counties. Community education events were held in 17 locations in South Dakota: three urban, nine rural, and five frontier counties. More than 1,400 nursing students, representing multiple states and numerous counties, received palliative care education.

Target Population

The network identified three target populations for the palliative care education initiative: undergraduate and graduate nursing students, interdisciplinary health care professionals, and community members. An emphasis was placed on these populations who practice or live in a rural or frontier area.

Need

The network conducted several [needs assessments](#) during a planning period, which identified education on palliative care as a priority as other needs relied on a clear understanding of palliative care.

Program Services

Description

Education activities focused on the three target populations, with palliative care education being incorporated into nursing coursework, 11 online on-demand education modules, and a one-day, in-person symposium. All the education aligned with the eight domains within the [Clinical Practice Guideline for Quality Palliative Care](#). For community education, 17 presentations on palliative care were offered in various locations across the state.

Role of Network Partners

Each network member had two representatives serving on the network's governing board, which oversaw all grant activities and decisions, including the planning, development, and implementation of the educational aims. Representatives served as the content experts for the education or invited content experts based on their connections to other palliative care experts.

Outcomes

Program Outcomes

A total of 2,106 individuals in the Upper Midwest received training in palliative care: 256 community members, 1,473 nursing students, 158 health care professionals, and 219 attendees at the symposium. Now, the network can further palliative care efforts in the region since more people understand what palliative care is and how it can benefit their patients or themselves.

Network Collaboration

The success of the education activities relied heavily on the network's partners and members for connections to content experts, funding and a venue for the symposium, and awarding of continuing education credits. Additional partners and members were added through deliberate engagement with the community and key sectors through the newsletter, emails, and presentations.

Sustainability

After taking the continuing education sessions, health care professionals reported enhanced knowledge, performance, competence, and teamwork skills. Health care professionals also reported being able to improve patient outcomes and practice habits. Preliminary data indicate that nursing students are increasing their knowledge of palliative care by partaking in the palliative care coursework (see Table 1: Nursing Student Knowledge and Preparedness). Students' self-reported preparedness to provide palliative care services upon graduation demonstrates a significant increase in preparedness, which will positively impact their nursing care of patients with serious illness and their families. The community education participants demonstrated a statistically significant ($p < .001$) improvement in knowledge of palliative care and confidence in finding palliative care services.

Table 1: Nursing Student Knowledge and Preparedness

	Knowledge of Palliative Care Mean (SD)	Preparedness to Provide Palliative Care Mean (SD)
Before Education	197.4 (18.8)	56.0 (18.1)^
After Education	208.6 (21.3)	68.3 (17.7)^
	Highest possible score: 235	Highest possible score: 90

N = 20; ^ improvement from pre-to post-survey, p < .05

Providing palliative care education to the health care professionals and nursing students will have a long-term impact as the knowledge and skills gained through the education will impact their practice and likely patient outcomes. Enhancing the public's knowledge of palliative care may foster discussions and use of palliative care services. Together, these educational efforts have reached 16 states and two countries so far, demonstrating a geographically broad impact. The continuing education will remain available until the end of 2023 and the palliative care education will remain integrated into the nursing student programs, thus furthering the impact of the network.

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Paris and Henry County Healthcare Foundation

GrowWell Telehealth Network Program

D06RH37518

Project focus area:
Telehealth

Other focus areas:
Behavioral Health/Mental Health

Network History and Members

The West Tennessee Delta Network is a formally established and self-governing membership organization. The network's mission is to promote health equity and enhance the well-being of residents of rural West Tennessee through partnership development, shared resources, education, and care coordination. The network grew out of the West Tennessee Delta Consortium, a group of more than 30 health care and nonprofit agencies that have worked together since 2010. Through a Rural Health Network Development Planning grant, the network members established a formal organizational structure, mission, bylaws, and self-governing board in 2018.

Member Organization	Location	Organizational Type
Henry County Medical Center	Paris, Henry County, TN	Hospital
Hardeman County Community Health Center	Bolivar, Hardeman County, TN	Federally Qualified Health Center
Lifespan Health	Savannah, Hardin County, TN	Federally Qualified Health Center
LeBonheur Community Health and Wellness	Jackson, Madison County, TN	Nonprofit Network Organization
Tennessee Department of Health	West Tennessee	Public Health Department
Hardeman County Schools	Hardeman County, TN	School Board

Community Characteristics

Area

This program served 13 rural counties in West Tennessee: Weakley, Henry, Gibson, Carroll, Benton, Haywood, Henderson, Decatur, Chester, Hardeman, McNairy, Hardin, and Wayne.

Target Population

Pediatric and adult patients located within the identified rural areas in West Tennessee were the target for this program. The purpose was to establish and build the capacity of the network to provide telehealth behavioral and obesity-related primary care and specialty health services for rural residents.

Need

Underserved populations in rural East Tennessee have the same health care needs and challenges as those in other rural areas, including limited access, transportation barriers, long distances to travel to providers, and time barriers due to employment demands. Many of the behavioral health and obesity-related services provided by the region's health care providers could be more efficient and cost-effective for patients using telehealth technologies.

Program Services

Description

Services within this program included behavioral health, obesity- and diabetic-related nutrition services, and school-based telehealth services. All services were marketed and shared with clinics, providers, and members within the target communities. Additionally, education was created to explain telehealth technology and its use in increasing access to quality care close to home. Support surrounding implementation, software and hardware training, and policy and reimbursement was consistently provided to clinics and providers who extended these services within their practice.

Role of Network Partners

All network partners participated in program planning and implementation. Each partner received equipment, thorough training and marketing support, as well as access to all available programs and services.

Outcomes

Program Outcomes

Outcomes that have resulted from this program have included increased access to telehealth services, including services that were not formerly available such as behavioral health and nutritional and diabetes counseling. These services have had a direct impact on the quality of care received by those within the targeted service area. In addition to direct services, patients have also received equipment to monitor their care remotely, including Bluetooth scales, blood pressure monitors, and thermometers. A total of 17 clinics and schools have received telehealth equipment and training to promote access to care.

Network Collaboration

The network was able to effectively collaborate through ongoing contact and communication. Despite challenges surrounding COVID-19 and staffing shortages, the network was able to continue accomplishing its goals and objectives. A key to this partnership has been flexibility and one-on-one support for the network members.

Sustainability

This program has had a tremendous impact on the knowledge, attitudes, and behaviors surrounding telehealth, including for providers and patients within their communities. Through hands-on training and support, providers could experiment and grow more comfortable with telehealth technology and utilization of a new modality of care for their patients. Patients benefited from having increased access to their providers and the elimination of barriers such as transportation, time barriers, and long-distance travel. Patients and providers were provided tools to help them take charge of the ways in which they receive and provide health

care. The community has received access to specialty services, with referrals throughout the state. While rural areas have been slower to adopt telehealth practice, this program has allowed these areas a chance to embrace a new form of care while receiving support from those who can identify with their unique needs.

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Bay Rivers Telehealth Alliance

Eastern Shore Telehealth Consortium

D06RH37494

Project focus area:
Telehealth

Other focus areas:
Behavioral Health/Mental Health —
Substance Use Disorders

Network History and Members

The Eastern Shore Telehealth Consortium (ESTC) was founded by Bay Rivers Telehealth Alliance (BRTA) in 2020 to build a telehealth delivery system infrastructure to promote increased resources, innovation, and coordination of health services on the Eastern Shore of Virginia.

Member Organization	Location	Organizational Type
Eastern Shore Community Services Board (ESCSB)	Tasley, Accomack County, VA	Nonprofit Organization
Eastern Shore Health Department (ESH)	Accomack, Accomack County, VA	Public Health Department
Eastern Shore Regional Jail (ESRJ)	Eastville, Northampton County, VA	County Government
Riverside Health System (RHS)– Riverside Shore Memorial Hospital (RSMH)	Onancock, Accomack County, VA	Hospital
Eastern Shore Community College (ESCC)	Melfa, Accomack County, VA	University

Community Characteristics

Area

The service area of this grant consisted of Northampton and Accomack counties, making up the peninsula known as the Eastern Shore of Virginia.

Target Population

The target population is individuals living on the Eastern Shore of Virginia with or at risk of substance use disorder (SUD) or opioid use disorder (OUD) and the organizations that serve them.

Need

The Eastern Shore's two-county service region is designated as a Medically Underserved Area as well as a Health Professional Shortage Area for primary care and behavioral health. The region was experiencing significantly higher drug-related mortality rates than the rest of the state. This grant addressed the growing SUD/ODU epidemic, fragmentation of services, and workforce shortages among organizations to prevent, treat, and sustain the recovery of people with OUD/SUD. By developing a more robust telehealth infrastructure and offering workforce development training, organizations were able to provide services via telehealth and coordinate fragmented services. Through the development of a formal network, increasing the use of evidence-based/culturally appropriate OUD/SUD interventions for prevention, treatment, and recovery through telehealth-enabled platforms, the project anticipated a reduction in morbidity and mortality related to SUD/ODU.

Program Services

Description

This project developed a sustainable consortium, ESTC, for the continued development of strategic virtual health initiatives designed to increase resources, innovation, and coordination of health services. The ability of partners was strengthened to leverage resources to meet the needs of individuals with or at risk of SUD/ODU through enhanced online training and certification opportunities for the existing health care workforce designed to increase exposure to evidence-based/informed, promising practices and culturally appropriate OUD/SUD interventions for prevention, treatment, and recovery through telehealth-enabled platforms; enhanced linkages to evidence-based practices for medication-assisted treatment (MAT) and other substance abuse services; establishing an emergency department (ED) bridge to SUD/ODU services for justice-involved population and other ED patients; expanded access to peer recovery and recovery support services; expanded integrated behavioral health (IBH) in the primary care setting through telehealth services; expanded telehealth services with the purchasing, training, and workflow development of telehealth equipment and services; and increased overall services delivery on the Eastern Shore of Virginia.

Role of Network Partners

Partners maintained strong communication links and provided consultation with project staff and members for guidance on telehealth program development and operations; telemedicine referrals for patients/clients; member leadership in identifying programs and business services that assist in meeting their needs; distribution of major telehealth news and public policy developments, and strategic planning for emerging health issues utilizing telehealth enabled innovations. In addition, partners participated in warm handoffs, direct clinical care, workforce development, online training and certification, Project Echo, peer support, service delivery, sustainability planning, business development, operational and quality improvement, and care coordination.

Outcomes

Program Outcomes

While final outcome data is not available at this time, some program outcomes observed to date include increased reach of telehealth programs to include outpatient, inpatient, primary care, and home care; increased access to specialty care and accessibility of care; expanded use of evidence-based practices; improved coordination of services between partners; training for staff on telehealth and with improved workforce retention; and establishment of workflows between ESTC members. The three-year goal was to see 130 individuals receive direct care clinical services from the project. In the first two years, 186 individuals

received direct care clinical services, and the IBH clinician has been able to see an additional 130 individuals, for 2,665 total visits in the health department.

Network Collaboration

ESTC is the only telehealth-focused consortium on the Eastern Shore. Being a partner in the consortium offered advantages to consortium members, such as access to telehealth information, training, and equipment. The other benefit is that there is potential for applying for more grants to increase sustainability of the consortium as a whole and the services funded.

Sustainability

ESTC will continue to focus on expanding access to prevention, treatment, and recovery services for uninsured individuals with OUD/SUD living on the Eastern Shore of Virginia. The establishment and ongoing collaboration among the six consortium partners will benefit the community over the long term by securing additional grants and guiding the allocation of opioid settlement funds in the region. The funding to one of the partners has allowed for community members without insurance to receive substance abuse services they otherwise could not access. The individuals are then linked to a case manager who helps them get access to community resources, including medical insurance. Sustained impact includes new collaborations between Eastern Shore Community Services Board (ESCSB) and Eastern Shore Health Department for IBH program; mental health counseling for the students at Eastern Shore Community College, in partnership with ESCSB; and continued investment in ongoing telehealth training continuing education units (CEUs) for clinicians who received a board certified tele-mental health (BC-TMH) credential through grant funding. The two clinicians that are part of this grant stated that due to the services they are able to provide with grant funding, they have seen positive changes in knowledge, attitudes, and behaviors of those receiving services. They note improved productivity, increased numbers of clients who have been able to maintain employment, and others who have returned to employment as mental health has improved. The IBH program has helped in a variety of ways, including overcoming the stigma for those seeking mental health services; allowed for interventions that have helped improve sleep hygiene, which improves mood and functioning; and included education of how alcohol use interferes with sleep. The treatment team noted improved self-care management as part of mental health care goals: improved measures of A1c, blood pressure, medication adherence, and maintenance of medical appointments. These services allowed for the reduction in the need for inpatient hospitalization. ESCSB culture and procedures have changed due to adding the Eastern Shore Regional Jail and the ESCSB's behavioral health mobile unit. ESCSB received opioid settlement dollars to expand tele-behavioral health and substance abuse services to Tangier Island. Although not a direct result of project efforts, in the state of Virginia there have been changes to the telehealth policies as a result of COVID-19 that are helping efforts to sustain and expand telehealth services on the Eastern Shore.

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Virginia Rural Health Association

The Virginia Rural Health Clinic Coalition

D06RH37532

Project focus area:

Behavioral Health/Mental Health —
Substance Use Disorders

Other focus areas:

None

Network History and Members

In March 2016, 13 of Virginia’s Rural Health Clinics (RHCs) held their first-ever statewide meeting. This meeting was the capstone event for a yearlong coalition-building process funded by a Rural Health Network Development Planning grant. The major focus of that meeting was to determine what was needed to ensure the viability of Virginia’s RHCs. The attendees’ conclusion was that it was necessary to create the Virginia Rural Health Clinic Coalition (VRHCC) for the purpose of “unifying Virginia’s Rural Health Clinics by providing advocacy, education, and networking opportunities.” The participating RHCs voted unanimously to commit \$1,000 per year to support the defined purpose. Over the next few years, RHC members grew to 28. Virginia The Rural Health Association (VRHA) received this grant in 2020 to provide extensive training opportunities for Virginia’s RHCs. Through this funding opportunity, VRHCC has been able to provide health care professional training and community stakeholder engagement to address behavioral health, and educational opportunities to optimize RHC practice management.

Member Organization	Location	Organizational Type
Glade Spring Community Clinic	Glade Spring, Washington County, VA	Rural Health Clinic
Rural Health Clinic Lebanon	Lebanon, Russell County, VA	Rural Health Clinic
St. Paul Family Practice	St. Paul, Wise County, VA	Rural Health Clinic
Community Physicians Group – Hot Springs	Hot Springs, Bath County, VA	Rural Health Clinic
Bath Community Physicians Group – Covington	Covington, Alleghany County, VA	Rural Health Clinic
Bath Community Physicians Group – Millboro	Millboro, Bath County, VA	Rural Health Clinic
Family Medicine – Giles	Pearisburg, Giles County, VA	Rural Health Clinic
Family Medicine – Lexington	Lexington, Rockbridge County, VA	Rural Health Clinic
Internal Medicine – Lexington	Lexington, Rockbridge County, VA	Rural Health Clinic
Clinch Valley Physicians Associates	Richlands, Tazewell County, VA	Rural Health Clinic

Family Care of Chilhowie	Chilhowie, Smyth County, VA	Rural Health Clinic
Olde Towne Medical & Dental Center	Williamsburg, Surry County, VA	Rural Health Clinic
Patrick County Family Practice	Stuart, Patrick County, VA	Rural Health Clinic
Tri-State Rural Health Clinic	Grundy, Buchanan County, VA	Rural Health Clinic
Family Medicine/Washington	Washington, Rappahannock County, VA	Rural Health Clinic
Luray Family Medicine	Luray, Page County, VA	Rural Health Clinic
Page Healthcare Associates	Luray, Page County, VA Luray, Page County, VA	Rural Health Clinic
Page Multispecialty Clinic	Luray, Page County, VA	Rural Health Clinic
Page Rural Health Center	Luray, Page County, VA	Rural Health Clinic
Page Shenandoah Health Center	Shenandoah, Shenandoah County, VA	Rural Health Clinic
Family Medicine Strasburg	Strasburg, Shenandoah County, VA	Rural Health Clinic
Family Medicine Mt. Jackson	Mt. Jackson, Shenandoah County, VA	Rural Health Clinic
New Market Multispecialty Clinic	New Market, Shenandoah County, VA	Rural Health Clinic
Woodstock Pediatrics	Woodstock, Shenandoah County, VA	Rural Health Clinic
Woodstock Multispecialty Clinic	Woodstock, Shenandoah County, VA	Rural Health Clinic
Warren Family Medicine	Front Royal, Warren County, VA	Rural Health Clinic
Warren Multispecialty Clinic	Front Royal, Warren County, VA	Rural Health Clinic
Warren Pediatrics	Front Royal, Warren County, VA	Rural Health Clinic

Community Characteristics

Area

Alleghany County, Bath County, Buchanan County, Giles County, Page County, Patrick County, Rappahannock County, Rockbridge County, Russell County, Shenandoah County, Smyth County, Surry County, Tazewell County, Washington County, Warren County, and Wise County.

Target Population

VRHA has worked to improve behavioral health for the 527,251 people who live in communities served by Virginia's RHCs.

Need

Many of Virginia's RHCs have gone out of business in the past 20 years due to their inability to stay current with RHC reimbursement regulations and be compensated appropriately for their work. To emphasize this point, eight RHCs closed in Virginia between 2014 and 2016. The facilities that closed have not been replaced. The loss of an RHC means loss of a health care access point for that community.

Program Services

Description

Services provided by this grant effort include (1) Mental Health First Aid — a skills-based training course that teaches participants about mental health and substance-use issues, (2) National Association of Rural Health Clinic Certified Rural Health Clinic Professional — a full spectrum course designed to teach how to operate a successful RHC, (3) ArchPro Coding — provides RHC staff an option to earn and maintain a recognized certification focused on RHC coding and billing, (4) telehealth implementation and updates, and (5) RHC staff registration and travel reimbursement to national RHC educational opportunities and statewide RHC summit.

Role of Network Partners

VRHCC members make contributions to the network through the payment of annual VRHCC dues, serving as the host sites for regional events, and conducting peer education and outreach.

Outcomes

Program Outcomes

The outcomes on the target population include quicker identification of mental health concerns and referrals to treatment; the ability to make better decisions on the prescription medications prescribed; continued access to quality health care in rural communities; and improvement in population health indicators including suicide, opioid overdoses, and increased life expectancy. The outcomes on the RHC staff include successfully providing the means for 92 individuals to obtain training, further education, or attend national conferences.

Network Collaboration

As the VRHCC's members seek to "unify Virginia's RHCs by providing advocacy, education, and networking opportunities," they continuously work together to meet their goal to position Virginia's RHCs to be leaders in improving population health in RHC communities with a focus on behavioral health.

Sustainability

Virginia's RHCs have increased potential for long-term viability that ensures they can continue to serve the health needs of rural residents. The clinics are prepared to adapt to upcoming changes in payment system reform and participate in quality-improvement programs. Virginia's RHCs now also integrate mental health and substance abuse services into primary care.

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Strength In Peers

Side-by-Side Recovery Network

D06RH37527

Project focus area:

Behavioral Health/Mental Health —
Substance Use Disorders

Other focus areas:

Peer Recovery Specialists

Network History and Members

The Side-by-Side Recovery Network was established in 2019. Its purpose is to develop partnerships among clinical treatment providers and peer-run, recovery community organizations (RCOs) to improve the quality of, accessibility to, and sustainability of services for vulnerable, high-need, and hard-to-reach populations in Virginia. It was founded by Strength In Peers, the Harrisonburg Center for Relational Health, and the University of Virginia. In 2020, On Our Own Charlottesville joined to pilot an expansion to a new community.

Member Organization	Location	Organizational Type
Strength In Peers	Town of New Market, Shenandoah County, Virginia	Nonprofit Organization
Harrisonburg Center for Relational Health	City of Harrisonburg, Virginia	Counseling Center
University of Virginia	City of Charlottesville, Virginia	University
On Our Own Charlottesville	City of Charlottesville, Virginia	Nonprofit Organization

Community Characteristics

Area

The project targeted three rural Virginia counties: Louisa, Page, and Shenandoah. It built on an existing program operating in Page and Shenandoah and piloted an expansion into Louisa by adding a new partner to the network that operates in that county.

Target Population

The project targeted low-income adults with substance use and mental health challenges. It included a special focus on vulnerable, high-need and hard-to-reach populations, particularly individuals who have histories of homelessness and incarceration.

Need

All three target counties are designated health professional shortage areas for mental health and experience significant disparities in access to services and mental and behavioral health outcomes. Disparities are especially pronounced among low-income populations who face additional barriers to services such as cost, insurance, transportation, and cultural stigma. As a result, many individuals fall into cycles of incarceration and homelessness, particularly those who lack strong social support networks. Vulnerable, high-need populations face additional barriers to accessing services, such as not having a phone, not having a calendar, and juggling the competing priorities of finding a safe place to sleep and enough food to eat versus tackling the seemingly insurmountable challenges of securing affordable housing and getting their life back on track. Many also struggle to remember appointments, produce eligibility documentation, coordinate their multiple services, and advocate for their personal needs. The main gap this project fills is the need for outreach to the target population, engagement of the target population in recovery services that meet their unique needs, and active collaboration and communication among service providers to coordinate care and overcome challenges.

Program Services

Description

The project established a substance use and mental health recovery program with a multidisciplinary, collaborative treatment team. It included on-the-ground peer recovery specialists to engage vulnerable populations and help them navigate and access program services. It also included clinical specialists providing services via telemedicine. The project developed the capacity to bill Medicaid for program services, including peer recovery support services provided by nonclinical RCOs. Strength In Peers enrolled in Medicaid under the professional license of its contracted clinical director and established a shared electronic medical record.

Role of Network Partners

Strength In Peers' network coordinator coordinated participant services, tracked participants' progress through the program, and liaised with network partners. Peer support specialists employed by Strength In Peers and On Our Own Charlottesville conducted outreach and recruited participants; provided individual and group peer recovery support; brought participants internet-connected tablets for telemedicine appointments; helped participants navigate services for health, housing, employment, and other needs; and provided transportation assistance to important appointments. Harrisonburg Center for Relational Health's clinical director provided clinical oversight and staff supervision. Its residents in the counseling program provided participants assessments and therapy via telehealth. Residents in the psychiatry program employed by the University of Virginia Medical Center provided participants psychiatry services, also via telehealth.

Outcomes

Program Outcomes

The three-year project enrolled 151 participants. At six months post-enrollment, 38% fewer participants were bothered extremely or considerably by mental health symptoms, 50% more participants were prescribed psychotropic medications for mental health challenges, 27% fewer participants used alcohol and 14% fewer used alcohol to intoxication, 42% fewer participants used drugs and 40% fewer used IV drugs, 20% more participants were stably housed, and 187% more participants were employed full time.

Network Collaboration

The project provided the network an opportunity to establish effective policies, procedures, and a workflow to deliver an effective integrated recovery program. The service delivery model is centered around a network coordinator position that is based on case management and care coordination practices and serves as the connector between participants and network providers of peer recovery support, counseling, and psychiatry.

The network coordinator receives referrals, screens individuals for eligibility, enrolls participants, connects participants to in-person and telemedicine services provided by network partners, tracks participants' progress through the program, collects follow-up assessments, and helps participants plan for discharge. The position also serves as the main point of contact and support for network providers, helps them to comply with data reporting and other program requirements, and facilitates a weekly care coordination meeting to touch base on specific participant cases and programmatic issues.

Sustainability

Strength In Peers worked with the Virginia Department of Medicaid Services to adjust the Medicaid enrollment application and approval process to allow a nonlicensed organization to enroll in Medicaid under the individual license of a behavioral health clinician. Strength In Peers became the first peer-run, nonclinical organization to enroll in Medicaid in November 2022. This paved the way for any number of nonclinical organizations to enroll in Medicaid for the provision of peer support services by employing or contracting an individually licensed behavioral health professional, such as a licensed professional counselor, to submit claims under. The clinician will assess participants, recommend peer support services (as appropriate), sign off on service plans and progress notes, and provide clinical supervision to peer recovery specialists.

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Northwest Rural Health Network

Northwest Rural Health Network

D06RH37499

Project focus area:
Telehealth

Other focus areas:
None

Network History and Members

The Northwest Rural Health Network (NWRHN) is a nonprofit, multicounty network of hospitals and rural health systems in eastern Washington state, formed for the purposes of sharing resources, promoting operational efficiencies, and improving health care services for member hospitals and the rural communities they serve. Initially organized in 2002 as the Critical Access Hospital Network (CAHN) the NWRHN grew in size and scope with support from Health Resources Services Administration's Federal Office of Rural Health Policy Rural Health Network Development program, the Washington State Flex Program, and its member organizations. As of 2023, the network has seven members, all Critical Access Hospitals and their associated clinics, in seven counties across eastern Washington.

Member Organization	Location	Organizational Type
Newport Hospital and Health Services	Newport, Pend Oreille County, WA	Hospital
Ferry County Health	Republic, Ferry County, WA	Hospital
Lincoln Hospital	Davenport, Lincoln County, WA	Hospital
Pullman Regional Hospital	Pullman, Whitman County, WA	Hospital
Tri-State Memorial Hospital	Clarkston, Asotin County, WA	Hospital
Garfield County Hospital	Pomeroy, Garfield County, WA	Hospital
Columbia County Health System	Dayton, Columbia County, WA	Hospital

Community Characteristics

Area

All in Washington state: Newport, Pend Oreille County; Republic, Ferry County; Davenport, Lincoln County; Pullman, Whitman County; Clarkston, Asotin County; Pomeroy, Garfield County; Dayton, Columbia County.

Target Population

The NWRHN Telehealth Collaborative is targeted at the residents of rural communities that are served by network members. On average, these populations are older than the rest of Washington state, have lower incomes, and have more chronic health conditions.

Need

The NWRHN was formed to help independent, small rural health systems learn from each other, share resources, and facilitate access to grant funding and other outside resources to improve the availability, efficiency, and quality of health care services in their communities. By working together, the NWRHN has enabled independent rural health systems to access information and resources and implement programs that they might otherwise not be able to do.

Program Services

Description

The NWRHN Telehealth Collaborative was intended to help rural health systems provide more services locally to their patients, improving patient access to care, and to strengthen the rural health systems in our network. The program was designed to connect via telehealth network members who currently have specialists on staff or can hire one to other rural health systems that need those services. This would not only provide services in communities that do not have access to specialists, but also ensure rural health systems that can hire specialists have sufficient patient volume to maintain support for those positions. The NWRHN Telehealth Collaborative also worked with a new family medicine residency program to help it plan and prepare for incorporating telehealth into their curriculum and connecting residents to rural communities.

Role of Network Partners

Network members have had multiple discussions and shared information on the need for specialty services and their ability to supply specialists to participate in the program. One network member took on the responsibility of staffing the project and developing a pilot telecardiology program and a telehealth implementation toolkit. A second network member initially agreed to make several specialists available for the program but was unable to implement these services when those specialists moved out of the community. Other network members have prepared for future telehealth programs by working with the NWRHN Telehealth Collaborative to plan for new services, install equipment, and train staff.

Outcomes

Program Outcomes

The NWRHN Telehealth Collaborative members have learned how to integrate telehealth into primary care. This is important given the shortages of specialists that are needed to provide ongoing care for individuals with chronic medical conditions. Members of the NWRHN Telehealth Collaborative team developed training and a toolkit for staff that will be implementing and supporting telehealth programs, with an emphasis on operations and needs of rural clinics, and refined them through a pilot telecardiology program. Telehealth equipment was purchased and installed in five rural health systems to prepare for future telehealth programs.

Network Collaboration

Through the work of the NWRHN Telehealth Collaborative, rural health systems have learned to think about and plan for telehealth programs more comprehensively. They are reaching out to each other to identify the potential for shared resources, which can help improve their operational capacity and sustainability. Rural health systems also have an increased focus on regional collaboration around shared populations.

Sustainability

Participating rural health systems have developed new institutional policies in how to integrate telehealth into their practices. There were considerable changes in state and federal policies around telehealth during the same time, and the NWRHN Telehealth Collaborative team helped members navigate those changes. There is an increased likelihood that health care organizations will use telehealth and increased acceptance of telehealth by staff and patients, in part due to the COVID-19 pandemic but also supported by the work of the NWRHN team. The work of the NWRHN Telehealth Collaborative has helped rural health systems in the region move from the short-term, reactionary thinking that drove telehealth decisions early in the pandemic to a more comprehensive, integrated approach for the use of telehealth in the future.

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Fort HealthCare

Rock River Health Care Network “HealthWorks”

D06RH37502

Project focus area:
Care Coordination

Other focus areas:
Social Determinants of Health

Network History and Members

The HealthWorks Network was created in 2020 to address health equity issues in the greater Jefferson County region of Wisconsin. The largest initiative to date has been creating and supporting the Rock River Community Clinic (RCCC), which has become designated as a Federally Qualified Health Center–Look Alike (FQHC-LAL) through the assistance of this grant. Other major initiatives have included a care navigation pilot project and developing a countywide parish nursing program.

Member Organization	Location	Organizational Type
Fort HealthCare (FHC)	Fort Atkinson, Jefferson County, WI	Hospital
Watertown Regional Medical Center (WRMC)	Watertown, Jefferson County, WI	Hospital
Rainbow Hospice (RH)	Johnson Creek, Jefferson County, WI	Hospice
Jefferson County Health and Human Services Department (JCHHS)	Jefferson, Jefferson County, WI	Public Health Department
Watertown Health Department (WHD)	Watertown, Jefferson County, WI	Public Health Department
Greater Watertown Community Health Foundation (GWCHF)	Watertown, Jefferson County, WI	Community Funding Organization
Madison Area Technical College (MATC)	Fort Atkinson, Jefferson County, WI	University
Rock River Community Clinic (RCCC)	Whitewater, Jefferson County, WI	Federally Qualified Health Center

Community Characteristics

Area

The service area includes 16 ZIP codes in Jefferson, Dodge, and Walworth counties, in Wisconsin. The included communities are Hustisford, Ixonia, Johnson Creek, Juneau, Watertown, Helenville, Palmyra, Whitewater, Cambridge, Fort Atkinson, Jefferson, Lake Mills, Reeseville, Waterloo, and Clyman.

Target Population

The target population for this project is all Medicaid-covered, uninsured, and underinsured low-income residents (pediatric and adult ages) living in the above 16 ZIP code rural area. *Low-income* is defined as households living at approximately 400% of the federal poverty level or below. The primary identification of patients is through the newly formed FQHC-LAL, created through this grant.

Need

Prior to this grant award in 2020, the low-income population in the Jefferson County region was served by two free medical clinics and a charitable dental clinic. Due to lack of providers (who were mostly volunteer), services were not well coordinated and were focused on urgent care instead of primary care. The medical clinics served only the uninsured population and those who were underinsured or were “on and off” of Medicaid and did not have consistent primary care. There has not been a source of operating revenue to invest in preventive screenings and new models of care for this target population.

Program Services

Description

The initial and most substantial goal of the HealthWorks Network was for RRCC to receive FQHC-LAL status to eliminate fragmented primary care and address unmet health needs for the target population. By creating this medical home that focuses on regular primary care, annual cancer screenings, chronic-care management, and social determinant of health (SDOH) identification and referral, the overall health status of the community was elevated. In addition, the groundwork was laid to integrate both dental and behavioral health services within the FQHC-LAL model to further improve the overall well-being of the community’s most vulnerable. A care navigation pilot project was also implemented utilizing the PRAPARE screening tool for SDOH needs, and a committee was formed to assist in the development of referral pathways for safety net services. Finally, the creation of a communitywide parish nursing program occurred through this grant funding, and between seven and 10 congregations are now participating in training, education, and outreach to improve the health of their congregants.

Role of Network Partners

The partners took on a variety of roles including:

- Fort HealthCare — overall leadership and management of project, participation in care navigation pilot, and additional funding
- Rainbow Hospice — leadership of parish nursing program and participation in care navigation pilot
- RRCC — leadership in FQHC-LAL designation process and participation in care navigation pilot Watertown Regional Medical Center, Jefferson County Health and Human Services Department, and Watertown Health Department — guidance
- Greater Watertown Community Health Foundation — additional funding
- Madison Area Technical College — new member as of 2023 to assist with next steps in the business and sustainability plans

Outcomes

Program Outcomes

FQHC-LAL designation (received Dec. 1, 2022); PRAPARE data collection (1,000-plus surveys administered and analyzed); parish nursing program implemented (Jan. 1, 2023); RRCC breast, cervical, and colorectal screening improvement by at least 10% each year from previous year over the three-year grant period.

Network Collaboration

Engaged the C-suite leaders of network partner organizations quarterly at HealthWorks steering committee meetings, which led to high-level and strategic decisions. Established committees to operationalize the decisions and direction set by the HealthWorks steering committee. Conducted annual “pulse checks” through one-on-one meetings with leaders to ensure their goals for involvement stayed strong. Sent monthly, simple, one-page newsletters with updates and opportunities. Required recommitment memorandum of understanding midgrant stating what assets each network partner organization promised to bring to the network.

Sustainability

First and foremost, the community is now home to an FQHC-LAL. In addition, by creating the HealthWorks steering committee, key leaders in the regional health care community met regularly to strategize collectively about ways to address health inequities. This engagement established new and more tangible relationships. Several network partners will continue to develop programs to “meet patients where they are” through home and worksite health visits. These tactics will begin to minimize SDOH barriers for the target population. New sliding-fee discount policies were implemented across the network for FQHC-LAL patients, and financial eligibility was streamlined for these patients. Several network partners joined together by implementing a common SDOH screening tool (PRAPARE) so data can be aggregated and analyzed as a larger community. Employees across the network have been trained on motivational interviewing and now have a common language using this evidenced-based practice.

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Rural Wisconsin Health Cooperative

Rural Wisconsin Health Cooperative

D06RH37522

Project focus area:
Care Coordination

Other focus areas:
Chronic Disease

Network History and Members

Established in 1979, the Rural Wisconsin Health Cooperative (RWHC) is a mature network of 44 Wisconsin rural hospitals that have organized to improve rural health care access and outcomes. RWHC serves its members and other rural hospitals with an array of collaborative services intended to reduce the cost and improve the quality of patient care, including clinical quality measure submission, credentialing, peer roundtables, leadership and nurse mentoring, and various technology services. In 2017, seven of the network's member organizations began sharing Merit Based Incentive Payment System (MIPS) quality data and network support staff in order to collaboratively implement hypertensive disease and diabetes management best practices that ultimately led to improved MIPS measure outcomes for blood pressure control, HbA1c control, and body mass index screenings. In 2019, the network expanded its focus to chronic disease management through care coordination, and the project cohort expanded to 17. Since then, project participants and network staff have been working together to implement seven care coordination services: chronic care management (CCM), principle care management (PCM), transitional care management (TCM), advanced care planning (ACP), annual wellness visit (AWV), initial preventive physical examination (IPPE), and general behavioral health integration (BHI).

Member Organization	Location	Organizational Type
Black River Memorial Hospital	Black River Falls, Jackson County, WI	Hospital
Crossing Rivers Health	Prairie du Chien, Crawford County, WI	Hospital
Cumberland Healthcare	Cumberland, Barron County, WI	Hospital
Divine Savior Healthcare	Portage, Columbia County, WI	Hospital
Door County Medical Center	Sturgeon Bay, Door County, WI	Hospital
Fort Healthcare	Fort Atkinson, Jefferson County, WI	Hospital
Memorial Hospital of Lafayette County	Darlington, Lafayette County, WI	Hospital

Member Organization	Location	Organizational Type
Mile Bluff Medical Center	Mauston, Juneau County, WI	Hospital
Sauk Prairie Healthcare	Prairie du Sac, Sauk County, WI	Hospital
Southwest Health	Platteville, Grant County, WI	Hospital
St. Claire–SSM Baraboo	Baraboo, Sauk County, WI	Hospital
St. Croix Regional Medical Center	St. Croix Falls, Polk County, WI	Hospital
The Richland Hospital Inc.	Richland Center, Richland County, WI	Hospital
ThedaCare Medical Center–Berlin	Berlin, Green Lake County, WI	Hospital
ThedaCare Medical Center–Shawano	Shawano, Shawano County, WI	Hospital
Upland Hills Health	Dodgeville, Iowa County, WI	Hospital
Western Wisconsin Health	Baldwin, St. Croix County, WI	Hospital

Community Characteristics

Area

The counties served as part of this project include Barron, Columbia, Crawford, Door, Grant, Green Lake, Iowa, Jackson, Jefferson, Juneau, Lafayette, Polk, Richland, Shawano, and Sauk.

Target Population

The service area includes the Wisconsin counties served by the project participants. The total population of the service area is approximately 960,000 people. The project’s target population is people in the service area with a chronic disease. The target population is approximately 40% of the total population, or 384,000 people.

Need

Most of the participant service areas have higher than average rates of obesity, lower incomes, and higher rates of hypertension and heart attack deaths. Additionally, this program was implemented to address the fact that Wisconsin practitioners were much less likely to provide care coordination services than practitioners in most other states.

Program Services

Description

Project activities have included (1) network participants submitting quality data to track the trajectory of five project-related National Quality Forum/MIPS quality measures; (2) participants and network staff developing best practice tools and protocols to facilitate effective care coordination service implementation (compiled in the network’s Rural Wisconsin Chronic Disease Toolkit); and (3) participants and network staff planning, testing, and implementing the various care coordination services.

Role of Network Partners

Each network member participated in group best practice development and planning activities, followed by the implementation of care coordination services at its primary care clinics.

Outcomes

Program Outcomes

Nearly all of the project participants have implemented their selected care coordination services. The number of CCM services performed has increased by 190%. TCM has increased by 37%. AWV has increased by 63%. And IPPE has increased by 46%. Additionally, network participants in aggregate improved on nearly all of their MIPS measures.

Network Collaboration

Collaboration included regular network meetings to develop care coordination best practices; provide education; and share barriers, successes, and outcomes. The network project manager worked closely with each participant organization to provide assistance and ensure lessons learned at one organization would be transferred to other network members.

Sustainability

Network members have implemented or expanded care coordination services that will have a sustained impact on their service area populations. The network has developed the Rural Wisconsin Chronic Disease Toolkit, which will continue to be a resource for any rural health organization interested in implementing care coordination services. The network has also developed several new roundtables and services that will maintain focus on care coordination after grant funding ends. Additionally, 26 RWHC member organizations have signed up to participate in the next phase of chronic disease—management work — which is cancer prevention.

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ThedaCare Medical Center – Shawano

Behavioral Health Rural Development Network

D06RH37528

Project focus area:
Behavioral Health/Mental Health

Other focus areas:
Behavioral Health/Mental Health –
Substance Use Disorders

Network History and Members

The Behavioral Health Rural Development Network was developed new as a result of the HRSA funding. This funding provided a chance to formalize existing partnerships in the community focused on behavioral health efforts. The network consisted of an oversight committee to direct the work of the grant and ensure the community's voice and needs were reflected. Two subcommittees were also formed, one for Shawano County and one for Waupaca County, so that focused community work and dialogue could occur in each area.

Member Organization	Location	Organizational Type
ThedaCare Medical Center	Shawano, Shawano County, WI	Hospital
Shawano County Department of Human Services	Shawano, Shawano County, WI	County Behavioral Health
Waupaca County Department of Health and Human Services	Waupaca, Waupaca County, WI	Public Health Department
Menominee Tribal Clinic	Keshena, Menominee County, WI	Tribal Clinic
Family Health La Clinica	Wautoma, Waushara County, WI	Nonprofit Organization

Community Characteristics

Area

Shawano and Waupaca counties in Wisconsin.

Target Population

Patients receiving Behavioral Health Collaborative Care Management (CCM), substance use disorder (SUD) treatment, and medication-assisted treatment (MAT) within Shawano and Waupaca counties.

Need

Behavioral health needs in the two identified counties remain unmet, primarily because of a lack of behavioral health providers.

Program Services

Description

Rural behavioral health services have been expanded via this project. This included implementation of the Behavioral Health Collaborative Care Model in primary care, including support of patients with substance use disorders. The role of ambulatory pharmacist in primary care was added, and through the use of a dashboard in the electronic medical record (EMR), they were able to identify patients with high-risk medication regimens and offer safer alternatives, as well as provide academic detailing to providers increasing safety and quality of patient care. This project has allowed ThedaCare to increase the number of primary care providers (PCPs) that are offering MAT for patients with SUD and expand outpatient substance use treatment within the rural community. In addition, the emergency departments (EDs) are now able to offer MAT induction for patients that present to the ED requesting help for SUD and provide a warm handoff from the ED to a PCP for follow-up.

Role of Network Partners

ThedaCare Medical Center-Shawano

- As the fiscal agent, ThedaCare provided project leadership throughout the grant period. In addition, ThedaCare provided BH Collaborative Care, outpatient SUD treatment, ambulatory pharmacy, MAT in primary care, and free Naloxone.

Shawano County DHHS-Behavioral Health

- County behavioral health including SUD treatment

Menominee Tribal Clinic

- SUD and MAT for tribal members

Family Health La Clinica

- Behavioral health and SUD outpatient treatment

Outcomes

Program Outcomes

The project saw decreased numbers of ED patients chronically prescribed opioids, and transfers to urban areas for ongoing SUD treatment. Patients also saw improvement in depression and anxiety as measured by Patient Health Questionnaire–9 (PHQ-9) scores and General Anxiety Disorder–7 scores.

Network Collaboration

The establishment of the network of other providers in the community has launched ongoing, collaborative initiatives with the goal of identifying and addressing gaps in services as members work to strengthen recovery support services. Community programs across various counties are now providing those who seek recovery support with a direct path to treatment, whether that is through the ED or via outpatient services. Inversely, there are funding opportunities available from the community to allow for easier access to services. Some communities have started or have had public resources centers allowing for multiple agency collaboration to reach more of those seeking help. A team approach to SUD treatment in both the Shawano and Waupaca

health care systems now exists to establish a workflow that ensures a smooth transition of care for patients with SUD. There are plans to create an SUD clinic, where providers from multiple health care systems will offer MAT/medications for opioid use disorder and have collaborated with the Shawano County Health Department to open appointments in ThedaCare's SUD counselor's schedule to allow for expanded access to counseling services.

Sustainability

The network implemented the Behavioral Health Collaborative Care model in primary care, and expanded the role of the collaboration manager to support patients with substance use disorder. Added the ambulatory pharmacists in primary care, who identify patients with high-risk medication regimens and offer safer alternatives, and provide academic detailing to providers to increase safety and quality of patient care. Increased the number of PCPs that are offering MAT for SUD patients and expanded outpatient substance use treatment within the rural community. EDs offer MAT induction for patients that present to the ED requesting help for SUD, and provide a warm handoff from the ED to a PCP for follow-up. Ambulatory pharmacists are providing patient education around safe opioid use and assisting patients in tapering/weaning off addictive medications where appropriate. Collaborative care managers, SUD counselors, ambulatory pharmacists, and primary care providers offering MAT are all able to provide at least some of these services via telehealth, which can aid in eliminating the identified transportation barrier for patients. Wisconsin Medicaid is now reimbursing for collaborative care codes. Between this project and New Hope Coalition initiatives, the network is working with all systems to increase access to the recovery services. ThedaCare is continually working to reduce stigma surrounding SUD and has been integral in the development of resources for patients.

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