Rural Health Network Development Planning Program Sourcebook

July 2022

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

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Background

Health and health care in rural areas are currently characterized by a number of competing stressors, including fragile systems of care, high rates of poverty, longer distances to health services, provider shortages, and, for the past two years, the COVID-19 pandemic, that have stretched the health care system and its providers and patients to their limits. As a result of these factors, there is a tremendous need for rural-relevant models of care to be developed. The Health Resources & Services Administration (HRSA) Federal Office of Rural Health Policy (FORHP) invests in rurally generated solutions that provide needed capacity and access locally to meet the health care needs of their communities in ways that are efficient, effective, and accessible.

Under Section 330A 254(c) of the Public Health Services Act, Congress enacted legislation to provide funding that addresses rural health needs through a focus on expanded delivery of health care services, development of integrated health networks, and enhancement of provider quality-improvement initiatives. FORHP created the Rural Health Network Development Planning Program (Network Planning Program) grant to respond to the changing rural health care landscape and persistent challenges faced by many communities. HRSA's definition of a rural health network is "a formal organizational arrangement among rural health care providers (and possibly insurers and social service providers) that uses the resources of more than one existing organization and specifies the objectives and methods by which various collaborative functions are achieved."[1]

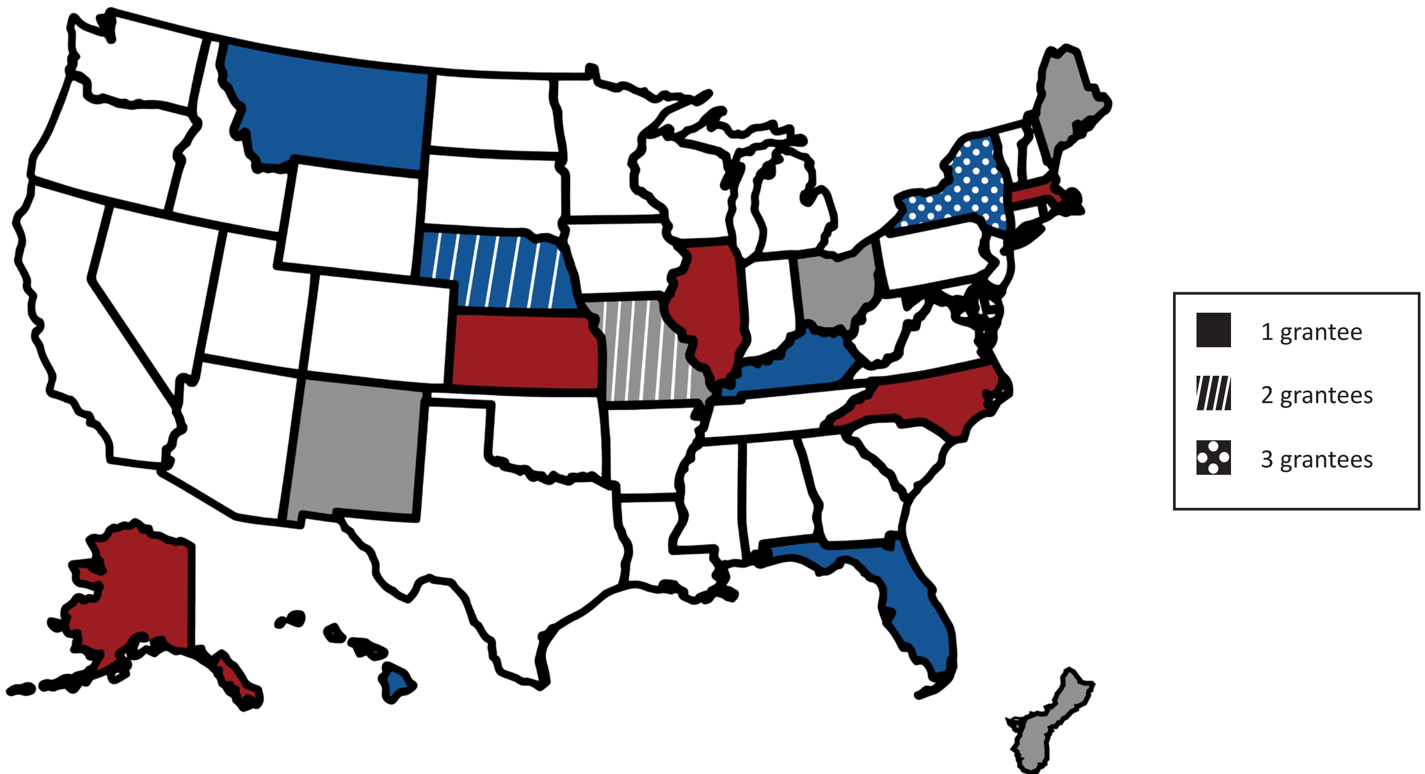
Health care networks can be an effective strategy to help smaller rural health care providers and health care service organizations better align resources and strategies, achieve economies of scale and efficiency, and address challenges more effectively as a group than as single providers. The purpose of the Network Planning Grant program is to assist in the planning and development of an integrated health care network to (1) achieve efficiencies; (2) expand access to, coordinate, and improve the quality of essential health care services; and (3) strengthen the rural health care system.

The Network Planning Grant program brings together key parts of a rural health care delivery system, particularly to establish and improve local capacity and coordination of care. The program supports one year of planning, with the primary goals of helping networks create a foundation for their infrastructure and focus member efforts to address important regional or local community health needs.

[1] HRSA Notice of Funding Opportunity for Rural Health Network Development. (2019). Retrieved from https://www.hrsa.gov/grants/find-funding/hrsa-20-026

Cohort Snapshot

In 2020, FORHP awarded approximately $2 million to 20 awardees for the Network Planning Grant program. These awardees from 15 states received up to $100,000 each for a one-year grant period.



During that time, the funded organizations focused on:

- Conducting community health needs assessments;
- Building and formalizing integrated health care networks and systems; and
- Developing program strategic plans that lay out collaborative approaches for improving access to care, building local health system capacity, and improving health outcomes in rural communities.

The 20 grantees focused on a range of populations within their rural communities (e.g., justice-involved individuals, the elderly, women, children) and explored ways to expand access to services in areas including behavioral health, mental health, and maternal child health. Grantees and their partners planned for the reorganization of care and identified ways to improve the quality of care provided. They developed strategic plans for building care coordination initiatives, setting up telehealth programs, or exploring joint quality-improvement initiatives. Multiple grantees focused their planning efforts around strengthening their network organization by formalizing their collaboration through defining their leadership and decision-making structures and establishing policies and procedures.

Grantee Primary Focus Areas

Grantee Organization	Behavioral Health	Care Coordination	Child Health	Elder Care	Justice-involved population	Maternal Health	Mental Illness*	Network Organization†	Patient Safety	Population Health‡	Quality Improvement	Substance Abuseµ	Telehealth
Blue Ridge Community Health Services								●					
Center for Health Innovation	●												
ComWell (Formerly Human Service Center of Southern Metro East)		●											
Lake Okeechobee Rural Health Network, Inc. (LORHN)													●
Lexington Regional Health Center											●		
Maine Primary Care Association									●				
Margaretville Memorial Hospital				●									
Nemaha Valley Community Hospital							●						
Ohio University										●			
Outer Cape Health Services										●			
PIH Health Good Samaritan Hospital													●
Pikeville Medical Center Inc.			●										
Powerhouse Community Development Corporation												●	
Southcentral Foundation Rural Health Network				●									

* Mental Illness/Mental Health Services
† Network Organization/Infrastructure Development
‡ Population Health/Social Determinants of Health
µ Substance Abuse/Addiction

Grantee Organization	Behavioral Health	Care Coordination	Child Health	Elder Care	Justice-involved population	Maternal Health	Mental Illness*	Network Organization†	Patient Safety	Population Health‡	Quality Improvement	Substance Abuseµ	Telehealth
Southern Tier Rural Integrated Performing Provider System Inc.	●												
South Central Missouri Community Health Center d/b/a Four Rivers Community Health Center						●							
St. Vincent Healthcare						●							
Sullivan 180 Inc.							●						
West Hawai’i Community Health Center					●								
Winnebago Comprehensive Healthcare System												●	

* Mental Illness/Mental Health Services

† Network Organization/Infrastructure Development

‡ Population Health/Social Determinants of Health

µ Substance Abuse/Addiction

Impacts

The investment in the developing rural health networks is designed to support rural health organizations in developing new ways of working together and building the infrastructure to support and sustain collaborative efforts over the long term. Grantees reported a range of key outcomes and impacts from their planning efforts.

Powerful Partnerships

- Most of the grantees reported that the Network Planning Grant provided the time and space for new partners to understand each other's work, learn about their communities' needs, and strategize carefully before moving to implementation. One grantee described the results of their planning grant in this way: "This process allowed community stakeholders to come together and gain a better shared understanding of what is happening in the community and an opportunity to explore why we might be facing some of these challenges. Because of this grant, partners identified a common goal, and developed a solid plan and action steps."

Infrastructure Development

- As a result of the dedicated focus on network development, grantees reported stronger collaboration and shared vision among network partners. Partners were able to develop a shared understanding of the needs and gaps in their community and work to align their interests in strategies to address health needs.
- All of the grantees reported that as a result of their planning grant, they had developed formal agreements to support their work beyond the planning year. Grantees reported developing governance structures and working committees and signing memoranda of understanding that define the roles of partners in the work ahead.
- For many grantees, the ability to have staff supported by grant funds to lead the planning efforts and keep partners engaged was crucial to the progress and success they achieved during the planning year.

Added Capacity

- Grant funds permitted grantees to hire staff to support the work of the developing collaboration.
- Multiple grantees provided training to network partners and their staff. Trainings focused on topics including generational trauma, telehealth implementation, and clinical safety, among others.

New Service Models

- As a result of focused planning, grantees reported the development of collaborative models of care. One grantee plans to build a Pathways Hub model, developing and certifying the program and working to establish a platform to be used to make referrals and to share patient/client information among health care providers to achieve better integration of services and sustainable funding.
- Grantees reported that the Network Planning Grant provided the opportunity to develop new direction for the delivery of health care. One developing network formed a Telehealth Advisory Group that enabled network partners to do a deep dive into the technicalities of telehealth services, build their capacity as a network, and explore opportunities to expand access to care through telehealth services delivery.

This *Sourcebook* provides a summary of 20 Network Planning Grant projects that were funded during the 2021-2022 grant period. Following a summary of the grant focus areas, each awardee is profiled. The awardee entries contain a summary of the purpose of the planning year, network focus, partnerships, organizational and programmatic development, and plan for long-term sustainability.

North Carolina

Blue Ridge Community Health Services

Community Health Network of Western North Carolina

P10RH41756

Project focus area:
Network Development

Other focus areas:
Increase Health System Efficiencies, Integrated Health Services, Substance Abuse/Addiction

Network Statement

The most vulnerable populations are suffering under the harsh economic conditions of Western North Carolina. Those most desperate, including children, the uninsured and underinsured, minorities, and people with complex health issues, have seen decreased access to quality, consistent health care and increasing costs for care. At the same time, increasing numbers of retirees have relocated to the area, resulting in rising costs of housing and daily living, as well as placing a greater demand on the health care system. This leaves the overall health of the community at risk.

In response, Federally Qualified Health Centers (FQHCs) in Western North Carolina have come together to form the Community Health Network of Western North Carolina (CHNWNC) with the goal of improving regionwide access to integrated medical, dental, behavioral health, and substance use services. The collaboration between the health centers and community partners will bolster communication and teamwork to create a coordinated safety net for residents. One of the primary goals of CHNWNC is to increase access to treatment and recovery services for the estimated 29% of people in the Western North Carolina community dependent on opioids or other substances. Recognizing that the strength of a community is in its people, the network's mission is to strengthen available resources so residents can thrive and live healthier lives.

Network Development

Over the years, five CEOs of FQHCs located in Western North Carolina have discussed forming a regional collaboration. The Rural Health Network Development Planning Program grant has enabled the five FQHCs to come together to develop an infrastructure that will allow the FQHCs to work together to maximize their resources; make community impact and engagement in their communities; implement shared administrative services; and increase access to health care, dental, mental health counseling, treatment, and medication-assisted treatment services for the most vulnerable populations in Western North Carolina. CHNWNC is a separate 501(c)(3) nonprofit organization that will work to develop sustainable programs that meet the needs

of the vulnerable population and address the social determinants of health in Western North Carolina. This will be accomplished through federal grant funding, two federal Rural Communities Opioid Response Program grants completed in collaboration with the five FQHCs, local private foundations, and state and local grants available to address barriers in communities.

While the challenges have been minimal, time commitment to attend regular meetings has been the biggest challenge due to obligations the CEOs had prior to the Network Planning Grant award. This challenge was addressed by having the second-in-command from each organization attend regularly scheduled meetings on behalf of the CEOs. This allows the members' organization to remain committed, have representation at each meeting, and exercise decision-making ability to any processes that are initiated. As a group, it was concluded to remain open to the process and find alternatives to achieve the goal of establishing an entity that will be beneficial to everyone — members and clients.

Programmatic Development

CHNWNC made great strides in completing the necessary paperwork needed to create a nonprofit 501(c)(3) entity that will be able to develop programs addressing gaps in services and aimed at providing resources to the community and the population it serves. The focus of CHNWNC is to reach individuals who are outside of the treatment loop, not receiving direct services such as medical, dental, mental health counseling, treatment, or medication-assisted therapy. The members recognized that in order to achieve this goal, the network had to engage local partners, including the county jails, to provide access to care coordination for inmates upon re-entering the community, and to engage consortium members to create direct links to social agencies that can provide needed direct services and resources.

Collectively, members and their staffs have been able to engage people in their community about the role of CHNWNC and the additional services. The network faces a difficult process while waiting for the grant award to begin hiring staff for CHNWNC. Currently the area faces a worker shortage, with experienced staff leaving the mental health profession and nonprofits unable to compete for candidates because many cannot afford to pay the asking rate. Members have been slow to integrate these services into their current services and models until they know where the network stands regarding grant funding.

Sustainability

CHNWNC applied for two federal grants that if awarded will sustain and support programming for a maximum of three years. This will provide the organization with ample time to implement the federal income guidelines used by many social services agencies to enable patients to afford the cost of their care and services based on their income. This will also provide CHNWNC with the opportunity to apply to Medicaid and private insurance to support the services that will be provided. With the expansion of Medicaid into North Carolina in the future, this will enable CHNWNC to grow its patient base and have a reliable payer source to sustain and grow its programs.

CHNWNC will be looking to diversify its membership and include members who bring different expertise and resources to the board. This diversification will enable CHNWNC to look at different opportunities and audiences in order to survive and grow as an organization. The other advantage of CHNWNC diversifying

its board is the possibility of sharing staff, services, programs, and resources. This will also allow CHNWNC to sustain the growth of the program and the services being offered and decide at what pace to grow the program. Initially, the partners envision implementing jail re-entry care coordination with limited participants in order to slowly transition and increase numbers. This will also help control the growth and sustainability of the program.

As mentioned, by starting the program with a reduced number of participants, this will allow for focus on the actual process, outcome, and progress made with services provided. The network will sustain the program and have a benchmark for the number of clients accepted, staff needed to care for these clients, and the ability to expand the program and further introduce additional services.

Region Covered by Network Services (County/State)

- Rutherford County, NC
- Clay County, NC
- Burke County, NC
- Watagua County, NC
- Transylvania County, NC
- Graham County, NC
- Polk County, NC
- Haywood County, NC
- Avery County, NC
- Yancey County, NC
- Mitchell County, NC
- Swain County, NC
- Cherokee County, NC
- Buncombe County, NC

Network Partners

Organization	Location (City, State)	Organization Type
Appalachian Mountain Community Health Center	Asheville, NC	Federally Qualified Health Center
Mountain Community Health Center	Bakersville, NC	Federally Qualified Health Center
Hot Springs Community Health Center	Hot Springs, NC	Federally Qualified Health Center
Blue Ridge Community Health Center	Hendersonville, NC	Federally Qualified Health Center
WNC Community Health Services	Asheville, NC	Federally Qualified Health Center
High Country Community Health Center	Newland, NC	Federally Qualified Health Center

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Center for Health Innovation

New Mexico Four County Justice-Involved Behavioral Health Network

P10RH41757

Project focus area:
Behavioral Health

Other focus areas:
Care Coordination, Justice-involved Population, Integrated Health Services, Network Development, Reimbursement for Health Services, Workforce Development, County Government

Network Statement

In rural New Mexico, county governments are underfunded and overburdened with poor health outcomes, sparse resources, and high rates of crime related to behavioral health. The majority of the state is designated as a Health Professional Shortage Area, both for primary care and mental health care professionals. Even worse, such extreme provider shortages can make a rural county ineligible to bill Medicaid for needed health services. This means that individuals living in these communities often get funneled in and out of jails without ever being treated for their underlying behavioral health issue, and the county's budget struggles to prop up this system. Because this is a systematic issue stemming from lack of funding, difficulty with provider retention and recruitment, and policy, a truly innovative and multisector solution is needed to improve the health of residents.

The New Mexico HRSA Four County Justice-Involved Behavioral Health Network has done just that. By creating an open partnership between its behavioral health service providers and county governments, the network is leveraging resources, integrating services, and offering greater diversion instead of incarceration, all through this cost-effective partnership. Through the network's collective capacity, they have even developed cutting-edge approaches to expanded Medicaid funding for behavioral health services through county and behavioral health agencies. The network hopes to serve as a model for other counties and is seeking additional funding to continue implementing and expanding this great work.

Network Development

Four-County and State Partnership Development: The eight entities represented have worked together to identify key policy and funding issues that either positively or negatively impact substance use disorder (SUD)–related behavioral health services to the justice-involved in rural counties in New Mexico. As a result

of these discussions, the Behavioral Health Collaborative has shared updates on new initiatives at the state level to better integrate behavioral health throughout all of the state departments and related initiatives; provided updates on Medicaid waiver expansion; and facilitated dialogue at senior levels of government about rural behavioral health needs, capacity, system development, and policy and funding solutions. New Mexico Counties (NMC), the statewide association of counties, has provided leadership to policies being developed and informed by rural counties that seek to reduce silos among different justice-related providers, facilitate reintegration rather than recidivism, and offer ongoing training and technical assistance to county managers and staffs on related issues, encouraging collaboration around behavioral health. NMC continued to share behavioral health information throughout its network of health councils, looking for opportunities to provide collaborative training, technical assistance, and future shared funding opportunities for health councils involved in behavioral health. It provided leadership to support health councils playing a "big-tent" collaborative and convening role, working collaboratively across traditional silos. The Center for Health Innovation, New Mexico's public health institute, is committed to continuing to work with the HRSA Behavioral Health Network (through the no-cost extension and consulting fund carryover) to keep up with regular quarterly meetings in the next fiscal year, and to continue to develop the collaboration, seek additional sources of funding, and build the base of support for local service networks.

The four counties of Rio Arriba, Sierra, Luna, and Grant share much in common and have specific areas of priority and network development in their own counties.

Rio Arriba County Health and Human Services (RACHHS) continues to seek and obtain a significant amount of diversified state and federal funding for different types of behavioral health services, with a focus on SUD and the justice-involved. These include grants and contracts from the Substance Abuse and Mental Health Services Administration (SAMHSA), HRSA, the Department of Justice, and the New Mexico Behavioral Health Services Division. They also are building out the Medicaid funding, following years of challenges with electronic health records and Medicaid billing. The next tasks for RACHHS will be to take these multiple funding streams for specific types of services related to the sequential intercepts model (SIM) and build out the framework that addresses the quilted nature of the funding into a cohesive whole that allows for aggregation and disaggregation of the different elements in a way that ensures client-centered care that meets behavioral health, contractual, and billing standards.

Sierra County–OliveTree Hub Partnership: This highly delegated partnership between the county and the local behavioral health Hub is an especially good fit for this small rural county with a small county government having a small budget and very heavy workload. This allows the county to assume a few key functions related to planning, grant development, and back-office support, with OliveTree serving as the behavioral health partner and network, providing a turnkey operation with delegated authority and responsibility through memoranda of understanding.

Luna County: Through its Community Services Department, Luna County has a very "big-tent" and holistic approach to providing community services to promote wellness. Because Luna County is a small border community, there are important unique elements to its work, the most important of which is its deeply collaborative and community-rooted approaches to work utilizing the promotora model, which employs many community health workers as promotoras. Luna County is part of Border Area Health, which includes multiple states in both the United States and Mexico. The county has continued to develop its behavioral health services in ways that are holistic, integrated, and fit for this unique cultural landscape. The county is working to investigate the potential for developing the Certified Community Behavioral Health Clinic (CCBHC) model, which is a more deeply community-rooted model for funding more community behavioral health services than either the Federally Qualified Health Center or the current state model for Behavioral Health Agency certification and Medicaid managed care organization funding for core community support services.

Grant County: This county in far southwestern New Mexico represents a health care, business, and cultural hub for the region that has experienced multiple economic shocks during COVID-19. The local hospital, Gila Regional, has experienced changes in leadership and the loss of some of its departments, which reduced the overall capacity of the regional hospital hub. Hidalgo Medical Services, the regional Federally Qualified Health Center, carried a great number of services throughout the pandemic that were not well or fully reimbursed, which created significant stresses on the infrastructure. Grant County pulled together a small behavioral health committee to more intentionally link these different providers into a collaborative. During this year, the county manager was able to begin that work, bringing on board a new health and human services coordinator, who is bringing together disparate elements of health and human services into a more coordinated system of care, and providing staffing to key behavioral health initiatives.

Programmatic Development

Each of the four counties has programmatic development areas in common, as well as differences among them driven by county needs, priorities, and funding sources. Programmatic areas in common where there have been developments include SUD-related behavioral health services to the justice-involved population. The four counties have worked to identify what types of services need to be expanded, enhanced, or leveraged. They have sought and developed additional resources to support the SIM-based behavioral health network of services in their counties. Grant County hired a human services coordinator and is developing its behavioral health leadership group. Luna County has expanded services and worked to develop readiness for the CCBHC new model of care, which is established in several states and will become a model in the state. Sierra County has continued to develop its highly delegated partnership between Sierra County and the BHA, with additional new funding through Medicaid. Rio Arriba County has expanded its network of state and federal funders for a range of services and expanded its Medicaid funding.

Programmatic areas that are different include the mix of services provided at what level of intensity, numbers and types of clients, and the providers that form the hub.

Sustainability

Each of the four county networks has made moderate to significant progress with its own sustainability. They have obtained funding through various sources including the Department of Justice, SAMHSA, LEAD , states' BHJSD contracts, Medicaid, county funding, and federal Marshals funding.

The network continues to watch for funding opportunities and has requested a no-cost extension for the project consultant to continue to meet with the network at least quarterly during FY 2023 until the HRSA implementation funding notice of funding award is released. This will help the network continue to build in three key areas, continue the process of planning and review of potential grant opportunities, and ready the network for the HRSA implementation proposal. The three key areas that could benefit from ongoing quarterly meetings in FY 2023 include (1) Medicaid funding for counties, (2) the CCBHC model, and (3) ongoing federal funding opportunities for justice-involved services.

Region Covered by Network Services (County/State)

- Luna County, NM
- Grant County, NM
- Rio Arriba County, NM
- Sierra County, NM

Network Partners

Organization	Location (City, State)	Organization Type
New Mexico Alliance of Health Councils	Statewide, NM	Nonprofit
New Mexico Association of Counties	Statewide, NM	Nonprofit
Behavioral Health Collaborative	Statewide, NM	Government
Grant County Local Government	Grant County, NM	Government
Luna County Local Government	Luna County, NM	Government
Rio Arriba County Local Government	Rio Arriba County, NM	Government
Sierra County Local Government	Sierra County, NM	Government

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Illinois

ComWell (Formerly Human Service Center of Southern Metro East)

Community Strategies Network of Randolph and Washington Counties

P10RH41758-01-00

Project focus area:
Care Coordination

Other focus areas:
Mental Illness/Mental Health Services, Network Development, Reimbursement for Health Services, Quality Improvement, Substance Abuse/Addiction

Network Statement

The Randolph and Washington County communities have seen a higher-than-average number of youth reporting alcohol misuse compared to the state of Illinois. As a result, the network began with a coalition of individuals focused on educating children and parents on drug and alcohol misuse, but they recognized so much more was needed. The network saw a shortage in collaboration and awareness of available resources in their communities. The need for care coordination among community partners was identified to improve the overall health of our community. According to the Centers for Disease Control and Prevention, mental and physical health are equally important components of overall health.

Therefore, the network looked beyond the original goal of substance use prevention and toward a greater integration of health and wellness. The network wants to break the barriers of judgment and encourage everyone in the community to be the healthiest version of themselves. The network wants every person to know how to seek help and support when needed. Establishing the Healthy Communities Alliance is moving the network one step closer to merging physical health and mental well-being together. Through partnerships, the network creates a healthy environment where the community can thrive and flourish.

Network Development

In 2015, the Illinois Department of Human Services approached Human Service Center (now ComWell) to be a part of its application for an SPF-PFS (Strategic Prevention Framework – Partnerships for Success) grant to address high rates of alcohol use in Randolph County. The first coalition coordinator was hired in December 2015 and held the first coalition meeting in February 2016 to orient partners to grant goals and objectives. Since that time, the network holds monthly coalition meetings to facilitate community assessments, strategy

selection, implementation, fidelity, and sustainability processes with the coalition members. In 2017, the network created operating procedures and coalition committees. At the same time, a second community coalition led by Sparta Community Hospital, law enforcement, and community leaders formed with a focus on opioids. In 2018, both coalitions voted to combine and took the name Southern Illinois Substance Abuse Alliance (SISAA). That year, the Illinois Youth Survey data showed a 3% reduction in past 30-day use of alcohol among 10th-graders, indicating the coalitions' interventions were having an impact on the community. In 2019, ComWell applied for SISAA to become a Recovery-Oriented Systems of Care grantee coalition, which allowed the coalition to assess how to help individuals find recovery and help those in recovery thrive. Since 2019, the coalition's efforts have expanded from prevention and opioid focus to include mental health and recovery as well.

Currently, the network is in the process of a rebranding and identified a new name that is inclusive of community health and wellness, rather than focused solely on substance use prevention. The network chose these areas to increase communication between clients that are shared between organizations. By working together, they increase the overall health benefits to clients and the community and create efficiencies for all organizations by reducing duplication of services. The network also made updates to bylaws, committee structures, and the network mission and vision during this planning period.

A challenge the network faced includes multiple entities and individuals coming together from various perspectives. Each entity brings its own idea of priorities, so gaining and keeping consensus is one of the greatest challenges as a network. As the network continues to grow, the goal is to keep individuals engaged through specific committee participation. Current committees include Prevention, Intervention and Treatment, and Recovery. This structure allows each organization to focus on an area it is passionate about but still work toward meeting mutual goals. The network seeks to break down silos across organizations by meeting regularly to reevaluate goals and objectives as a group to ensure an improved understanding of mission and vision.

Programmatic Development

As the network has evolved, members identified ways partners can both serve their communities and provide value to their organizations through programmatic work. Interventions were identified based on federal and state best practices in coordinated care. Direct services provided by the network include behavioral health and emergency department referral procedures; evaluation of the feasibility of either an inpatient substance use facility or behavioral health crisis stabilization unit; initiation of behavioral health huddles between partners related to high-need, high-utilization, and complex cases; and increased access to psychiatric care through a shared staffing model.

One of the largest challenges but also one of the greatest innovations was working through a shared psychiatric staffing model to increase psychiatric availability within the community. This lengthy process involved difficult discussions to determine what the model would look like but resulted in an increase in psychiatric time from seven days per month to approximately seven days per week. The wait time for a psychiatric assessment moved from an average of 80 days to 14 days. Beyond improving the wait-time for psychiatric care, this also has the added benefit of potential reduction in the number of individuals seeking care at the local emergency departments.

The network also focused on reimbursement for health services in the second half of the grant year. Care in the emergency department is no person's choice, and it is very expensive for the health care system. Network partners are increasing access to outpatient care and focusing on communication around complex cases to address this issue.

Sustainability has also become a focus. Each partner must have appropriate staffing models to deliver the care and competitive salaries to hire and retain the best people. Therefore, it is also imperative for each partner to be reimbursed fully for care, and ensuring that quality services are cost-effective guarantees the services are available in the future.

Sustainability

The network's sustainability is dependent upon partner commitment, and partners are in the process of revising the network name, bylaws, mission, and vision. The network is focused on increasing areas for committee involvement opportunities for network expansion and growth aligned with the new name and mission. They are formalizing the executive committee structure to increase focus on strategy, evaluation, and funding sustainability.

The services and programs that were initiated through the network planning grant will continue because it has demonstrated success in improved patient access and care. Communication between entities has increased, resulting in discussions surrounding next steps for improved service delivery. At this time, all elements initiated will be sustained.

Region Covered by Network Services (County/State)

- Randolph County, IL
- Washington County, IL

Network Partners

Organization	Location (City, State)	Organization Type
ComWell	Red Bud, IL	Behavioral Health
Sparta Community Hospital	Sparta, IL	Critical Access Hospital
Washington County Hostpital	Nashville, IL	Critical Access Hospital

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Florida

Lake Okeechobee Rural Health Network, Inc. (LORHN)

P10RH41760

Project focus area:
Telehealth

Other focus areas:
Community Health Workers, Increase Health System Efficiencies, Quality Improvement

Network Statement

The rural communities surrounding Lake Okeechobee are experiencing higher rates of heart disease, diabetes, lung disease, and mental and behavioral health issues compared to other parts of Florida. This is in part because rural residents have very limited access to quality and specialty care due to distance, transportation barriers, and limited specialty provider presence in the area. When people do not get the health services they need, the result is often more serious health challenges, preventable hospitalizations, and even death. Telehealth can be an important potential solution for addressing these access barriers among rural residents and a demonstrably successful strategy for increasing health care access, providing options to receive care, treatment, and important health counseling services without having to leave home or travel far to access services. Telehealth can also increase the proportion of adults who have had a medical checkup in the last year, thus helping to improve their overall quality of life.

The Lake Okeechobee Rural Health Network Inc. (LORHN) convened a diverse group of community partners in October 2021, forming the Telehealth Advisory Group (TAG) to inform and guide a telehealth needs assessment of the service area, assess ways telehealth could drive health improvement, and consider both implementation and enhancement strategies. Findings from this assessment include available health and technology data as well as insights of TAG members and the community at large. LORHN will continue to engage the community and lead the charge on advocating for and working to improve telehealth awareness, acceptability, and infrastructure and to secure funding to support the cause. The network welcomes community partners and rural residents to join and inform this effort as the network partners explore the most effective and efficient opportunities to expand access to telehealth throughout the rural communities, to improve access to quality health care, and ultimately to improve the health of residents.

Network Development

LORHN was formed in 1994 and formalized through established bylaws, roles and responsibilities, and a signed memorandum of agreement from each member. Like many rural health networks around the country,

the network has been challenged with turnover and member attrition over the last few years. Unfortunately, two losses have been due to the unexpected passing of two members, while others have been due to turnover in key positions, competing priorities, and lack of time and resources to devote to LORHN. The COVID-19 pandemic has further exacerbated some of these challenges, with nearly all LORHN's members serving as public health leaders, responding to surges, health care demands, and political unrest within their communities.

In the face of these challenges, LORHN has engaged three new network members who have agreed to serve on the board of directors. Two of these new members are newly appointed administrators for local county health departments, and the other is a housing authority executive director who has been a long-standing supporter and partner of LORHN's work. In addition to their professional expertise and experiences, each of the new members also has personal connections to and lives in the rural communities served by the network.

LORHN is dedicated to gleaning diverse perspectives. As such, LORHN has recruited and engaged more than a dozen community leaders and partners via TAG to further engage stakeholders as an extension of the network to provide insight and guidance related to the telehealth assessment and related work. This group of committed stakeholders will continue to advise and collaborate with LORHN for objectives related to these telehealth-related planning and programmatic needs. To address the previously mentioned stakeholder engagement challenges, LORHN has worked to accommodate schedules by providing an opportunity for members to vote on meeting dates, developed a TAG UR IT brand (Telehealth Advisory Group: Uplifting Rural Implementation of Telehealth), and engaged members between meetings through promotional items, personalized thank-you emails, and TAG newsletters.

Program Development

LORHN has made progress determining the direct services that the network can provide to members, community partners, and rural communities to expand the adoption of telehealth. LORHN has convened TAG, which consists of partners from various fields that also represent the rural communities that LORHN serves. LORHN has successfully completed an external environmental scan, network statement, telehealth readiness assessment, and organizational assessment, all of which included analysis of quantitative and qualitative data related to telehealth and broadband expansion efforts. These tools helped solidify the role of TAG and inform goals and objectives that are feasible for LORHN to expand telehealth access and adoption throughout the service area.

Challenges faced through program planning, in addition to partner engagement, were the lack of awareness among providers and residents of the availability of telehealth services, limited infrastructure (accurate broadband mapping and technology device access), and a lack of streamlined communication between providers to discuss best practices, implementation, and lessons learned regarding telehealth services and reimbursement. These identified challenges helped shape future goals and objectives for LORHN's strategic plan. TAG has provided insight on the current health care and telehealth landscape, including strengths and opportunities to leverage momentum, as previously mentioned. LORHN's board of directors unanimously agreed with findings and recommendations from TAG and are all fully engaged and supportive of LORHN's taking the necessary steps to move forward.

LORHN will explore opportunities to provide direct services and address these challenges by supporting the implementation of the following strategies: (1) leveraging community health workers (CHWs) to close the

digital divide through health and digital literacy education and telehealth navigation and care coordination, (2) identifying broadband cost savings opportunities for providers (and potential revenue streams for LORHN), (3) coordinating and providing telehealth training and support for health care providers, (4) further understanding access by assisting with the broadband mapping assessment currently underway through the Florida Office of Broadband, and (5) identifying and securing funding to increase access to telehealth resources among rural health care providers and residents.

Program Development

LORHN will continue to function under normal operating procedures beyond the Rural Health Network Development Planning Program grant. As previously mentioned, three new network members have been engaged, with those partnerships formalized via memoranda of agreement. Staff will continue to function in their capacity implementing additional network programs, as salaries are covered by a diverse funding pool. All community programs utilizing CHWs to provide education, outreach, linkage, and advocacy (current programs focus on COVID-19 vaccine uptake and opioid/substance overdose prevention and treatment) will be sustained at their full capacity. CHWs in each of these programs also assist rural residents with navigation and linkage to health and human services, which may include access to utility assistance, technology equipment, and technology trainings via referrals. LORHN is exploring opportunities to expand services for rural residents and trainings for CHWs to expand these efforts and close the digital divide.

Primary data regarding health care access and telehealth adoption will continue to be captured during the implementation of these programs via resident and community partner feedback. CHWs in the field provide invaluable insight into specific geographic areas and subpopulations that may require more, or tailored, services. LORHN will continue to convene TAG in some capacity to provide insight for LORHN's network as well as engage in the work to address the digital divide and improve access to telehealth. While LORHN's network/board of directors will continue to serve in a systems and governance role, the network partners envision that TAG will continue to operate in an advisory and programmatic capacity to help inform and collaborate on the "boots on the ground" work. LORHN is using the information gleaned during the Network Planning Grant as a springboard to identify and apply for additional funding opportunities that address access to health care via telehealth, closing the digital divide in rural communities.

Region Covered by Network Services (County/State)

- Okeechobee County, FL
- Hendry County, FL
- Glades County, FL
- Palm Beach County, FL (Western rural census tracts)
- Martin County, FL (Indiantown rural census tract)

Network Partners

Organization	Location (City, State)	Organization Type
Palm Beach County Health Department	Belle Glade, FL	Public Health
Hendry/Glades County Health Department	LaBelle, FL Clewiston, FL Moore Haven, FL	Public Health
Martin County Health Department	Indiantown, FL	Public Health
Hendry Regional Medical Center	Clewiston, FL LaBelle, FL	Critical Access Hospital
Florida Community Health Centers Inc.	Okeechobee, FL Moore Haven, FL Clewiston, FL Pahokee, FL	Federally Qualified Health Center
Raulerson Hospital	Okeechobee, FL	Hospital

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Lexington Regional Health Center

Rural Health Clinic Quality Improvement Network

P10RH41761-01-00

Project focus area:
Quality Improvement

Other focus areas:
Chronic Disease Management, Health Information Technology, Increase Health Systems Efficiencies, Patient Safety

Network Statement

While alternative payment and delivery models have sharpened the health care industry's focus on quality measurement and improvement, most private-sector, state, and federal initiatives have exempted rural providers. As a result, too few rural residents have access to information about provider performance, and many rural practices and clinicians lack payment incentives for which their nonrural counterparts are eligible. Payment models commonly are tied to quality scores, so it is essential that rural health clinics (RHCs) accelerate their movement toward public reporting and pay-for-performance to help them succeed in an increasingly competitive environment.

Formed in 2021, the Rural Health Clinic Quality Improvement Network (R-QIN) seeks to expand the readiness of its member RHCs to ratify a core set of quality and cost performance indicators, organize and warehouse the relevant quality data, conduct benchmarking, and prepare for the future value-based payment environment. R-QIN currently has two critical access hospitals operating 12 rural health clinics in 10 rural counties and has formalized an initial, core set of quality measures to identify variation and improvement opportunities and spread best practices across the member RHCs. Their vision is a collaborative community of rural primary care providers across rural Nebraska that leverages quality measurement to modernize patient access, care delivery, and reimbursement models.

Network Development

When properly utilized, technology can serve as a powerful catalyst for collaboration. Through its successful development and implementation of the data extraction, transformation, and loading process of protected health information, R-QIN has formalized its grant application goals, documented the privacy and security requirements across the network actors, and established a path toward completion of the core grant objective. The network has galvanized its mission, vision, goals, relationships, and systems — and translated

those achievements into a valid, reliable, and replicable data-management system that functions as the network's direct service foundation.

From a human factors perspective, the two main challenges have been (1) coordination at the senior leadership level among the partner organizations and (2) ratification of the core quality improvement measures that will encompass the first cycle of data reporting and benchmarking. The engagement challenge was addressed through structured and systematic consensus-building sessions (via Zoom) and documented action planning. Staffing issues were exacerbated by the variability of patient visit demand across the multiple COVID variants. The personnel issues were surmounted from a network-development perspective by shared flexibility and creative diversification of accountability for planning processes at the local hospital organizations and respective clinics. From a technology perspective, the main challenge was the amount of time and technical resources required to plan the process, investigate the electronic medical records (EMRs) configuration, create technical specifications for provider identities, test the data transmission methods, finalize the technical specifications for the quality measures, and then complete the iterative quality assurance testing processes to ensure data integrity.

The network's most relevant and generalizable innovation centers on the ratification of the core National Quality Forum quality measures for rural health clinics. With the spate of measures developed for various primary care public reporting programs over the past decade, it is essential that a relatively small and manageable set of measures emerges as a statewide and ideally national "starter set" as a means of simplifying and clarifying the key clinical domains.

Programmatic Development

The R-QIN team has successfully extracted, transformed, and loaded the core National Quality Forum data into the network's web-based, secure data reporting and benchmarking portal. The network's (beta test) durable, mass-customizable software application and process will be replicated at both member hospitals for both retrospective quarterly periods as well as going forward during the remainder of the grant period and beyond.

In terms of challenges, the COVID pandemic drained key resources from the core clinical and technology teams for a sustained period. Notwithstanding these barriers, the R-QIN technologists have successfully created a method and set of software applications to extract clinical data from the members' EMR systems. As expected, this data-extraction process was challenging because the source data are highly detailed and subject to changes in the configuration of the subject EMR — and because the data-governance requirements intrinsic to protected health information are significant. These challenges, while formidable, were overcome through a transparent and collaborative approach to problem-solving and the ongoing commitment of senior leadership at the network member hospital provider organizations.

Another challenge for the network was identifying invested partners with common goals and the desire to achieve said goals. R-QIN had a committed partner that faced challenges in workforce and lacked the commitment to ensure that time was dedicated to the goals of the network. The network attempted to reach out to the partner and offer many resources and assistance to meet the goals and objectives of the network. The network's hope was to assist this partner with resources to complete a community health needs assessment to be able to identify community barriers in all the partner communities. The partner chose not to participate in the network, which really allowed the network to identify a need to develop a member onboarding process to ensure all partners shared the same vision.

Innovation will likely occur in two dimensions: first, the network anticipates that the now-fragmented portfolio of rural-relevant quality measures will coalesce and then expand in a more systematic manner as public reporting moves from voluntary to mandatory status for RHCs, and second, they recognize that EMR vendors will continuously adapt to the changing environment and its client needs. These innovations will be helpful for future partners and members in terms of R-QIN's surveillance of relevant measures and the ongoing technological demands associated with data management.

Sustainability

R-QIN's sustainability strategy has three major components. First, the provider membership will grow to include additional RHCs (both provider-based as well as independent clinics), and its formalization will be aligned with one or more statewide or regional member-based partner organizations. Second, the R-QIN technologies will serve as the infrastructure for data collection and reporting for an emerging set of anticipated government payer-based quality incentive initiatives. Last, R-QIN provider members will assume a leadership position as it relates to the design and development of value-based payment models with commercial payers, including Nebraska's Medicaid managed care organizations. Each of these three strategies, when fully mature, will provide adequate funding to support current and future network activities.

R-QIN anticipates sustaining its current core functions in terms of data management and governance and will expand to include more advisory and technical assistance resources as the health care environment evolves and new opportunities to tie quality to finance emerge for rural providers.

Region Covered by Network Services (County/State)

- Antelope, NE
- Madison, NE
- Boone, NE
- Nance, NE
- Dawson, NE
- Phelps, NE
- Dundy, NE
- Gosper, NE
- Greeley, NE
- Hitchcock, NE

Network Partners

Organization	Location (City, State)	Organization Type
Lexington Regional Health Center	Lexington, NE	Hospital
Boone County Health Center	Albion, NE	Hospital
ruralMED Health Cooperative	Holbrook, NE	Collaborative

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Maine Primary Care Association

Maine Patient Safety Organization Network

P10RH41762

Project focus area:
Patient Safety

Other focus areas:
Network Development,
Increase Health System Efficiencies,
Population Health/
Social Determinants of Health

Network Statement

The safety and well-being of patients is a top priority at the Maine Primary Care Association's Patient Safety Organization (PSO) Network. They work with partners in creating a trustworthy system of health care delivery and a network culture of patient safety. In creating a culture of safety, they partner with community health centers (CHCs) to conduct activities to improve patient safety and quality of care for the patients they serve. Utilizing a patient safety lens, the network assists in identifying patient incidents and near misses, and aids in determining both why they happened and how they can be prevented. Focusing on patient safety allows for better overall clinical outcomes, patient and provider satisfaction, and, overall, a safer environment for work. Working together allows partners to share best practices amongst the CHCs' quality leaders and identify CHC-specific patient safety trends.

The Maine Primary Care Association (MPCA) is a membership organization that represents CHCs in the state of Maine. Their health center members provide comprehensive medical, behavioral, dental, and pharmacy services to the most medically underserved Mainers in rural locations. In 2019, MPCA created the first ever Federally Qualified Health Center–focused PSO to increase patient safety and foster a safety culture amongst its members. Currently, 12 of Maine's health centers belong to the PSO Network. As the network grows, they will eventually include all 20 health centers located in Maine, fostering and promoting a culture of patient safety throughout the state.

Network Development

The Maine PSO Network has been working to become a more formal network since its inception in 2017. Throughout its work with the Rural Health Network Development Planning Program grant, the network created a charter; established a programmatic focus (uploading of vaccine event errors within health center settings); and created a mission, vision, and values statements. The network also fine-tuned its focus to

include a streamlined approach to patient safety reporting, education, and understanding of just culture and safety culture.

Like many new networks, they faced challenges that have pushed the network to be innovative and flexible. Challenges include workforce shortages and provider burnout related to COVID-19, confusion among network partners about the Network Planning Grant and its relationship to the PSO Network, and scheduling meetings that work for all health centers to maximize participation. They have overcome these challenges by holding one-on-one meetings with PSO Network members to allow for open lines of communication throughout planning stages. The network achieved a goal of including all 12 network members by working around schedules, offline communications (email), short huddles and meetings, and constant communication. This, in turn, has allowed for shared team building and improved relationships.

In addition, they worked with health centers to streamline an onboarding process for new network members. They are in the beginning phases of completing this project and have a solid foundation and support from network members to complete this work.

Programmatic Development

Since they began work on the Network Planning Grant in July 2021, the network accomplished many work plan objectives, such creating a streamlined process for the PSO Network to upload events. They accomplished this through a work-around that was developed by a vendor and are in the process of training network members to use the tool to upload patient safety events.

The network also developed solutions to technology-related challenges impacting patient safety data input. The current tools being used by their vendor were not supported by the IT departments for many CHCs (Tableau and Microsoft Silverlight). Bringing this insight to the vendor provided a better understanding of the challenges they face as a network and allowed them to collaboratively develop a solution. Working together with the vendor, the network created a spreadsheet to send patient safety data to ECRI through a secure network. Then ECRI uploaded the patient events into their patient safety data dashboard on Tableau.

An innovative solution to the problems the network faced included the development of a work-around tool to upload patient safety events and technical support from the network's executive commitee to the network members to support the uploading process. In addition, they are working with another vendor, Compliatric, to research the potential of using a shared risk-management information system (RMIS)/PSO tool. This would allow for all CHCs within the network to use one RMIS system, which could streamline all event reporting and allow for an automatic upload into the Tableau program.

Sustainability

The Maine PSO Network aspires to achieve long-term sustainability through the creation of a new governance process and setting a regular meeting schedule with quarterly meetings involving all network partners. Innovation, grant funding, and connectivity through Health Resources and Services Administration Primary Care Associations (HRSA PCAs) activities, Bureau of Primary Health Care, and Health Center Controlled Network will help to provide long-term sustainability.

The goal is to grow the network by engaging all Maine PCA members. In fall 2021, the network executive team held one-on-one interviews with six current PSO members to discuss return on investment for being a PSO member. Maine PSO will use this information to guide discussions with the PCA board of directors, comprising CEOs and executive directors for all CHCs. Sharing this information with the PCA board will help engage PCA health centers outside of the Maine PSO Network. Future planning is also in place to include health centers outside the state of Maine, as well as Maine-based rural health centers and critical access hospitals.

The network strives to become a thought leader in the just culture and culture of safety arenas, as well as to continue facilitating excellence in quality improvement and quality assurance work within the health center setting

Region Covered by Network Services (County/State)

- State of Maine (all 16 counties)

Network Partners

Organization	Location (City, State)	Organization Type
DFD Russell Medical Center	Bridgton, ME	Federally Qualified Health Center
Fish River Rural Health	Eagle Lake, ME	Federally Qualified Health Center
Greater Portland Health	Portland, ME	Federally Qualified Health Center
Hometown Health Center	Newport, ME	Federally Qualified Health Center
HealthReach Community Health Centers	Waterville, ME	Federally Qualified Health Center
Katahdin Valley Health Center	Patten, ME	Federally Qualified Health Center
Maine Mobile Health Program	Augusta, ME	Federally Qualified Health Center
Nasson Health Care	Springvale, ME	Federally Qualified Health Center
Penobscot Community Health Care	Bangor, ME	Federally Qualified Health Center
Regional Medical Center at Lubec	Lubec, ME	Federally Qualified Health Center
St. Croix Regional Family Health Center	Princeton, ME	Federally Qualified Health Center
Sacopee Valley Health Center	Porter, ME	Federally Qualified Health Center

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Margaretville Memorial Hospital

Delaware-Ulster Senior Care Network

P10RH41763

Project focus area:
Elder Care

Other focus areas:
Care Coordination, Chronic Disease Management, Health Education, Population Health/Social Determinants of Health

Network Statement

State and national statistics show that people are living longer than previous generations, and as people live longer, staying healthy and maintaining a high quality of life become increasingly difficult. Particularly in rural areas, transportation and distance issues, lack of affordable, accessible housing, and a scarcity of providers combine to challenge elders with chronic conditions. Although this challenge is a monumental one, healthy aging has long been at the periphery of the public health agenda.

Since 2020, the Delaware-Ulster Senior Care Network has been working to bring that challenge to the forefront and improve the lives of our elders. The network seeks to guide them regarding health decisions, promote new and enhanced programming, and collaborate with community members to encourage environmental and policy changes. The network is passionate about helping older adults stay in their homes as long as possible. The partners envision providing greater access to health care and community-based services, not just for elders but also for their caregivers and families, and ultimately, all members of the Delaware-Ulster community.

Network Development

The Delaware-Ulster Senior Care Network is in its early stages. It functions as a group of organizations bound together by a formal memorandum of understanding, mission and vision statements, and shared goals. The mission is to offer accessible rural health-promotion programs through all possible means, including in-person, telehealth, and written communication to the aging population and general community, with a vision of providing greater access to health care and community-based services for all members of the community. The network works collaboratively across two counties to identify areas of concern for the aging population's health care needs and address them systematically. The partners have a history of working collaboratively with other partners individually, but this is the first time all partners are working toward a shared vision/mission and goals.

Through a series of meetings, focus groups, interviews, and a comprehensive needs assessment, the network has worked to identify the top issues facing the aging population in the two counties. Out of those fact-finding instances, the partners have also identified the strengths the community has to offer. The partners acknowledge they are committed to systematic, collective change in offering services to the aging population. As is true in many communities, the COVID-19 pandemic has restricted interaction and forced people to conduct business, not as usual, but in ways that would never have succeeded two years ago. Partners agree that video conferencing is not ideal; it is much more engaging and, possibly, more effective to meet in person. However, due to the distance between partner locations and length of travel times, teleconnecting makes for more effective communication. Staff turnover for partners has also been a challenge, not only for the individual partners, but also for the network itself. To alleviate that issue, the network is working on an "orientation" package for new staff, partners, and stakeholders.

Programmatic Development

As shown by the network needs assessment, the greatest challenges for the aging population in our rural area are the lack of these three elements: transportation; health care providers; and internet, broadband, and cell service. Repeatedly, in meetings and through surveys, these issues always emerge. As a result of this data gathering, a pilot program/solution has surfaced. The Office for the Aging is spearheading a program that will improve these difficulties by creating partnerships with community centers where a dedicated room will be outfitted with teleconferencing equipment to connect members of the aging population with a health care provider. Elders will be transported to this "hub," where an advocate will be there to assist the individual, prepare them for their visit, and troubleshoot any issues that may occur during the visit. This pilot program is still in the planning stage, but quickly moving toward implementation. Once this is up and running, the hope is that this service can be expanded to include telewellness and education opportunities. While not perfect in design, these telehealth visits will be used to mitigate broadband connectivity issues, lessen the need for transportation, and connect people with providers so desperately needed in the rural communities.

Sustainability

Collectively, the network partners have voiced commitment to continue efforts past the planning year, including researching additional funding sources and dedicating specific staff to carry out program activities. The network has applied for two additional grants through HRSA and plans to submit for the forecasted Rural Health Network Development grant. One key strength that solidifies the structure is that the lead agency, Margaretville Hospital, and two other partners are members of a large hospital system, which provides access to a great many resources. In addition, the network is fortunate to have resources within the respective agencies and can offer many services that will be shared and enhanced, although the level of services to be provided will be dependent upon external funding. Finally, the Delaware-Ulster Senior Care Network will continue to cultivate new and existing relationships with organizations that have a similar focus and will continue to grow its membership with those stakeholders sharing the same priorities of addressing issues facing the aging population in Delaware and Ulster counties.

Region Covered by Network Services (County/State)

- Delaware County, NY
- Ulster County, NY

Network Partners

Organization	Location (City, State)	Organization Type
Margaretville Hospital	Margaretville, NY	Critical Access Hospital
Mountainside Residential Care Center	Margaretville, NY	Skilled Nursing Facility
Advanced Physician Services	Margaretville and Kingston, NY	Physicians' Clinic
Catskill Hudson Area Health Education Center	Highland, NY	Area Health Education Center
Delaware County Office for the Aging	Delhi, NY	Area Agency on Aging
Ulster County Office for the Aging	Kingston, NY	Area Agency on Aging

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Kansas

Nemaha Valley Community Hospital

Health Innovations Network of Kansas Suicide Prevention Improvement Network

P10RH41764

Project focus area:
Mental Illness/
Mental Health Services

Other focus areas:
None

Network Statement

Rural Kansas is experiencing an alarming rate of suicide, particularly among residents working in agriculture. All rural residents, young and old, need and deserve better access to mental health care and more tools to increase their mental wellness.

The Health Innovations Network of Kansas Suicide Prevention Improvement Network (HINK SPIN) brings together a unique collection of representatives with strong ties to both health care and agriculture. Through these deliberate and strategic connections, network partners are committed to researching and implementing approaches that have proven successful in other rural regions in reducing suicide and increasing access to needed services. Network partners are working together to create a system of focused services to reduce suicide rates, educate the broader community, and integrate primary and mental health care, with specific focus on residents involved in agricultural production. The result will be improved mental wellness and quality of life across rural Kansas.

Network Development

HINK SPIN focused on collaboration across industry lines. Development of a behavioral health task force that includes representatives of hospitals, community mental health centers, addiction treatment centers, and agricultural organizations is key to its strength. Members of the task force have focused on building relationships based upon a mutual goal of reducing the rate of death by suicide in its rural Kansas region.

Members of the HINK SPIN behavioral health task force are submitting letters of intention reflective of their desire to remain engaged in the network and its mission. The relationships developed between members and

within the task force will allow for opportunities to focus on the goals developed in the strategic planning process. Additional members will be recruited to HINK SPIN to further strengthen engagement and develop partnerships to support the network's focus. The HINK board of directors voiced their support of the ongoing work HINK SPIN will undertake to meet the goals of reducing the rate of suicide and increase access to mental health care within the region. This support includes time and financial resources from HINK in addition to supporting their hospital staff members who serve on the Behavioral Health Task Force.

The development of HINK SPIN was not without challenge, primarily due to the timing. Implementation of the HRSA Rural Health Network Development Planning Program grant and the goals within the work plan happened at the same time the region was experiencing another surge in COVID-19. Use of virtual forums allowed for continued contact; however, the hospital staff members involved were often limited in their ability to engage due to the needs of their staff and patients. Relationships can be developed in a virtual format but will also need additional energy to be sustained and grow as opportunities to meet safely in person can be taken.

Programmatic Development

HINK SPIN members focused their attention on the following:

- Collection of regional data through surveys and town hall meetings to gain clarity in understanding of the challenges and opportunities in addressing the issue of suicide and mental health access within the region.
- Development of a strategic plan that allows HINK SPIN members to focus their efforts on increasing access to mental health services and decreasing the rates of death by suicide in rural Kansans, aged 15-64, within a 20-county area in northeastern and north-central Kansas.

Development of programming to meet the needs determined through the surveys, town hall meetings, and planning sessions are underway. To meet the goals of decreasing the rate of death by suicide and increasing access to mental health within the region, HINK SPIN will focus on the following strategic pillars:

- Community education
- Public awareness
- Professional development
- Sustainable funding

As programming is proposed by HINK SPIN members, it is imperative that options meet the strategic pillars to support the goals of HINK SPIN.

Sustainable resources will be the greatest challenge to programmatic development. The goals of decreased suicide rates and increased access to mental health services in these rural and agricultural communities will not be met quickly. Maintaining the focused energy on the goals in addition to obtaining sustainable funding to support programming will be a challenge for HINK SPIN to meet. At a time when recruiting and retaining mental health providers is difficult in rural communities, increasing access to mental health supports will also be a challenge. Last, HINK SPIN hospitals and communities are still working through the current phase of the COVID-19 pandemic. Hospital staff are rapidly catching up on tasks that have been put aside during patient surges while preparing for future surges. This work can limit their capacity to engage in further opportunities. This challenge will not last forever, while taking a great deal of bandwidth currently.

Sustainability

Sustainability of HINK SPIN is imperative to meeting the goals of the organization. The network will leverage the long-term relationships created within the Health Innovations Network of Kansas, as well as the board of directors' commitment to support SPIN through staffing the executive director.

As programmatic development occurs, the executive director and HINK SPIN task force members will research opportunities for further grant funding through federal avenues and statewide and regional funding sources. Sustainable funding is a pillar of the strategic plan, elevating the importance of this aspect to the success of the organization.

Region Covered by Network Services (County/State)

- Atchison, KS
- Brown, KS
- Coffey, KS
- Dickinson, KS
- Jackson, KS
- Morris, KS
- Nemaha, KS
- Pottawatomie, KS
- Riley, KS Shawnee, KS

Network Partners

Organization	Location (City, State)	Organization Type
Amberwell Health Atchison	Atchison, KS	Critical Access Hospital
Amberwell Health Hiawatha	Hiawatha, KS	Critical Access Hospital
Central Kansas Foundation	Salina, KS	Nonprofit
Coffey County Hospital	Burlington, KS	Critical Access Hospital
Community Health Care System	Onaga, KS	Critical Access Hospital
Frontier Farm Credit	Manhattan, KS	Other
Holton Community Hospital	Holton, KS	Critical Access Hospital
Kansas Corn	Manhattan, KS	Other
Kansas Department of Agriculture	Manhattan, KS	Other
Kansas Farmers Union	McPherson, KS	Other
Kanza Mental Health	Hiawatha, KS	Behavioral Health
Memorial Health System	Abilene, KS	Critical Access Hospital
Morris County Hospital	Council Grove, KS	Critical Access Hospital
Nemaha Valley Community Hospital	Seneca, KS	Critical Access Hospital
Sabetha Community Hospital	Sabetha, KS	Critical Access Hospital
Stormont Vail Health	Topeka, KS	Hospital
Washington County Hospital	Washington, KS	Critical Access Hospital

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Ohio University

Southeastern Ohio Rural Diabetes Care Network

P10RH41765

Project focus area:
Population Health/
Social Determinants of Health

Other focus areas:
Care Coordination,
Chronic Disease Management,
Community Health Workers,
Integrated Health Services

Network Statement

Lying at the foothills of the Appalachian Mountains, the southeastern Ohio community embraces the basic values of Appalachian culture: kinship, loyalty, generosity, and caregiving. Family extends beyond blood to include neighbors, business owners, and leaders. Just as every member of the family is expected to contribute to the community, our area health care professionals are dedicated to treating all patients like part of the family. Diabetes is one of the most significant chronic conditions affecting the community that the network serves, and barriers pervasive to our region interfere with people's ability to manage their diabetes. The southeastern Ohio Rural Diabetes Care Network is here to bring together primary care, specialists, pharmacists, behavioral health experts, diabetes educators, and community health workers (CHWs) to support residents in their diabetes care. The network's vision is to integrate high quality diabetes care services to optimize the health and well-being of all members of the southeastern Ohio community.

Network Development

The Southeastern Ohio Rural Diabetes Care Network represents a partnership among Ohio University, the Ohio University Diabetes Institute, the Ohio University Psychology and Social Work Clinic, Diabetes Navigation Program, the Heritage Community Free Clinic, the Athens City-County Health Department, the OhioHealth Endocrine Center, OhioHealth Primary Care Clinics, the Rising Suns Pharmacy Nonprofit, Diabetes Community Partners, and the Corporation for Ohio Appalachian Development. The network was formed to integrate primary care, specialty care, pharmacy services, diabetes education, diabetes navigation, CHWs, behavioral health, and peer mentoring to achieve efficiencies and expand access to, coordinate, and improve the quality of diabetes care in southeastern Ohio. This network builds on a long-standing history of successful collaborations among these members in diabetes-related programming.

Strengths of the network include a commitment to addressing diabetes in southeastern Ohio. To best meet the needs of the southeastern Ohio community, network members have invested heavily in advancing diabetes care through infrastructure, innovative programming (i.e., patient navigation, CHWs), clinical research, and professional education. Further, network members recognize the importance of representing Appalachia. The majority of network members were born and raised in southeastern Ohio. This is essential to developing a network that fosters trust among health care professionals and the Appalachian community.

In the future, the network will focus on two areas of organizational improvement: cross-system integration of services and sustainable funding. The community's primary and specialty care services are not colocated with diabetes navigation, CHWs, charitable pharmacy, peer mentoring, or behavioral health. To address this issue, the network will acquire an online platform to be used for referrals and to share patient/client information among health care professionals. To address sustainable funding, the network will continue to apply for external funding to support diabetes navigation, CHWs, charitable pharmacy, and peer mentoring. In addition, the network has formed a new partnership with the Corporation for Ohio Appalachian Development to certify a Pathways Community HUB.

Programmatic Development

After an extensive needs assessment with key informant interviews, an environmental scan, and an analysis of secondary data, the network determined that care coordination and social determinants of health would be the main priorities of the network in order to achieve its goals. To capitalize on these priorities, the network will implement evidence-based models of patient navigation, CHWs, and peer mentoring to support care coordination and address social determinants of health in the region. To strengthen the network, the Corporation for Ohio Appalachian Development became a partner in 2022. The Corporation for Ohio Appalachian Development is in the initial stages of certifying the first Pathways Community HUB in southeastern Ohio. Formal certification of a Pathways Community HUB will enable the network to commence billing to managed care plans for the outcomes achieved by diabetes navigators and CHWs, which, in turn, will support the sustainability of our comprehensive programming.

As the network moves forward, there is a need to address ongoing barriers pervasive to rural regions, including a lack of broadband connectivity, lack of new technology for telehealth, transportation difficulties, and lack of health care professionals. In addition, the COVID-19 pandemic has created additional barriers that may negatively impact the work of the network, such as low vaccination rates in southeastern Ohio, negative outcomes with COVID-19 infections and type 2 diabetes, health care professional burnout, and unforeseen barriers due to new COVID-19 variants. The network will address issues with telehealth, transportation, and access to care. To address low vaccination rates, navigators, CHWs, and peer mentors will be trained to build vaccine confidence among community members with diabetes. In addition, the network is working with OhioHealth to address health care professionals' mental health and burnout through the Tranquil Virtual Reality Program. The network has focused efforts on assisting health care professionals in recovering from burnout intensified by the COVID-19 pandemic.

Sustainability

The Southeastern Ohio Rural Diabetes Care Network will continue to seek external resources from diverse funding mechanisms. One major goal of this project is to certify the first Pathways Community HUB in southeastern Ohio. The work with the Corporation for Ohio Appalachian Development to certify the Pathways Community HUB will align payments with outcomes via contracts with managed care plans. Payment for outcomes supports accountability, quality, and equity in the services provided by the CHWs. In addition, the network has explored philanthropic support from regional foundations that provide funding to support the health of southeastern Ohio communities. Last, the network will explore a potential tax levy through a local property tax with the local and state government to support the network.

Region Covered by Network Services (County/State)

- Athens County, OH
- Perry County, OH
- Hocking County, OH
- Vinton County, OH
- Meigs County, OH
- Washington County, OH
- Morgan County, OH

Network Partners

Organization	Location (City, State)	Organization Type
Ohio University	Athens, OH	College/University
Ohio University Diabetes Institute	Athens, OH	College/University
Ohio University Psychology and Social Work Clinic	Athens, OH	Behavioral Health
Child Diabetes Navigation Program	Athens, OH	Other
Heritage Community Free Clinic	Athens, OH	Physicians' Clinic
Athens City-County Health Department	Athens, OH	Public Health
OhioHealth Endocrine Center	Athens, OH	Physicians' Clinic
OhioHealth Primary Care Clinics	Athens, OH; Nelsonville, OH; Racine, OH	Physicians' Clinic
Rising Suns Pharmacy Nonprofit	Athens, OH	Nonprofit
Diabetes Community Partners Community Group	Athens, OH	Other
Corporation for Ohio Appalachian Development	Athens, OH	Nonprofit

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Massachusetts

Outer Cape Health Services

Outer Cape Community Solutions Health Planning Network

10RH41766

Project focus area:
Population Health/
Social Determinants of Health

Other focus areas:
Behavioral Health, Child Health,
Elder Care,
Substance Abuse/Addiction

Network Statement

The rural Outer Cape community is known for its beauty, seclusion, creative arts, and local culture. While droves flock to this popular tourist destination during warmer weather, the area's year-round population has faced historical challenges and barriers to equitable health and wellness. The COVID-19 pandemic has only widened the burden of health inequity for the year-round population. As out-of-towners transitioned to work remotely and sought refuge in the open spaces of this rural community, the little available affordable year-round housing vanished at an astounding rate. With this increase in population, the already-scarce primary care clinicians and mental health specialists in this Medically Underserved Area became even less available — unable to hire and retain staff effectively due to the remote isolated location and lack of housing. The extreme seasonality of the workforce on the cape and the consequential "feast-or-famine" mentality exacerbate the already higher rates of mental health and substance use issues, as well as factors that lead to chronic health disparities such as limited public transportation, broadband service, child care, nutrition, and so on.

Since 2019, partners of the Outer Cape Community Solutions (OCCS) have met, shared concerns, pooled resources, and worked together to find solutions to the issues that are too big for single organizations to conquer alone. As the network's momentum grows, partners are collectively focusing efforts on educating and engaging with at-risk communities and advocating for policies that would support the availability of resources that promote health and wellness. Partners are energized by the demonstrated ability to bring together the communities of the Outer Cape and create a healthier future for all Outer Cape residents.

Network Development

Open Forum Meetings: Diverse engagement is deeply intrinsic to building a common agenda to address issues in the rural, isolated, and underserved Outer Cape region. On the third Tuesday of every month, OCCS holds an open forum, recognizing the importance of bringing together — for listening, dialogue, exploration, and reimagining — all who care about the health and well-being of Outer Cape residents. This open forum space also ensures engagement with and accountability to the Outer Cape communities that many OCCS partners serve. Through regular email engagement, OCCS has drawn in nearly 120 community leaders representing 46 organizations that include clinical providers, community groups, local police departments, first responders, councils on aging, regional schools, town and county governments, behavioral health providers, skilled nursing facilities, addiction recovery networks, and others. And nearly 50 of these community leaders representing 30 organizations are active open forum meeting participants or engage with OCCS through one-on-one conversations.

Governing Mechanism: With such a large engagement of community organizations and leaders, a core governing mechanism is essential. Over the past year, three OCCS Health Planning Network (HPN) governance partners have shepherded the formation of an OCCS governance mechanism. The three OCCS HPN governance partners are Outer Cape Health Services, Helping Our Women, and the Barnstable County Department of Human Services. Additionally, the OCCS HPN steering committee, which includes faith-based and community-based organizations, has worked closely with the governance partners to create a network infrastructure capable of translating goals into action. As OCCS moves from planning into action, these two HPN bodies have merged to form a singular OCCS governance committee.

Co-designing With and Not For: Throughout the HPN process, OCCS centered equitable leadership in participation and decision-making. During monthly open forum meetings, every effort was made to maximize participation from network partners. For example, meetings were designed with smaller breakout room discussions and report-outs. Further, feedback loop opportunities were made available to ensure that what was captured accurately reflected the consensus of participants.

Programmatic Development

OCCS Rural Health Network has already used the learning from the HRSA Rural Health Network Development Planning Program grant to make significant progress in developing new programs. OCCS successfully applied for and was awarded a grant from the Massachusetts State Office of Rural Health and the New England Rural Health Association. This grant allowed for planning a new program to promote equitable access to community resources, including COVID-19 vaccines, and to help the rural Outer Cape communities continue planning for recovery from the negative effects of COVID-19. The funding for this project will enable OCCS to pursue some of the goals around health equity and education developed during strategic planning. In addition, this three-year award provides a measure of sustainability by helping to fund a network coordinator. The project also provides technical assistance from NERHA and a learning community component that will enable OCCS to learn from experts and to share best practices and learning with other rural health networks around the state.

OCCS has faced challenges in program planning in several areas. Like with most networks since COVID

emerged, most meetings were held on Zoom rather than in person. That has been a mixed blessing, as it has probably increased meeting attendance. However, some people are less comfortable with the technology, their screen image, and so on. Moderating conversations is a challenge in online meeting mode. However, the network coordinator and technical assistance consultants have proven adept at using Zoom breakout rooms to break participants into small groups for discussion and brainstorming, and then bringing them back to the plenary group for report-out. That has worked extremely well by creating small, nimble, less-threatening discussion groups. Another challenge has been the juxtaposition of the need to develop more structure and a governance model while recognizing the value that some network members place on informal networking and information sharing. This came to light through a survey sent to network members as part of the strategic-planning process. In some ways, the two sides of this coin appear to be conflicting. However, this can be an opportunity to have a rich discussion among network members to explore what could be a source of tension in the early days of the network. This is a validation of an approach that uses different modes of information gathering — plenary discussions, Zoom breakout rooms, asynchronous surveys, and hopefully in-person meetings — to get feedback from network members using different communication channels according to their preferences.

This concept of using different channels for information discovery, input, feedback, and validation is an innovation that other communities might find of value. Many of the network members are less comfortable with some modes than others, so providing multiple channels and venues of communication is critical in maximizing and optimizing participation. Likewise, the approach discussed above to use flexible, small virtual breakout groups during planning discussions and listening sessions has proven valuable. It does require some technical knowledge and familiarity with virtual meeting platforms, and some platforms work better than others. However, because of the value of increasing participation, it is well worth pursuing.

Sustainability

OCCS is well-positioned to sustain this rural health network beyond the HRSA Network Planning Grant period. A governing body is in place, and plans to further formalize the mechanisms of this governing body are under discussion. A network coordinator has been hired by the network and, additionally, the network has secured new funding to ensure this position will remain staffed over the next three years. Finally, the formation of work groups to carry on programmatic work is currently in the planning phase. Once these work groups are established, the network will be able to ensure programs are sustained by committed partners with the expertise and commitment necessary.

Region Covered by Network Services (County/State)

- Barnstable County, MA

Network Partners

Organization	Location (City, State)	Organization Type
AIDS Support Group of Cape Cod	Provincetown, MA	Social Services Agency
Alzheimer’s Family Support Network	Brewster, MA	Social Services Agency
Bay Cove Human Services	Hyannis, MA	Behavioral Health

Organization	Location (City, State)	Organization Type
Cape Cod Children's Place	Eastman, MA	Nonpofit
Cape Cod Community College	West Barnstable, MA	College/University
Elder Services of Cape Cod and the Islands	South Dennis, MA	Nonprofit
Eastham Police Department	Eastham, MA	Law Enforcement
Habit OPCO – Yarmouth	Yarmouth, MA	Social Services Agency
Helping Our Women	Provincetown, MA	Social Services Agency
Homeless Prevention Council	Orleans, MA	Social Services Agency
Independence House	Barnstable County, MA	Social Services Agency
Lily House	Wellfleet, MA	Hospice
Lower Cape Ambulance Association	Orleans, MA	Emergency Medical Services
NAMI Cape Cod & Islands	Cape and Islands (Martha's Vineyard and Nantucket) region, MA	Social Services Agency
Nauset School District	Orleans, MA	School System
Outer Cape Health Services	Wellfleet and Provincetown, MA	Federally Qualified Health Center
Provincetown COA and Human Services	Provincetown, MA	Senior Center
Provincetown Senior Center	Provincetown, MA	Senior Center
Saint Peter the Apostle Church	Provincetown, MA	Other
Samaritans on Cape Cod and the Islands	Cape and Islands (Martha's Vineyard and Nantucket) region, MA	Nonprofit
Sharing Kindness	Orleans, MA	Nonprofit
Town of Truro	Truro, MA	Government
Town of Wellfleet	Wellfleet, MA	Government
Truro COA	Truro, MA	Senior Center
Truro Police Department	Truro, MA	Law Enforcement
WE CAN	Harwich Port, MA	Other
Wellfleet Congregational Church	Wellfleet, MA	Other
Wellfleet Police Department	Wellfleet, MA	Law Enforcement

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Guam

PIH Health Good Samaritan Hospital

GUAM Rural Telehealth Network

PH10RH41759

Project focus area:
Telehealth

Other focus areas:
Care Coordination,
Chronic Disease Management,
Health Education,
Maternal Health

Network Statement

For generations, hypertension, diabetes, and lack of access to health care and relevant heart-healthy information have contributed to heart disease being Guam's number-one cause of death, especially in Guam's lower-income, underserved communities. Lack of access to care and relevant information also results in nearly 40% of pregnant women on Guam not receiving prenatal care early in their pregnancies, with over 14% receiving little to no care.

The Guam Rural Telehealth Network believes that cardiovascular disease and maternal and infant mortality can be constructively addressed by the expanded use of telehealth. Having relationships that span two decades, local health care professionals and institutions are working together to extend medical and preventive care to a greater number of islanders through one-on-one virtual consultations. Through this planning process, the providers who are best able and equipped to provide a range of care via live telehealth consultations have been identified.

In addition, the network intends to increase knowledge and education about cardiovascular disease, as well as prenatal and perinatal health for both mothers and infants, using distance learning and virtual presentations, including live classes and prerecorded webinars. These resources will be accessible to individuals throughout Guam who are interested in e-learning to prevent disease and improve their overall health.

The network aims to optimize the health of individuals at risk of heart disease in Guam and to bring enhanced education to expectant and new mothers and their families through the telehealth network.

Network Development

Network members have established an excellent and close working relationship based on shared values and having worked together for decades in envisioning the formation of this telehealth network on Guam. The network focus is to improve the coordination of care and increase access to health care services on Guam using telehealth. During the Rural Health Network Development Planning Program grant year, partners have been actively expanding the use of telehealth on the island. Desired outcomes include increasing the prevention and treatment of cardiovascular disease and improving maternal and infant health on Guam. Network partners have met at least monthly to discuss current activities and how to continue to develop the network in the future. The network members are considering whether to include additional partners also located on Guam or on other islands in the region as it moves forward.

Challenges driven primarily by the COVID-19 pandemic limited the ability of some network members to personally attend all network meetings, but they would normally send at least one representative from their organizations to participate — even when their organizations were short-staffed. Providing all network partners with the flexibility to designate others within their organizations to join meetings on their behalf helped to build trust among network partners, encouraged the sharing of information, led to the contribution of innovative ideas by individuals new to the group, and helped solidify the respect of each participant for its partner organizations.

Programmatic Development

The network has made significant progress developing a plan for expanding the use of telehealth to alleviate cardiovascular disease, as well as maternal and infant morbidity on the island. First, the network assessed and identified the emerging needs of communities on Guam. One of the key needs is to provide maternal and child health education at the Guam Department of Public Health and Social Services for WIC recipients. To this end, the network has identified educational materials for new mothers that can be delivered by the network via telehealth. Partners developed a plan whereby the network can bring webinars, live maternal and infant wellness classes, and other virtual presentations to new mothers and their families on Guam. A key programmatic development includes telecasting weekly classes on Guam that are presented in Los Angeles by PIH Health Good Samaritan Hospital at a time that is convenient for mothers to view on Guam.

The network partners also assessed the ongoing, critical need to prevent and address heart disease on Guam, since it continues to be the leading cause of death on the island. To increase access to cardiac care, the network plans to have cardiac specialists hold educational presentations on island with primary care providers and their patients to explain the value of their being able to consult with heart specialists using telehealth anywhere on Guam.

The monthly network meetings — in addition to the efforts described above — have helped solidify planned strategies and kept them in alignment with the network mission and goals of improving both cardiovascular health and the health of mothers and infants on Guam. The plan is to bring additional consultations and education via telehealth to individuals to improve health outcomes. To this end, the network has assessed the number and types of telehealth consultations that each network partner on Guam can provide each month to better serve patients with heart problems and mothers and infants in need of improved health care and education.

One challenge experienced in the development of the program is the serious health workforce shortages that exist on Guam. Like elsewhere, these shortages have been exacerbated by COVID-19. Since these shortages affect all levels of health care workers, including allied health service workers, they can impede the ability to schedule and complete telehealth consultations with providers and their patients in the more remote areas of Guam where care is needed most. The network attempted to address this challenge in three ways: first, by having cardiac and other specialists in the network consult with individual providers who treat multiple patients on Guam through peer-to-peer physician consultations; second, by consulting with providers in remote areas who are willing to bring numerous patients for individual, private consultations conducted with the specialist and the patient's primary care provider; and third, by hosting educational group sessions with providers and their patients on Guam regarding general health topics important to all parties involved while ensuring the sessions do not violate the confidentiality of any single patient but deliver beneficial information to everyone in attendance. In this way, the network will increase the number of telehealth consultations held between cardiac interventionists or other specialists and existing providers who serve patients in the more remote areas of the island.

Another challenge on Guam is that many new, young mothers do not initiate doctor visits when they suspect or find that they are pregnant. As a result, they are often simply unaware of the need to receive prenatal vitamins, change their eating habits, and have regularly scheduled visits with a primary care doctor or obstetrician. The network plans to address this challenge by providing pre- and perinatal education in the WIC clinics as part of virtual telecasts and webinars. The hope is that this simple but innovative initiative will greatly benefit mothers, their babies, and families on Guam.

Sustainability

The partners in the network will continue to work together, and the proposed telehealth programs will be sustained. The planned consultations will help local providers, particularly those in the more remote parts of the island, obtain medical advice from specialists to better serve their patients. The specialists who provide the consultations will gain new insights about how their advice, delivered in an environment that includes patients from many diverse cultural and geographic backgrounds, can enrich their own knowledge and experience. The overall exchange will help disseminate knowledge and improve access to care and new information for everyone involved.

It is anticipated that the use of telehealth will expand and be sustainable because during the COVID-19 pandemic the benefits of telehealth became more evident. As a result, both federal and state governments, as well as private insurers, have begun to expand their support for telehealth. As this trend continues, the use of telehealth will expand not just in Guam, but also in adjacent islands throughout Micronesia.

The members of the network have been working to deliver health care on Guam using telehealth for more than a decade. During this time, they have seen an increased use of telehealth as it has been embraced by caregivers, their patients, and, increasingly, insurance providers. The pandemic accelerated this trend, and the creation of the network as part of this Network Planning Grant has helped to create a coordinated, combined effort among network partners, some of whom previously provided telehealth but were working alone. Now all are part of a group comprising of a range of diverse providers, both public and private, that is devoted to telehealth.

Region Covered by Network Services (County/State)

- U.S. Territory of Guam

Network Partners

Organization	Location (City, State)	Organization Type
Department of Public Health and Social Services (DPHSS)	Barrigada (Tiyan), GU (WIC) Dededo, GU (FQHC/WIC) Inarajan, GU (FQHC/WIC) Santa Rita, GU (WIC) Tamuning, GU (Central Office)	Government
FHP Health Center	Tamuning, GU	Rural Health Center
Pacific Cardiology Consultants LCC (PCC)	Tamuning, GU	Physicians' Clinic
PIH Health Good Samaritan Hospital	Hagatna, GU Los Angeles, CA	Hospital

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Kentucky

Pikeville Medical Center Inc.

East Kentucky Pediatric Healthcare Network

P10RH41767-01-00

Project focus area:
Child Health

Other focus areas:
Health Education

Network Statement

Eastern Kentucky has been affected and continues to be after decades by significant geographical and socioeconomic barriers. Unfortunately, this has been extremely evident in health care. The six counties comprising the network's target population are in a highly rural region spread out in a wide geographic area. These counties are characterized by low population density and are among the top 80 most economically distressed counties in the United States. The population of Central Appalachia faces economic hardship, the opioid drug crisis, and now COVID-19, resulting in significant health disparities among children and their families.

The East Kentucky Pediatric Healthcare Network is a collaboration of health care providers, social services, local school systems, and community agencies working together to understand and develop strategies to address and overcome these challenges. Together, this group is dedicated to improving the overall quality of life for the pediatric population by offering more comprehensive health care services for children and their families.

The network will have a specific focus on children, especially those who are at high risk for poor health outcomes due to poverty, homelessness, teenage parents, and family instability. A high percentage of children who fall into these categories are living with grandparents or other adult relatives resulting from abuse or neglect by their biological parents. Family members — especially grandparents — who are caring for these children often struggle to understand and address the children's health care needs. Many times, they are unaware of pediatric preventive health care practices and are unfamiliar with available pediatric physical and mental health resources.

As a result of the network's efforts, not only the children, but the entire community, will benefit.

Network Development

Core members of the Eastern Kentucky Pediatric Healthcare Network include Pikeville Medical Center, Pike County Health Department, Pike County Schools, and United Medical Group.

- *Pikeville Medical Center (PMC)* – (Pike County) is a locally controlled, not-for-profit health care organization based in Pikeville, Ky. This regional referral center services Eastern Kentucky, Southwest Virginia, and Southwest West Virginia. In addition to the 348 licensed inpatient beds, which include 320 acute care and 20 inpatient rehab beds, PMC has 22 nursery bassinets and 21 ambulatory clinic locations that offer 34 different specialties. PMC recently opened the Appalachian Valley Autism Center, the only behavioral health service providing pediatric autism services within 150 miles. The hospital opened the Children's Hospital in December 2021.
- *United Medical Group* – (Pike County) is a health care provider in Pikeville, Ky., specializing in family medicine and addiction medicine. Clinic staff are committed to improving care coordination so that children treated at Pikeville Medical Center can make a seamless transition to primary care. Its role in the network will be to provide primary care and expand its services across the region through telehealth.
- *The Pike County Health Department* provides services and education to safeguard health in Pike County. The department conducts some measurement of population health indicators. It operates a school health program that includes acute and chronic illness screenings; required acute treatments; case management for asthma, diabetes, allergies, and other chronic conditions; and dental services. The department also provides clinical preventive health services in the community to assist individuals in obtaining and maintaining an optimal level of wellness. In addition to providing direct care, its role in the network will be to continue to assist with quantitative and qualitative data collection and data management. Furthermore, its WIC program may screen patients for primary gaps and make referrals to appropriate network members. Finally, the department will leverage its community health education services to promote specific health topics such as asthma or immunizations via appropriate communication channels for the various target populations.
- *Pike County School System* provides school nursing services in partnership with the Pike County Health Department. Because of the high homelessness in the Eastern Appalachian region (up to 27,000 families), the school system also employs one of only two homeless coordinators in Kentucky. This person will represent the school system on the network to serve as a liaison between it and homeless families and to explore additional options for integrating health services in the schools.

Pikeville Medical Center selected these entities because they provide services along the continuum of care (screening to acute care). These members are also committed to and invested in a local health care system that increases health care access and quality in the Appalachian region. The network builds on previous collaborations between these entities.

Programmatic Development

The East Kentucky Pediatric Network established a time for monthly meetings and had participation from all partners. The network identified programmatic, administrative, and financial objectives to develop activities and strategies as set forth in the work plan. Through a collaborative effort, a vision and a structure were

established for open-ended strategic network communication, gathering and managing qualitative data on vulnerable families' health care needs and barriers. The network identified and leveraged state, regional, and local resources to investigate and sustain gap analysis for pediatric health care services. There was a strategic implementation of collaborative and evidence-based interventions that assisted in executing an effective care coordination plan and administering a network operation plan while implementing a strategic plan for the region's only children's hospital, which opened in December 2021.

Each network partner played a key role in advancing community health in eastern Kentucky as they each possess a unique institutional capacity to address identified pediatric health care priorities. The collective impact brought the partners together, which resulted in a far more robust and sustainable pediatric rural health system to address the health needs of at-risk children.

The direct grant funds covered the cost of a project director and stipends for partners to conduct focus groups and surveys, provide expert guidance on the development of the strategic plan, and offer recommendations. These resources are leveraged by the in-kind contributions offered by network partners and other non-network community partners.

Evaluating the Rural Health Network Development Planning Program enhanced the quality of collaboration among network partners. There continue to be many opportunities to enhance collaboration and strengthen relationships among network partners, particularly when preparing and executing the strategic plan and network self-assessment. The network conducted a network self-assessment using a tool from the National Rural Health Resource Center. The self-assessment is an iterative process with opportunities to evaluate and incorporate results into the final assessment report. Network partners collectively evaluated input from each partner's self-assessment and collectively identified and integrated suggestions for network changes. These steps have been documented through meeting agendas, meeting minutes, and reports prepared by the project director and coordinator. The strategic plan activities were evaluated against the stated activities and measurable outcomes described in the work plan. The network held its first in-person event at the local YMCA to promote Healthy Kids Day. Around 100 children and their parents or guardians enjoyed a day of activities, educational material, and an opportunity to be vaccinated.

The planning process gave network partners numerous opportunities to build relationships of trust and collaboration while working together to progress through the proposed goals, objectives, and activities. The network partners have a robust history of collaboration in other coalitions and networks. The Network Planning Grant program allowed for key partners to focus on an identified health need and develop new and innovative responses to health and mental health outcomes among at-risk children to enhance eastern Kentucky's health care delivery system.

The ongoing evaluation is critical to ensuring the network strategies will be relevant, sustainable, and beneficial. The year of planning has allowed the network to strategize and determine the best way to design and implement. The evaluation of the network's progress and performance was observed in the content of the strategic planning document; network self-assessment report; information and reporting gathered on targeted strategies to implement collaborative, evidence-based interventions to decrease chronic disease rates; and mechanisms that enhanced efficiency and capacity of services.

Sustainability

The East Kentucky Pediatric Healthcare Network partners are committed to ensuring that progress toward completing the network goals and objectives is continuously assessed and tracked throughout the grant period and that these assessments are used to inform the network's quality improvement strategy and sustainability beyond federal funding.

The vice president of development, the project director, and the project coordinator will continue completing project activities and incorporating the participation of all network partners. Each partner has committed to contributing staff time to its key leaders to participate in all stages of project implementation. Network partners provided in-kind office space to host meetings, community meetings, and focus groups so that grant dollars did not need to be expended for these activities. The members have made a long-term commitment to working as a team and continuing the mission of the network. Team contribution and tangible progress are noticeable in the assessment and strategic plan publication.

All network members have worked together to prepare a robust quality improvement process. The processes were used when applying strategies to improve the pediatric health care pathway with a focus on at-risk children and the health care services they need involving prevention, screening, and treatment. Data from each network partner was collected, and the information was compared.

The East Kentucky Pediatric Healthcare Network is committed to caring for and supporting each child through the process without any gaps in service. The network pinpointed gaps in services and implemented strategies needed to better support the children in the community. Identified strategies included an increase in preventive screenings or well-child checkups, supplemental nutritional programs, home outreach programs, school-based health and education, and so on. The goal is to support the pediatric patient continuum of care without any gaps in health care and pediatric services in order to improve the health outcomes of children in Eastern Kentucky, while responding to immediate and emerging needs of the pediatric population with a focus on children who are underserved, vulnerable, or at high risk.

The network sees the importance of meeting and will continue to increase community education and awareness, increase access to care, improve quality of life, and increase resources to prevent health disparities and inequities while improving the pediatric health outcomes for the children in a region with a concentration of vulnerable, underserved, or at-high-risk children. The Rural East Kentucky Pediatric Network continues to collaborate and improve the effectiveness of the pediatric network pathway and programs and services offered to children and their families to ensure positive health outcomes for the children.

Region Covered by Network Services (County/State)

- Pike County, KY
- Floyd County, KY

Network Partners

Organization	Location (City, State)	Organization Type
Organization	Location (City, State)	Organization Type
Pikeville Medical Center Inc.	Pikeville, KY	Hospital
Pike County Health Department	Pikeville, KY	Public Health
Pike County Board of Education	Pikeville, KY	School System
United Medical Group	Pikeville, KY	Other

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Powerhouse Community Development Corporation

Missouri

Central Missouri Behavioral Health Network

P10RH41768

Project focus area:
Substance Abuse/Addiction

Other focus areas:
Health Equity,
Integrated Health Services

Network Statement

Missouri rural communities are greatly affected by the opioid epidemic and the rise in use of other illicit substances. In 2019, the Central Missouri Behavioral Health Network (CMBHN) formed to exchange information, conduct activities, share resources, and enhance the capacity of each member for mutual benefit to achieve the common goal of addressing opioid use disorder, substance use disorder, and the effects they have on the people who have them and the communities they live in.

The consortium is a vertically integrated network able to provide warm handoffs for individuals in need during their continuum of care. The network consists of diverse partners that represent the mental health, behavioral health, primary care, education, and social service sectors. The partners recognize the need to address all aspects of addiction issues in Mid-Missouri, including opioids, methamphetamines, alcohol, and other illegal drugs, to improve the health outcomes of our communities. CMBHN is committed to working collectively to elevate Central Missouri out of the opioid crisis to achieve healthier outcomes for our families and communities.

Network Development

CMBHN was established in 2019. The network was created to discuss information and ideas, perform trainings and other activities, collaborate and pool resources, and increase the capacity of each member for the collective benefit to achieve the shared goal of addressing opioid use disorder, substance use disorder, co-occurring disorders, and the impact they have on the people who have them and the communities they live in. CMBHN meets monthly to convene and address issues related to completing all required items for the grant.

One challenge the network faced was staffing and a high rate of turnover within the organizations. The members of the network were able to convene at a monthly meeting to share best practices from all organizations to help with recruitment and retention. An executive committee was formed to address the

pertinent items of the grant to bring more relevant items to the larger group for discussion. This helped to streamline the discussions with the larger group to make the meetings more efficient and effective. Next steps for network development include evaluating the size and engagement level of current network partners to determine if restructuring is the best course of action. With several coalition partners involved, it may be best for the network to consist of a few core members with key stakeholders. This would allow for increased engagement among network partners and support network sustainability.

Programmatic Development

Network members have enhanced community and partner relationships; promoted engagement and participation in the network; and collectively planned for substance use prevention, treatment, and recovery. The network has worked diligently to significantly reduce the gap that strongly affects the capacity to respond to prevention, treatment, and long-term recovery needs related to emotional and mental health, co-occurring disorders, opioid use disorder, and substance use disorder. They are working toward close collaboration among network members from various organizations, including colocated services in the same location, where, for example, a colocated partner then refers to other partners. Since the award of this grant, Burrell Behavioral Health developed a shared-space project with Powerhouse Community Development Corporation. This shared-space project allows for a centralized location for Burrell employees to have office space so more services can be administered in the community. Various other organizations within the network are also discussing shared-space projects to further the services and collaboration with partners.

Sustainability

The network partners have established themselves as a group and are committed to continuing to collaborate. Each partner has signed a memorandum of understanding. The largest barriers to continuing the network are the need for funding to facilitate the group and staffing to continue meaningful engagement in the network. In the near future, the network will continue to share resources and refer clients to help with funding. In the future, the group plans to create a formal method for ongoing network support, perhaps by formalizing a smaller, core group of organizations to receive and facilitate funds on behalf of a larger group of key stakeholders. The network will continue to provide opioid treatment and treatment for other substance use disorders in rural Missouri communities. The network will (1) integrate behavioral health services (mental health and substance use disorders) in primary care, (2) work to increase the number of prescribers available to provide medication-assisted treatment, (3) integrate care facilitation to coordinate referrals to treatment and recovery programs and to community organizations addressing social determinants of health, and (4) develop pathways for transitions between clinics and other community organizations. These projects will impact individuals living in Saline, Pettis, Morgan, and Cooper counties.

Region Covered by Network Services (County/State)

- Saline, MO
- Pettis, MO
- Morgan, MO
- Cooper, MO

Network Partners

Organization	Location (City, State)	Organization Type
Phoenix House Inc.	Columbia, MO	Social Services Agency
Burrell Behavioral Health	Marshall, MO	Behavioral Health
Katy Trail	Sedalia, MO	Federally Qualified Health Center
Pettis County Public Health Department	Sedalia, MO	Rural Health Center
Cooper County Public Health Department	Booneville, MO	Rural Health Center
Morgan County Public Health Department	Versailles, MO	Rural Health Center
Recovery Lighthouse	Warrensburg, MO	Social Services Agency
West Central Community Action Agency	Versailles, MO	Social Services Agency
Powerhouse Community Development Corp.	Marshall, MO	Social Services Agency

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Southcentral Foundation Rural Health Network

P10RH41770

Project focus area:
Elder Care

Other focus areas:
Network Development

Network Statement

"When we lose an elder, we lose the world." Alaska Native elders are among the most cherished and respected parts of Alaskan communities; indeed, they are foundational to the preservation of culture, traditions, and continued ways of life. Sadly, when an elder passes, their stories and ways of knowing are lost. This can happen when they pass away or when their health and wellness needs become so complex that the only option to ensure they are supported is to move them away from their home and family. In rural Alaska this often means sending the elder to a larger community hundreds of miles away, where they unsurprisingly face mental and emotional deterioration at being displaced, in addition to their physical or medical concerns.

The Southcentral Foundation (SCF) Rural Health Network's Aging in Place initiative has brought together a vast partnership of tribes, clinics, and villages across Alaska to weave an evidence-based model for age-friendly, whole-person care into its robust system of services, resources, and health professionals. The network seeks to develop holistic strategies to improve health service delivery specifically for elders to allow for aging in place. By working together as a network, the communities will share solutions benefiting their elders' unique circumstances, while providing a greater voice and advocacy as a group. By building upon these distinctive customer-driven strengths to meet this challenge, the network and its member communities will honor our elders and ensure the culture and stories they embody will be gifted forever to the places they call home.

Network Development

SCF provides health care and related services to a vast geographic area of Alaska. Many of the foundation's customer-owners live in villages that are accessible only by air or boat. Developing relationships with these communities and the tribes that support them over a span of years is often the best and only way to ensure continued or expanding services for the people who live there. This network of communities has been evolving for over 20 years; the formalizing of the Rural Health Network relied upon the relationship-building of those many years.

When the opportunity to utilize the Rural Health Network for proactive health care presented itself, the then-interim CEO of SCF addressed the tribal and community leaders and tribal health councils of each of the partner villages. Each of those communities then worked with the foundation's Executive and Tribal Services division to come to agreement on the specific activities the network would be supporting. The written form of this agreement became the letters of commitment each tribal entity provided to SCF, formalizing their support for the efforts and acknowledging SCF as the leader in these efforts.

Challenges in this phase included the necessary time spent on each village and tribe; a single community could potentially present two to six entities to engage individually before coming to consensus. Being respectful and taking as much time as each entity required allowed SCF to ensure relationships were not just maintained but strengthened. Another challenge was the loss of a key project employee who passed suddenly in the early stages of the work. The position vacated was pivotal to the logistics of the project. To address these challenges, the project stakeholders realized that additional resources and more direct communication would be required. Two of SCF's vice presidents were engaged and approved the allocation of the needed resources, which included an additional project coordinator and the innovative delegation of the rural health clinic managers as direct proxies for the network members. Utilization of the rural health clinic managers has allowed for more timely decision-making, which included rearranged assignments for project staff in order to meet grant objectives within set timelines.

Programmatic Development

Caring for elders and aging-in-place concerns have been identified by each Rural Health Network community and at their respective tribal health councils, which advise on the operations of SCF's community health centers. Developing strategies to improve health service delivery specifically for elders and their individual situations was the impetus to apply the Community Readiness Assessment with all network members. Key respondents in each community were identified by network members, their delegates, and SCF management. These key respondents were invited to a series of scheduled focus groups for their community or region and were questioned by evaluators from the project team on multiple dimensions of information regarding elders and aging in place. The results of these focus groups are being analyzed and summarized.

SCF has recently begun a new initiative to enhance and integrate all service lines with the concepts of the Institute for Healthcare Improvement's 4M Model for Aging Well. This evidence-based model is aimed at creating an age-friendly health system and encompasses four areas that are directly linked to better health outcomes for elders: what matters, medication, mentation, and mobility. Many 4M informational handouts have already been culturally adapted, and specific ones have been created for different clinic locations, outlining the Trail Map to Wellness as the network's customer-owners get older.

A major challenge was low participation; there was no assurance there would be representation from each community or from each sector of the community. Addressing the communications for network members through delegation to the rural health clinic managers allowed the project team to respond quickly to grant activities and Rural Health Network concerns.

Sustainability

The Rural Health Network will continue to function beyond this grant as it has for the last 10 years with continuing guidance from SCF and input from tribal leaders and community customer-owners. Managers of the rural health clinics will continue to build relationships with local partners, increasing staffing as allowed and expanding services when invited, while working toward addressing the individual situations of elders in their villages. Service lines for elders aging in place will be sustained though integration of the Institute for Healthcare Improvement 4M model into all primary care services in addition to action items identified by the Community Readiness Assessment focus groups that will be carried out through rural leadership and potential future funding sources.

Region Covered by Network Services (County/State)

- Anchorage Borough, AK
- Matanuska-Susitna Borough, AK

*Alaska does not have counties. As a community health care provider, SCF's network services cover all Alaska Native and American Indian people across the state.

Network Partners

Organization	Location (City, State)	Organization Type
Aleut Community of St. Paul Island	St. Paul Island, AK	Alaska Native Tribe
Pedro Bay Village Council	Pedro Bay, AK	Alaska Native Tribe
Igiugig Village Council	Igiugig, AK	Alaska Native Tribe
Kokhanok Village Council	Kokhanok, AK	Alaska Native Tribe
Chickaloon Village Traditional Council	Chickaloon, AK	Alaska Native Tribe
Native Village of Tyonek	Tyonek, AK	Alaska Native Tribe
Newhalen Tribal Council	Newhalen, AK	Alaska Native Tribe
Nikolai Edzeno' Village Council	Nikolai, AK	Alaska Native Tribe
Nondalton Tribal Council	Nondalton, AK	Alaska Native Tribe
Port Alsworth Improvement Corporation	Port Alsworth, AK	Alaska Native Tribe
Takotna Tribal Council	Takotna, AK	Alaska Native Tribe

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Southern Tier Rural Integrated Performing Provider System Inc.

Chenango & Delaware County Behavioral Health Network

P1041771

Project focus area:
Population Health/
Social Determinants of Health

Other focus areas:
Behavioral Health,
Child Health,
Elder Care,
Substance Abuse/Addiction

Network Statement

For service providers, the ability to support individuals experiencing a behavioral health crisis is critical to achieving a healthy, sustainable system of care. Each day, community members encounter barriers to accessing the care and services they need, including agency hours that are limited by workforce availability, regulatory considerations that limit the coordination of patient care, and social determinants, such as food insecurity and homelessness. Further, service providers are challenged to meet the growing demand for services, leaving them even less equipped to provide the needed support. As stated by the National Alliance on Mental Illness, timely access to behavioral health services “leads to better outcomes,” and early treatment for behavioral health needs “may also lessen long-term disability and prevent years of suffering.”

Partners of the Chenango & Delaware County Behavioral Health Network (CDCBHN) have come together to build a sustainable, collaborative behavioral health care model for the community. The network is committed to implementing promising practices and evidence-based solutions that will help reduce barriers to care. Since inception, the cross-sector network has been leveraged to establish a strategic planning committee focused on the creation and implementation of solutions related to behavioral health crisis response, education, prevention, and community-based supports and services. Network partners envision CDCBHN as a convener of community stakeholders, where behavioral health initiatives come together to align, integrate, and grow. The goal is to create a united system of care in which service providers are empowered to meet the needs of the community, with a no-wrong-door safety net system. As the network continues to build and implement a strategic road map, CDCBHN invites others to join in creating meaningful and sustainable solutions for this generation and beyond.

Network Development

CDCBHN partners worked to formalize as an integrated behavioral health network during the grant performance period. In July 2021, the network created a project team (including the project director and a project champion from each rural county) to plan partner meeting agendas and navigate grant deliverables. Next, partners established a regular collaborative meeting to collectively work on building network capacity and define programmatic initiatives. Through these meetings, CDCBHN partners created a network mission, vision, goals, and objectives, and defined the roles and responsibilities for each, which were all formalized in a network charter signed by each of the partners. Next, the network drafted and executed service agreements, purchased service agreements, and created a statement of work for each CDCBHN partner to further formalize each of the respective roles and the commitment to the network. During this process CDCBHN was able to identify, recruit, and onboard three additional partners considered crucial to the improvement of the behavioral health landscape in each county — yielding a total of 10 network partners in two counties at the point of grant closure.

Approximately halfway through the performance period, the network updated the governance structure to incorporate three strategic planning work groups representing key elements of behavioral health landscape transformation. This allowed the network to align each of the partners with their respective expertise and passion, while simultaneously working with other key agencies and community stakeholders to focus on programmatic development. Additionally, the network worked to build adaptive capacity through multiple modes, including regular network meetings; work group meetings; one-on-one conversations; targeted, county-level in-person meetings, and by requesting additional input on programmatic and network development goals through Smartsheet surveys.

Programmatic Development

The programmatic focus of CDCBHN is to expand access to and improve the quality of behavioral health care coordination and crisis intervention services in Chenango and Delaware counties. The network has made significant progress in developing programs and selecting direct services over the planning period. In order to ensure that the programs and services are aligned with the needs of each individual county, CDCBHN partners and other essential county-level stakeholders identified gaps, brainstormed improvement ideas, and prioritized them based on the level of community benefit and ease of implementation. Improvement ideas were then funneled through the action planning process of CDCBHN's strategic planning work groups, where they were researched as evidence-based or promising practice models and broken down into steps for implementation. The process yielded nine total action plans representing programs and direct services to be included in CDCBHN's three-year strategic plan.

In order to prioritize these programs, CDCBHN created a rubric to further define criteria for inclusion and the feasibility for implementation within the three-year cycle. As aligned with the CDCBHN mission, programs and services have been collaboratively selected based on evaluation criteria that indicate the greatest potential for both sustainability within a value-based model of care and contribution to overall system transformation in Chenango and Delaware counties.

Two significant challenges were encountered within the context of programmatic development. First, the network was impacted by workforce shortages (further compounded by the COVID-19 pandemic). This at times pulled network partners away from planning activities. Next, the network found it difficult to plan for cohesive programs and services that could be implemented in both rural counties. While the network had identified that the potential for funding and shared services could be strengthened through cross-county collaboration, they learned that many specific programs and services require tailoring at the county level due to factors such as resource availability, funding, risk tolerance, and political climate. To overcome this challenge, partners worked throughout the planning process to shift the network mindset away from the need to have the same standardized plan in both counties and toward embracing a complementary approach, which allows each county to leverage its own unique opportunities while continuing to solicit input and feedback from a team of dual-county stakeholders.

Sustainability

The vision of CDCBHN is to operate as a collaborative, integrated behavioral health network. CDCBHN is dedicated to identifying and providing solutions for critical gaps in behavioral health care services. They are committed to growing as a cohesive network in a transparent and results-focused manner to consistently address the rapidly evolving dynamics of the rural behavioral health ecosystem in Delaware and Chenango counties. The network's mission over the next three years is to implement its strategic plan and undertake activities needed to localize mobile crisis-response services in both counties, increase cross-sector collaboration and care coordination, develop a sustainable funding model, and wrap around the behavioral health care needs of the rural population.

As aligned with its vision and mission, CDCBHN intends to achieve sustainability through a phased governance model. Initially, CDCBHN will utilize a two-tiered model comprising a strategic planning committee and three strategic planning work groups (Prevention/Education, Acute Intervention, and Community-based Supports & Services), with the county-level project champions fulfilling the administrative components of meeting facilitation and oversight of strategic plan implementation. As the network evolves in years 2-3 of the strategic plan, the intention is to grow network membership and embrace a three-tiered governance model where a steering committee will be introduced to fulfill administrative roles and responsibilities. At this time, CDCBHN will continue to fulfill governance roles on a voluntary basis, and the programs and services outlined in its strategic plan will be managed through a network partner agency designated as the "lead" for that program or service, with the collective support of CDCBHN. While no network-driven programs or services were implemented or administered during the planning performance period, the focus on programmatic implementation is intended to start in July 2022.

Region Covered by Network Services (County/State)

- Chenango County, NY
- Delaware County, NY

Network Partners

Organization	Location (City, State)	Organization Type
Care Compass Network	Binghamton, NY	Nonprofit
Chenango County Behavioral Health Services	Norwich, NY	Behavioral Health
Chenango Memorial Hospital	Norwich, NY	Hospital
Catholic Charities of Chenango County	Norwich, NY	Social Services Agency
Chenango Health Network	Norwich, NY	Public Health
Delaware County Behavioral Health Services	Walton, NY	Behavioral Health
Delaware Opportunities	Hamden, NY	Social Services Agency
Liberty Resources Help Restore Hope Center	Norwich, NY	Nonprofit
Norwich Police Department	Norwich, NY	Law Enforcement
The Neighborhood Center	Utica, NY	Behavioral Health

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South Central Missouri Community Health Center d/b/a Four Rivers Community Health Center

Meeting Outcomes for Moms with Support

P10RH41769

Project focus area:
Maternal Health

Other focus areas:
Care Coordination, Network Development, Population Health/ Social Determinants of Health, Substance Abuse

Network Statement

It is not widely known in the South Central Missouri region how the lack of clean diapers is harmful to families. Known as "diaper poverty," the lack of diapers greatly impacts family self-sufficiency. Without a consistent supply of clean diapers, children cannot access traditional day care, which interferes with parents' ability to stay in the workforce. Without employment, the family encounters other barriers to care and self-sufficiency. Diaper poverty is just one example that illustrates the need for increased access to nonjudgmental, integrated services and supports to meet maternal health needs. Meeting Outcomes for Moms with Support (MOMS) can make a difference by identifying resources to address diaper poverty and many other more complex maternal health issues.

The MOMS Network is a group of local leaders dedicated to improving maternal health care. The network's desire is for every mother in the five-county region of South Central Missouri to receive the health care she needs for herself and her baby before and after delivery. The network members are partnering to improve maternal health care for rural underserved residents by addressing gaps in access to care and treatment using evidence-based models and tools. MOMS is an open forum for anyone interested in maternal health and welcomes participation in its most important work — our future generation. As momentum grows and more collaborators join the network, the partners seek to create a positive impact for moms and babies in the region.

Network Development

The MOMS network has solidified its core partners and has conducted an environmental scan and an organizational assessment and is finalizing a strategic plan to help identify priorities for action in the

future. Network goals at the outset of the planning grant focused on program planning and organizational development. Related to program planning, goals were to develop a plan for improving access to comprehensive, coordinated, high-quality maternal health care in the five-county region through a pregnancy medical home model and to improve collaboration around technology, training, and integrated service delivery using evidence-based models and practices to improve the quality of maternal health services in the region. MOMS has been successful in its program planning, working toward completion of an approved strategic plan that will direct future efforts toward implementation of evidence-based best practices and provision of comprehensive coordinated maternal health care. Goals related to organization development were to establish or strengthen relationships and partnerships to address gaps in maternal health and substance use disorder services for the maternal health population in the region and to develop a plan for the financial sustainability of the MOMS Network and services. The first goal was met by assessing maternal health needs and models of care and strengthening the relationship with the local hospital, Phelps Health, to develop a plan for addressing maternal health care gaps in the region. Planning for sustainability is an ongoing effort that will require additional resources for meeting future maternal health needs in the community.

The network's biggest challenge has been staying focused on planning rather than implementation. To address this challenge, there was continued emphasis on strategic planning and reminders that implementation would follow plan development once consensus on a strategic plan is achieved.

While not specifically an innovation, the network found it helpful to hear from others with patient-centered models of care. This provided network members an opportunity to explore different models, identify and understand challenges that might be encountered, and establish relationships with others who could assist with implementation when resources become available.

Programmatic Development

The primary focus of the planning year was to assess strengths, resources, and gaps in care and identify ways to achieve efficiencies through network collaboration and resource sharing. Network members were able to strengthen relationships and to fully understand the services currently provided to ensure mothers receive access to available resources. One resource that was identified as lacking is access to diapers, which network members have been able to begin addressing collectively without a new injection of resources. The greatest challenge has been around the lack of awareness of local resources that address maternal health gaps and how these gaps have a broader impact. As an example, diaper poverty contributes to barriers to employment. By investing in resources early to ensure moms have adequate supplies of diapers, their children can them be enrolled in child care, which allows the mother to seek or maintain employment.

No specific innovations were identified. However, as a result of information-sharing and learning during the assessment and planning process, network partners developed a stronger commitment to addressing maternal health gaps.

Sustainability

The MOMS Network is a volunteer network comprising organizations with a strong interest in maternal health. The strategic plan and corresponding priorities that have been identified will be the focus of future network meetings. The members will seek resources, internally (e.g., program revenue) and externally, to support identified gaps and will continue to seek participation of other local and regional entities that may have resources that could be leveraged (e.g., workforce investment boards, local public health agencies, day cares providers, etc.) to help sustain ongoing planning and development efforts.

Region Covered by Network Services (County/State)

- Phelps County, MO
- Maries County, MO
- Crawford County, MO
- Dent County, MO
- Pulaski County, MO

Network Partners

Organization	Location (City, State)	Organization Type
South Central Community Health Center d/b/a Four Rivers Community Health Center (previously Your Community Health Center)	Rolla, MO	Federally Qualified Health Center
Crawford County Health Department	Steelville, MO	Public Health
Dent County Health Department	Salem, MO	Public Health
Maries/Phelps County Health Department	Rolla, MO	Public Health
Phelps Health	Rolla, MO	Hospital

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Montana

St. Vincent Healthcare

Eastern Montana/ Central Wyoming Integrated Rural Network for Maternal Fetal Medicine

P10RH41772

Project focus area:
Maternal Health

Other focus areas:
Network Development, Telehealth

Network Statement

The health of mothers and newborns is an important indicator of the well-being of the community as a whole. Unfortunately, the pregnant women living in rural Montana and Wyoming are at higher risk for premature birth and maternal complications. Partners of the Eastern Montana/Central Wyoming Integrated Rural Network for Maternal Fetal Medicine came together in 2021 to identify and develop strategies to increase health equity in maternity care by overcoming barriers such as distance and transportation. Momentum for this work is growing and includes leveraging telehealth for maternal fetal medicine, education of obstetric sonographers, and the development of a shared prenatal care model between local and delivering providers for normal-risk and high-risk patients. The network is excited about its ability to bring perinatal providers together to provide seamless and safe prenatal care for all pregnant women in our local communities.

Network Development

The network's commitment to improving access to care for pregnant women in their communities has remained high throughout this work. Creation of a mission and vision statement, completion of community assessments and site assessments, and completion of the SWOT (strengths, weaknesses, opportunities, and threats) analysis all confirmed the need to increase access to obstetric specialty services and collaboration in the care of high-risk obstetric women. Leveraging expertise, knowledge, and resources was identified as important in order to achieve success. Access to maternal and fetal medicine is challenging due to distance and transportation, particularly for American Indian women living on the reservations. Each member completed a telehealth site assessment that examined readiness to contract for maternal and fetal medicine telehealth services. Telehealth contract templates have been created, and each member has identified contracting

processes for their sites. An assessment of obstetric ultrasound services and trained sonographers was also completed, but no further work or planning in this area has been completed.

The network has been challenged with engaging network members in completing some tasks outside of scheduled meetings. This is not for lack of desire or value of the work but due to members' response to the COVID-19 pandemic, busy schedules, and competing priorities. The network is struggling with moving from collaboration to a formal network structure and seeing this as a long-term solution to help each community achieve improved maternal and neonatal outcomes. Although there has been progress in achieving strategic priorities, not every member can make decisions and commitment on behalf of their organization, particularly the Indian Health Service and tribal partners. For the network to grow and move into sustainability, each member will need to find some way to build capacity to fully engage in the network and identify strategies to advance toward improving maternal and neonatal outcomes. Formalization of the network and identifying roles and responsibilities are important if the network is going to be sustainable and truly improve the desired outcomes.

Programmatic Development

Increasing access to maternal fetal medicine services was identified as the top strategic priority. The network spent time developing drafted contracts for telehealth services, understanding equipment needs, credentialing processes, and so on. Two of the five partners have moved forward with contracting for telehealth services. Others are federal entities and have draft contracts but are challenged with advancing through contracting processes. An assessment of obstetric ultrasound services and trained sonographers was also completed, but no further work or planning in this area has been completed.

The network identified a need to build a shared model for the delivery of prenatal care and coordination with the delivering providers. This is an innovative model that came as a result of local prenatal providers and delivering providers listening to each other, hearing concerns and challenges, and, as a result, drafting shared models of care for both normal-risk and high-risk pregnant patients, identifying how they can better coordinate and together manage care of patients. The shared models include frequency of prenatal visits, antenatal testing, ultrasound, and criteria for co-management or transfer of care. Care coordinators have increased collaboration for women across communities.

The fact that many of the network members provide care to a broader population than just pregnant women means their primary jobs are busy and complicated by multiple other responsibilities. This makes it challenging for them to carve out time for network-related work, review information, complete assignments, and the like, between network meetings.

Sustainability

St. Vincent Healthcare requested a no-cost extension for an additional 12 months to continue to advance the work of this network, including engaging members in further understanding of the long-term benefits of formalization of this network. Formalization will need to include finalizing bylaws, roles, and responsibilities.

Additional time will allow for the other network members to work through contracting processes for telehealth maternal and fetal medicine services. Forming a plan to expand obstetric sonography resources will also require focused attention and action in order to bring these services into more rural areas. There are additional clinics and hospitals that are interested in this work, and bringing others into the network will increase the scale of efforts and ability to improve desired maternal outcomes. There is also potential for the network to align with the Montana Perinatal Quality Improvement Collaborative and the state's Montana Obstetrics & Maternal Support program for support in advancing the network toward improving outcomes in this part of the state.

Region Covered by Network Services (County/State)

- Richland County, MT
- Big Horn County, MT
- Roosevelt County, MT
- Treasure County, MT
- McCone County, MT

Network Partners

Organization	Location (City, State)	Organization Type
St. Vincent Healthcare	Billings, MT	Hospital
One Health Bighorn	Hardin, MT	Federally Qualified Health Center
Sidney Health Center	Sidney, MT	Hospital
IHS Crow/Northern Cheyenne Hospital	Crow Agency, MT	Tribal Health Clinic
IHS Northern Cheyenne Service Unit	Lame Deer, MT	Tribal Health Clinic
Wind River Family and Community Health Center	Arapahoe, WY	Tribal Health Clinic

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Sullivan 180 Inc.

Sullivan Hands4Health Network

P10RH41773

Project focus area:
Network Development

Other focus areas:
Chronic Disease Management,
Community Health Workers,
Increase Health Systems Efficiencies,
Population Health/
Social Determinants of Health

Network Statement

Sullivan County, N.Y., is a beautiful place to live, filled with forests, waterways, mountains, and wildlife. There are many ways to enjoy outdoor exercise opportunities. It is a prime spot where people visit to enjoy glorious fall foliage. Residents of the county have a right to fully enjoy all of this in good health.

Yet, because of an array of social conditions, too many Sullivan County residents affected by chronic diseases such as hypertension, heart disease, diabetes, or chronic lung disease stay unwell and experience repeated hospital or emergency department visits. These repeated health crises not only affect individual quality of life, they also negatively impact the local economy through lower work productivity and affect the health system stability by increasing costs and decreasing capacity. In addition, since 2020, people suffering with chronic disease and impacted by poverty have had much higher rates of death and disability from COVID-19, further destabilizing local health care systems.

As solution-minded health and human service partners, health stakeholders in the region convened the Sullivan County Hands4Health Network to plan and develop a community health worker system in Sullivan County to address this issue. Multiple studies have proven that community health workers provide a cost-effective strategy to support vulnerable residents and keep them connected with health and social support systems, preventing hospitalizations and emergency department visits, and improving length and quality of life. The Sullivan Hands4Health Network believes in equalizing the playing field for all Sullivan County residents, regardless of income, race, nationality of origin, gender identity, or disability.

Network Development

Upon receipt of the Network Planning grant, five partners representing organizations within the health sector convened. Partners included Sullivan 180 Inc., the lead agency for the grant and a nonprofit dedicated to improving the county's health rankings; Garnet – Catskills Medical Center (Sullivan County's only hospital system); Sun River Health Care, a Federally Qualified Health Center; Sullivan County Public Health Services, the public health department, which also has a certified home health agency; and Maternal Infant Services Network (MISN), a regional perinatal network that has a maternal health community health worker component in Sullivan County. To be strategic about adding additional members, a policy and procedure was developed for bringing in new member organizations that requires new member organizations to sign memoranda of understanding. Three organizations subsequently were recruited and joined as the network felt they were critical to its work. New members included two nonprofits: one serving a wide range of people with disabilities and social determinants of health challenges and a county extension of Cornell University that identifies and confronts food deserts and provides a local food pantry on wheels. In addition, Cornell University assisted with focus groups, key informant interviews, and surveys. The third additional member is a primary and urgent care center with five county locations that is affiliated with, but run completely independently from, the hospital system. Network bylaws have been developed in draft form, pending finalization.

Challenges have been related to infrastructure and workforce issues for many of the member organizations, often related to COVID and the "great resignation." Because email communications are not always read and responded to in a timely fashion, finding alternative ways to communicate to ensure continued participation has been useful. Examples of alternative communication strategies include follow-up to email requests for participation and input, Doodle polls, SurveyMonkey questionnaires, individual or "pop-up" phone calls, use of smaller groups to work on specific projects, and providing a Zoom option for meetings. Once members were convened virtually or in person (and often a hybrid of both), the participation and group energy were dynamic, creative, and committed. After a period of extended virtual-only meetings because of winter and a COVID-19 uptick, people were brought back together and warmly encouraged to attend, with the hosting agency providing healthy and delicious refreshments and in-person human connection as an incentive.

Programmatic Development

The Sullivan Hands4Health Network was created to plan a sustainable community health worker program for Sullivan County residents dually affected by chronic disease and social determinants of health challenges. The key objective was to identify the best model that could serve affected county residents and also function in a variety of settings, not limited to only one venue and not limited to health care settings. The intention was that a community health worker could successfully serve an individual without that person having to change their health care or social support provider. After interviews and presentations representing a variety of programs and program models, the network decided on the Pathways Community Hub (PCH) model, as it meets all these requirements. An important achievement was the collection of qualitative data and research with the community in a way that had not previously occurred. Several key informant interviews and focus groups were conducted to compile information from residents severely impacted by social determinants of health and the providers who serve them. In addition, about 2,000 county residents, half of whom identified as Latin, answered a survey that asked them about their physical and social environment, their ability to access

health and dental care, their perceptions of how they were treated while receiving care, and other questions specifically relevant to areas that could be impacted if the envisioned community health worker program were available. This included information from residents who were undocumented. This information was shared countywide, which was very helpful to many organizations that provide services to county residents. The information also contributed to the public health system's community health assessment.

During the one-year planning grant period, it was discovered that a regional organization, Hudson Valley Collective for Community Wellness (HVCCW), had taken very preliminary steps intending to eventually join in the creation of a PCH to serve this large, seven-county geographic area, early in 2019. Since the region includes Sullivan County, the network has agreed to support this effort however it can. Completing the measures to establish and participate in the Hub will take some time and will also involve a significant funding source for at least two years until the model becomes self-sustaining. In the meantime, Sullivan Hands4Health Network's focus will be on bringing additional partners into the network and encouraging partners and other clinical and community-based organizations serving residents with social determinants of health issues to move toward certification as Pathways agencies. Additionally, the network will identify other ways to support the creation of community health worker or care coordination positions within organizations through education and advocacy.

Challenges during programmatic development were related to communication, specifically when the network learned late in the grant year of HVCCW's effort (see above). The approach to this challenge was to convene a work group to specifically address how to go forward in support of, and not in competition with, this effort to create a regional PCH. Key stakeholders from HVCCW as well as other volunteers from the network have been participating. This has been very effective and has successfully fostered teamwork to plan collaborative actions and has eliminated concerns about competition. Other challenges were related to organizational transfers or resignations of key partners involved in the network, which necessitated bringing in new people late in the game. The network's project director reached out to new members to orient them and bring them up to speed.

Sustainability

After the Network Planning Grant ends, and while new and diverse funding from other sources is explored and secured, the network will continue to convene through shared governance by the network partners. Each partner has agreed to host meetings and chair on a rotating basis. In-kind services, including meeting facilities and information technology services, printing and copying, and in-house staff to support the work, will continue. Bylaws have been drafted for adoption, and a renewed memorandum of understanding will be signed by each partner agency. Through continued efforts of network partners to seek grant and philanthropic funding, including committing competent and experienced fundraising staff, the plan will be to hire a network director.

As alluded to in the section "Programmatic Development," particularly important going forward will be outreach to organizations to encourage them to apply for certification as a Pathways agency with the Pathways Community Hub Institute. Agencies working toward this certification will create a pool of like-minded organizations with shared standards and goals that will all have a stake in being part of this network.

Region Covered by Network Services (County/State)

- Sullivan County, NY

Network Partners

Organization	Location (City, State)	Organization Type
Sullivan 180 Inc.	Liberty, NY	Nonprofit
Sullivan County Public Health Services	Liberty, NY	Public Health
Garnet Health Medical Center – Catskills	Harris, NY	Hospital
Sun River Health	Monticello, NY	Federally Qualified Health Center
Maternal Infant Services Network	Newburgh, NY	Nonprofit
Cornell Cooperative Extension of Sullivan County	Liberty, NY	Nonprofit
Action Toward Independence (ATI)	Monticello, NY	Nonprofit
Garnet Health – Doctors	5 locations in Sullivan County, NY	Physicians' Clinic

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West Hawai'i Community Health Center

Hawai'i Island Health-Justice Collaborative

P10RH41774

Project focus area:
Justice-Involved Population

Other focus areas:
Behavioral Health, Care Coordination

Network Statement

On the island of Hawai'i, all of the population's health is connected. Every day, though, members of the local communities find themselves entangled in the justice system because of their unmet health needs. This stresses the justice system, health providers, and families. The Hawai'i Island Health-Justice Collaborative knows that more can be done. The network's dedication to communities means that a better way forward can be forged, together. The network envisions a future that does not preclude caring for friends and family engaged in the justice system.

The health care, justice system, and social service agency partners are committed to improving care for those who are justice-involved. Through coordinating appropriate health care services, both during and after incarceration, the partners can provide the supports necessary to avoid reincarceration. By ensuring that people are enrolled in Medicaid before they are released from incarceration and that they can meet with providers as soon as possible after release, the network hopes to stop the cycling in and out of the justice system. By sharing the burden with our brothers and sisters in the justice system, a more equitable system can be built for all.

The collaborative is changing the way the community talks about justice involvement on Hawai'i Island by demonstrating that people with unmet mental health and substance use needs can be better supported in the community rather than in jail. The network believes that by working together, a more just island that creates a better life for us, our children, and our communities can be made.

Network Development

Because it is the most remote population center in the United States, Hawai'i Island has always been a place that focuses on close collaboration among partners. As such, formal partnerships are often less useful than the day-to-day partnerships that already exist. At the start of the Rural Health Network Planning Program grant period, West Hawai'i Community Health Center and Bay Clinic were two separate Federally Qualified Health Centers (FQHCs), and now they are in the process of merging to become one FQHC. In order to build a focus on the justice-involved population into clinic practices in the future, justice-involved people will be a target population for the newly merged FQHC. This will allow for continued focus on the needs of this population.

The work to develop the network is not done. Each month, partners participate with a consortium called Going Home Hawai'i that was created to focus on the variety of needs that justice-involved populations face. Community Oriented Correctional Health Services (COCHS) is a member of their executive committee, and individuals from Bay Clinic chair their Health & Wellness subcommittee. By integrating members of the collaborative into consortia in the community, delivery of services can be improved and alignment of network goals with other community partners that focus on employment, housing, and other critical needs of people returning from incarceration can continue.

Getting buy-in from state agencies is always a challenge, and the network has faced bumps in the road with bringing in new state agencies as partners. However, through community relationships, the network has been asked to participate in meetings with the Department of Human Services and the Department of Public Safety. While moving the state along will remain a challenge, the network partners use each available opportunity to communicate with additional partners and share its vision of where this effort could go with the state's support.

Programmatic Development

A key programmatic goal has been to improve access to Medicaid and streamline Medicaid determinations for people leaving the justice system. To accomplish this, partners have worked with United Healthcare, a major payer in Hawai'i, on improving Medicaid eligibility. Ideally, every individual will be enrolled in Medicaid before they leave jail. Unfortunately, that would require a lot of collaboration with the state, as COVID-19 has reduced the number of programs that can exist in the jail. In this environment, United Healthcare only will be providing some Medicaid education as people leave incarceration. The hope is that this education process will pay off once Kumukahi Health & Wellness begins enrolling people in the jails.

The hope is that once enough people are enrolled as they leave the jail that the FQHC partners on the outside will have reserved spaces for people within a week of jail discharge. Ensuring access to care as quickly as possible upon release will help them avoid missing important medications and will also help the clinics connect more people with access to substance use treatment opportunities.

Creating a system for justice-involved populations is a challenge due to long-standing barriers in the Medicaid system that preclude Medicaid funding for services while an individual is incarcerated. To reduce these challenges, the network is exploring opportunities through Medicaid 1115 waiver authority that can adjust when an individual can begin receiving Medicaid services. This is a heavy lift that requires state support, but it is something the network is excited to continue exploring after this grant.

Sustainability

Because justice-involved populations are a target population, more funds will be focused on programming for that population at the soon-to-be-merged health centers of West Community Health Center and Bay Clinic. Beyond that, the network will continue to work with partners at the Going Home Hawai'i consortium to identify opportunities to approach philanthropies that are interested in improving care for justice-involved populations.

The network has applied for continuing behavioral health grants to support this work. In addition to the work connecting to philanthropy, the network is also looking to work with the state to ensure the Medicaid program can support this endeavor. Targeting state policies to improve access to care and reimbursement for services for justice-involved populations will allow for the establishment of new FQHC workflows and be reimbursed. This is an important step for ensuring long-term sustainability. In addition, the continued partnership with COCHS will support this work.

Region Covered by Network Services (County/State)

- Hawai'i County, HI

Network Partners

Organization	Location (City, State)	Organization Type
West Hawai'i Community Health Center	Kailua-Kona, HI	Federally Qualified Health Center
Bay Clinic	Hilo, HI	Federally Qualified Health Center
Kumukahi Health and Wellness	Hilo and Kailua-Kona, HI	Nonprofit
Going Home Hawai'i	Hilo and Kailua-Kona, HI	Nonprofit
Community Oriented Correctional Health Services	Walnut Creek, CA	Nonprofit

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Winnebago Comprehensive Healthcare System

Winnebago Public Health Department –Behavioral Health Northeast Nebraska Native Alcohol/Substance Abuse Network

P10HR41775

Project focus area:
Substance Abuse/Addiction

Other focus areas:
Behavioral Health,
Care Coordination,
Increase Health System Efficiencies,
Quality Improvement

Network Statement

The Native American people in the northeastern region of Nebraska and western portions of Iowa comprise a very close-knit and connected community. However, alcohol and substance abuse are evident within this community and pose a threat to the health and well-being of the tribal members. An individual's mental health is a significant factor in their level of happiness, success, and overall well-being. The abuse of alcohol and other substances negatively impacts a person's mental health as well as their family relationships, their work performance, their community, and their entire circle of influence. Alcohol and substance abuse are major risk factors for both acute and chronic health issues.

The Northeast Nebraska Native Alcohol/Substance Abuse Network (NENNASAN) was created to address these urgent issues. Network partners recognize that basic health care includes having access to both alcohol and substance abuse treatment services as well as mental and behavioral health treatment services. All the network partners are established in the local communities with many years of service history to the local Native American population to help bring health, healing, and growth through mental and behavioral health therapies and treatment services. However, broader treatment services for alcohol and substance use disorders in this rural area are greatly needed. By working together, partners intend to more efficiently refer clients within the network organizations. The network's combined efforts to combat health issues will positively impact individuals' mental health, family bonds, and overall community well-being.

Network Development

The initial five partners of NENNASAN included two tribal alcohol programs, two tribal behavioral health facilities, and an Indian Health Service drug dependency unit. Since the beginning of the grant cycle, several supporting partners have been added, including a halfway house, an inpatient mental and behavioral health facility for adults and adolescents, and two outpatient mental and behavioral health organizations. All the network partners work either directly or indirectly with the Native American community in this region. Most partners have a prior history that established a foundation on which to build the partner relationships for the network. Partners have come together to focus on the common goal of providing treatment as well as mental and behavioral health services to the Native American community in the region.

Programmatic Development

At this time, the network is still very new, and relationships between partners are still being solidified. The focus is on engaging all network partners in strategic planning and goal setting. The environmental scan and network organizational assessment will point the network to the future direction. The ultimate objective is to provide mental and behavioral health services to address the alcohol and substance abuse issues in the Native American community in the geographic region.

Partners have been very forthcoming with information sharing within the network. A database of each organization's contact information, treatment services, inpatient capacity, and general referral information has been created and shared among partners. This information will be updated as partners are added and as individual organization capacities or services change.

A training on cultural awareness and historical and generational trauma was offered and very well received and attended by several staff from each of the network members. This training helped to spotlight the issue as well as the needs of the target population. There are many organizations within the network that do not have this type of experience, expertise, or training. At least one additional training is being planned for the network partners in the coming months. It is hoped that these trainings will strengthen relationships and help the network move forward toward its common goal of providing mental and behavioral health services to the Native American community.

Sustainability

NENNASAN will continue to grow by building and strengthening relationships between current partners. It will also extend the reach of the network by adding partners who share the goal of addressing alcohol and substance abuse issues within the Native American community in this region.

The network will seek additional funding sources to keep the project coordinator employed to keep the network intact and moving forward. Partners will continue with the monthly meetings in order to strengthen relationships and grow the network.

Region Covered by Network Services (County/State)

- Thurston County, NE
- Dakota County, NE
- Woodbury County, IA

Network Partners

Organization	Location (City, State)	Organization Type
Winnebago Comprehensive Healthcare System	Winnebago, NE	Tribal Health Clinic
Carl T. Curtis Behavioral Health Clinic	Macy, NE	Tribal Health Clinic
Omaha Alcohol Program	Macy, NE	Tribal Health Clinic
Winnebago Alcohol Program	Macy, NE	Tribal Health Clinic
IHS Great Plains Area Regional Drug Dependency Unit	Winnebago, NE	Tribal Health Clinic
Rosecrance Jackson Centers	Sioux City, IA	Behavioral Health
Frank LaMere Hope Street of Siouxland	Sioux City, IA	Behavioral Health
Heartland Counseling Services	South Sioux City, NE	Behavioral Health

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