Rural Health Network Development Planning Program

2022 Grantee Directory

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

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Background

Access to health care is limited in many rural areas in the United States. Challenges to access include higher levels of poverty and lower rates of insurance when compared to more urban areas, health care workforce limitations, and long distances to care. In addition, rural Americans have generally poorer health outcomes compared to their urban counterparts and higher rates of avoidable or excess mortality from some of the leading causes of death (cancer, heart disease, injury, and respiratory disease).[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. As the U.S. health care payers and key stakeholders seek to achieve better population outcomes and cost reductions through a shift toward value-based payment, the need for strong networks has become even more apparent.[2]

The Federal Office of Rural Health Policy's Rural Health Network Development Planning Program brings together key parts of a rural health care delivery system, particularly to establish and improve local capacity and coordination of care. The Network Development Planning Program promotes the planning and development of health care networks 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 program supports one year of planning with the primary goal of networks creating a foundation for their infrastructure and focusing member efforts to address important regional or local community health needs.

The funded partnerships use their planning year for two purposes:

- **Program planning**, to assess and more fully understand the gaps and the unmet health needs in their communities and within their health care systems, and explore best practices and strategies to address unmet needs
- **Infrastructure development**, to explore leadership, governance, policies, and procedures that will support a sustainable rural health network

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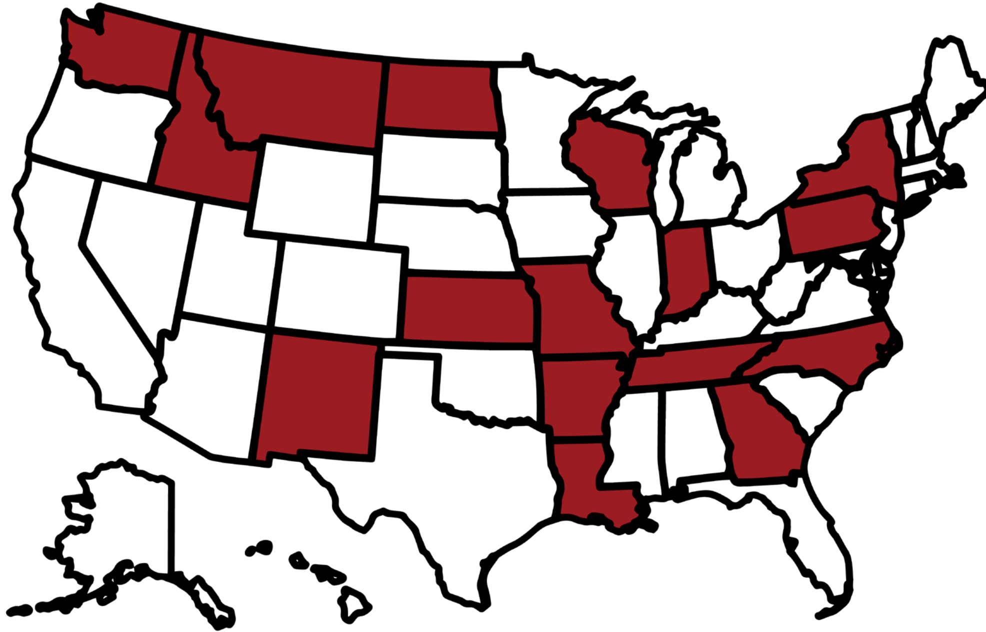
[1] Moy E., Garcia MC., Bastian B., et al. (2017). Leading Causes of Death in Nonmetropolitan and Metropolitan Areas — United States, 1999– 2014. *MMWR Surveillance Summary 2017*. Available at: https://www.cdc.gov/mmwr/volumes/66/ss/ss6601a1.htm

[2] Henning-Smith, C., and Story-Tuttle, M. (2021). Evaluating the Rural Health Network Development Planning Program. University of Minnesota Rural Health Research Center. October, 2021. Available at: https://www.ruralhealthresearch.org/projects/100002508

Cohort Snapshot

With funding provided by the fiscal year 2022 Rural Health Network Development Planning Program, 23 grantees in 16 states are addressing these challenges by bringing together a broad range of partners to form rural health networks.



Grantees by Organization Type

Lead organizations include a range of health care providers and other health-related organizations.

Organization Type	Grant Organization
Acute Care Hospital	UPMC Kane
Critical Access Hospital	Bingham Healthcare St. Clare Memorial Hospital Sullivan County Memorial Hospital
Hospital	Citizens Memorial Hospital Garnet Health Medical Center–Catskills Good Samaritan Hospital Union Hospital Inc. Westchester-Ellenville Hospital

Organization Type	Grant Organization
Nonprofit Organization	Arkansas Behavioral Health Integration Network Cornerstone Whole Healthcare Organization Foundation for Health Leadership & Innovation Inc. Hope for a Drug Free Stephens Corp. Indiana Rural Health Association Jamie's Place Louisiana Rural Health Association Missouri Alliance of YMCAs North Country Healthy Heart Network Rural Health Association of Tennessee Thrive Allen County
Public Health Department	Rio Arriba County
University	University of Montana University of North Dakota

Grantees by Primary Focus Area

Many funded networks have identified a focus area around which they are conducting their assessment and planning efforts. The table below summarizes the primary focus areas identified by the grantees

Grantee Organization	Cancer Care	Care Coordination	Chronic Disease Prevention/Management	Health Equity	Health Information Technology	Health System Efficiencies	Housing	Integrated Health Services	Mental/Behavioral Health	Network Organization/ Infrastructure Development	Telehealth	Transportation
Arkansas Behavioral Health Integration Network									●			
Bingham Healthcare								●				
Citizens Memorial Hospital								●				
Cornerstone Whole Healthcare Organization				●								
Foundation for Health Leadership & Innovation Inc.										●		
Garnet Health Medical Center–Catskills												●
Good Samaritan Hospital		●										
Hope for a Drug Free Stephens Corp.								●				
Indiana Rural Health Association						●						
Jamie's Place						●						
Louisiana Rural Health Association					●							

Grantee Organization	Cancer Care	Care Coordination	Chronic Disease Prevention/Management	Health Equity	Health Information Technology	Health System Efficiencies	Housing	Integrated Health Services	Mental/Behavioral Health	Network Organization/ Infrastructure Development	Telehealth	Transportation
Missouri Alliance of YMCAs										●		
North Country Healthy Heart Network										●		
Rio Arriba County							●					
Rural Health Association of Tennessee										●		
St. Clare Memorial Hospital											●	
Sullivan County Memorial Hospital										●		
Thrive Allen County									●			
Union Hospital Inc.	●											
University of Montana										●		
University of North Dakota										●		
UPMC Kane			●									
Westchester-Ellenville Hospital												●

Grantee Profiles

This *Directory* provides a description of funded network planning initiatives and network structures, as written and submitted by the individual grantees. The geographic areas served by the network, a list of network partners, and the primary contact person for the network are also provided.

Arkansas Behavioral Health Integration Network

North Arkansas Referral and Consultation Network

Grant number:
P10RH45760

Primary focus area:
Mental/Behavioral Health

Other focus areas:
Health Equity,
Health System Efficiencies,
Integrated Health Services

Organization type:
Nonprofit Organization

Grantee Contact Information

Organization	Arkansas Behavioral Health Integration Network
Address	8955 Edgemont Drive
City/State/Zip	Greers Ferry, AR 72067
Telephone No.	479-871-3611
Website	www.abhinetwork.org
Project Director	Kim Shuler, LCSW
Email	kim.shuler@abhinetwork.org

Network Description

The North Arkansas Referral and Consultation (NARC) Network formed in 2021 and has entered an intensive strategic planning phase (2021-2022). The purpose of the network is to improve access to quality mental health and behavioral health (MH/BH) services by building an integrated health care network that increases regional capacity for psychiatric consultation, collaborative care, and bidirectional referrals among rural primary care providers (PCPs), psychiatric providers, and other specialty MH/BH providers. As scarce local resources across the health care system are maximized, unified, and become more efficient, more patients receive an appropriate level of care in a timely manner, which improves patient outcomes.

The network will focus services on three rural counties in North Arkansas, including Baxter County, Stone County, and Cleburne County. Initial network planning partners were chosen/came together because they are all dedicated to finding innovative ways to increase patients' access to quality MH/BH services in North Arkansas. Further, each organization offers an area of expertise that will be needed to advance regional collaboration to increase MH/BH care access. The Arkansas Behavioral Health Integration Network contributes expertise in integrated behavioral health and the collaborative care management model. Baxter Regional Medical Center has a broad reach across the region and serves

as a major hub for specialty mental health care in the region. Finally, Dr. Andy's Family Practice and Access Medical Clinic are primary care practices in the target area with deep experience of the challenges related to mental health care access in the region. These planning partners will leverage their unique expertise to conduct a community health needs assessment and engage additional network members throughout the planning year.

Program Description

The programmatic focus of NARC Network planning grant activities is improving patients' access to quality MH/BH services across provider types in rural North Arkansas. Despite the volume of patients seeking MH/BH treatment in primary care, many PCPs lack confidence in assessment and treatment of patients, especially patients with mental illness. Efforts by PCPs to assess and treat MH/BH conditions are limited without available psychiatric consultation, referral, and treatment resources. While some patients can be appropriately treated in primary care, patients with more complex MH/BH needs may be better suited for specialty MH/BH care. Likewise, patients with need for less-intensive management may be better suited for treatment in a PCP setting. Facilitated referrals and open communication among PCPs and specialty MH/BH providers can ensure better treatment uptake. Backlogs in specialty MH/BH services can be reduced and efficiencies achieved when patients are treated at the appropriate level. Appropriate treatment of MH/BH conditions by PCPs can increase access in rural areas because it lowers patient costs, increases availability of treatment, and increases the perceived acceptability to many rural patients.

The NARC Network aims to improve access to quality MH/BH services by increasing regional capacity for psychiatric consultation, collaborative care, and bidirectional referrals among rural PCPs, psychiatric providers, and other specialty MH/BH providers. As scarce local resources across the health care system are maximized, unified, and become more efficient, more patients receive an appropriate level of care in a timely manner, which improves patient outcomes. Network planning partners will conduct a community health needs assessment to determine needs and challenges related to mental health access and primary care/specialty care referrals and collaboration on complex patients. The needs assessment will be used to refine the network strategic plan and identify key collaborators.

Special Populations Being Served

- People with Serious and Persistent Mental Illness

Region Covered by Network Services

- Baxter County, AR
- Cleburne County, AR
- Stone County, AR

Network Partners

Organization	City, State	Organization Type
Arkansas Behavioral Health Integration Network	Greers Ferry, AR	Nonprofit Orgaization
Access Medical Clinic	Heber Springs, AR	Physicians Clinic
Baxter Regional Medical Center	Mountain Home, AR	Behavioral Health
Dr. Andy's Family Practice Clinic	Mountain View, AR	Physicians Clinic

HOPE for a Drug Free Stephens

Stephens County Wellness and Recovery Network

Grant number:
P10RH47171

Primary focus area:
Integrated Health Services

Other focus areas:
Care Coordination, Substance Abuse Prevention and/or Treatment, Telehealth

Organization type:
Nonprofit Collaborative

Grantee Contact Information

Organization	HOPE for a Drug Free Stephens
Address	467 W. Doyle Street
City/State/Zip	Toccoa, GA 30577
Telephone No.	706-491-3493
Website	www.facebook.com/drugfreestephens
Project Director	Kathy Whitmire
Email	kfwhitmire@gmail.com

Network Description

HOPE for a Drug Free Stephens Corp., in partnership with Avita Community Partners, Georgia Partnership for Telehealth, Stephens County Hospital and Physicians Group, Northeast Georgia Physicians Group–Toccoa Clinic, and the Center for Wellness and Recovery, will develop the Stephens County Wellness and Recovery Network focused on the following objectives:

- Supporting integration of health care delivery, behavioral health services, and social service entities for seamless, coordinated, whole-person-oriented care
- Developing care delivery standards like the universal screening of patients for depression, anxiety, and substance use disorders; tracking and treating patients who screen positive for higher levels of depression, anxiety, or substance use disorders; making referrals to specialty behavioral health care as needed; and care coordination across different types of care to provide measurable outcomes and improvements.
- Using standardized tools to screen patients, such as Patient Health Questionnaire-2/Patient Health Questionnaire-9, General Anxiety Disorder-7, CAGE adapted to include drugs, and adverse childhood experience (ACE) assessment

- Connecting the network to the Georgia Health Information Network (GHIN) to share patient discharge data, to combine health records and social records, and to close the loop on referrals.

The network members have a strong working relationship and will benefit from the network through reduction of ownership issues, improving communication strategies, reducing duplicate services, and the leveraging of buying and negotiating power with commercial insurance plans.

Program Description

The Stephens County Wellness and Recovery Network will work together toward the provision of integrated behavioral health and primary care services, including detox and treatment services, addiction and behavioral health counseling, and primary and preventive care delivered live and via telehealth. A care coordinator will be at the center of the network coordinating care among network partners and helping patients manage social determinants of health. This team-based, value-driven approach will:

1. Achieve efficiencies through the integration of mental health care and treatment for opioid/substance use disorders with primary care using the Centers for Medicare and Medicaid Services Integrated Behavioral Health Collaborative Care model
2. Expand access to patient-centered psychiatric care through the utilization of telehealth and secure FaceTime encounters
3. Coordinate and improve the quality of essential services through a behavioral health care coordinator to manage transitions of care
4. Deploy a population health strategy that includes a data tool to track quality and outcomes that will transform the delivery of care into a patient- and value-driven system
5. Create a business plan to sustain the operations of the network long term following the grant period

The Stephens County Wellness and Recovery Network blends the expertise of mental health, substance use, and primary care clinicians, with feedback from patients and their caregivers. This team-based and coordinated collaborative care approach is an alternative health care delivery model that will change the way care is delivered by offering mental health care and general medical care in the same setting.

Region Covered by Network Services

- Stephens, GA
- Franklin, GA
- Hart, GA
- Habersham, GA
- Rabun, GA

Network Partners

Organization	City, State	Organization Type
Avita Community Partners	Toccoa, GA	Behavioral Health
Stephens County Hospital	Toccoa, GA	Hospital
Northeast Georgia Physicians Group–Toccoa Clinic	Toccoa, GA	Physicians Clinic
Georgia Partnership for Telehealth	Waycross, GA	Nonprofit Organization
The Center for Wellness and Recovery	Toccoa, GA	Behavioral Health
Hope for a Drug Free Stephens	Toccoa, GA	Nonprofit Collaborative

Bingham Healthcare

Pharmacy Population Health Integrated Rural Enhancement

Grant number:
P10RH45761

Primary focus area:
Chronic Disease Prevention/ Management

Other focus areas:
Integrated Health Services, Network Organization/ Infrastructure Development

Organization type:
Critical Access Hospital and Rural Health Center

Grantee Contact Information

Organization	Bingham Healthcare
Address	98 Poplar Street
City/State/Zip	Pocatello, ID 83221
Telephone No.	208-785-3866
Website	www.binghammemorial.org
Project Director	Jenilee Johnson; Rachel Armstrong
Email	jejohnson@binghammemorial.org; rarmstrong@binghammemorial.org

Network Description

In 2020 Bingham Healthcare was a part of Marimn Health's Idaho Integrated Clinical Pharmacy Rural Network (II-CPRN), which focused on the delivery mechanism of clinical pharmacy services, enhancing multidisciplinary care teams to include pharmaceutical therapy. This network provided the prototype for the Pharmacy Population Health Integrated Rural Enhancement (PPHIRE) Network. This is a newly formed network that will use lessons learned from II-CPRN to advance pharmacy-driven protocols, standardization, and care coordination in the primary care setting. It is designed to reduce health care costs, improve medication adherence, and empower patients to work within their health care team to achieve their health goals.

The network includes three Critical Access Hospitals, four rural health clinics, Public Health District 6, and a private nonprofit organization. All network partners reside in rural areas. The partnership will help strengthen 12 counties in Idaho. The partners were selected as the utilization of clinical pharmacists within primary care teams has shown to be beneficial.

Program Description

The PPHIRE Network will focus on using clinical pharmacists in the primary care setting to improve prediabetes and diabetes population health management. This population was selected as the U.S. Preventive Services Task Force (USPSTF) reported in 2015 that diabetes screening guidelines missed 55% of high-risk individuals with prediabetes or diabetes. It has been shown that failure to identify individuals with dysglycemia (abnormalities of blood glucose levels) leads to missed opportunities in preventive education and support services, resulting in patients presenting with overt diabetes and other health complications including heart attacks and strokes.

The PPHIRE Network will target the following legislative aims: (1) achieve efficiencies as communication and coordination channels are optimized through the consortium among various agencies participating in patient care; (2) expand access to, coordinate, and improve the quality of essential health services as health professionals and non–health professionals are trained in diabetes population health management with pharmacy stewardship; and (3) strengthen the rural health system as a whole as the consortium builds capacity to care for complex and high-need patients with significant diabetes and pharmacy needs in the inpatient, outpatient, and community care setting.

Special Populations Being Served

- American Indian
- Migrant

Region Covered by Network Services

- Bannock, ID
- Franklin, ID
- Bear Lake, ID
- Lemhi, ID
- Bingham, ID
- Oneida, ID
- Butte, ID
- Payette, ID
- Camas, ID
- Power, ID
- Custer, ID
- Caribou, ID

Network Partners

Organization	City, State	Organization Type
Bingham Healthcare	Blackfoot, ID	Rural Health Center
Cornerstone Whole Healthcare Organization	Payette, ID	Nonprofit Organization
Lost Rivers Medical Center	Arco, ID	Rural Health Center
Public Health District 6	Pocatello, ID	Public Health
Shoshone Family Medical Center	Shoshone, ID	Physicians Clinic
Steel Memorial Medical Center	Salmon, ID	Rural Health Center

Cornerstone Whole Healthcare Organization Inc.

Pride in Idaho Care Neighborhood

Grant number:
P10RH47310

Primary focus area:
Health Equity

Other focus areas:
Health System Efficiencies, Network Organization/ Infrastructure Development

Organization type:
Nonprofit Organization

Grantee Contact Information

Organization	Cornerstone Whole Healthcare Organization Inc.
Address	11485 Payette Heights Road, Unit 2
City/State/Zip	Payette, ID 83661
Telephone No.	303-941-1701
Website	www.C-WHO.org
Project Director	Rachel Blanton
Email	rachelbh@c-who.org

Network Description

The Pride in Idaho Care Neighborhoods (PiICN) Network is designed to expand comfort, expertise, and skill among rural primary care providers and their care teams in delivering appropriate and affirming care for LGBTQ+ patients. The majority of the state of Idaho is considered a primary care shortage area, with the entire state designated as a mental health care provider shortage area (Idaho Department of Health and Welfare, 2016). The network aims to expand and strengthen ties in underserved and rural counties in Idaho, including Gem County, Canyon County, and Power County, which are designated Health Professional Shortage Areas (HPSAs) as well as low-income population HPSAs. The primary purpose is to expand appropriate and affirming care practices and support environments for LGBTQ+ patients and their families beyond these counties by building on strong existing partnerships and a gender-affirming care model successfully piloted in partnership with a Critical Access Hospital in rural Idaho.

The importance of the PiICN Network is highlighted by the 2020 pilot project in rural Idaho, which found that 72% of providers did not know where to send patients who wanted gender-affirming care, 85% of providers did not know where to send patients for HIV care, and less than 5% of encounters were accurately capturing sexual orientation, gender identity (SOGI) data (Cornerstone Whole Healthcare Organization, 2022). This network aims to focus on proper and

timely referrals, comprehensive gender-affirming care, and accurately capturing SOGI data are critical for LGBTQ+ care in that they allow for tailoring of health interventions and improving health equity overall for LGBTQ+ persons in rural areas. The scaling of this network hinges on strong partnerships including family medicine rural training tracks embedded in Federally Qualified Health Centers across the state of Idaho, a nonprofit, and a Critical Access Hospital.

Program Description

The PiICN Network will plan a training and peer-to-peer mentoring program to increase comfort and skill among rural primary care teams. Partners will pilot training programs and focus on building out a statewide network among training and practice sites for rural primary care. The network will improve access to care and strengthen the quality of care by first assessing current practices, then evaluating policies and workflows and training on coordination of services, appropriate language, and suicide prevention. The overarching aims of the network include increasing collaboration and facilitating novel partnerships, implementing a gender-affirming training model for a multitude of care providers and support staff, and implementing workflows to improve electronic health record documentation of SOGI data.

Special Populations Being Served

- LGBTQ+

Region Covered by Network Services

- Gem County, ID
- Canyon County, ID
- Power County, ID

Network Partners

Organization	City, State	Organization Type
Health West Inc.	Pocatello, ID	Federally Qualified Health Center
Full Circle Health	Nampa, ID	Federally Qualified Health Center
Valor Health	Emmett, ID	Critical Access Hospital

Indiana Rural Health Association

Indiana Transfer of Care Network

Grant number:
P10RH45768

Primary focus area:
Health System Efficiencies

Other focus areas:
Health Equity, Network Organization/ Infrastructure Development, Transportation

Organization type:
Nonprofit Health Association

Grantee Contact Information

Organization	Indiana Rural Health Association
Address	201 E. Main Street, Suite 415
City/State/Zip	Washington, IN 47501
Telephone No.	574-286-3839
Website	www.indianaruralhealth.org
Project Director	Kathleen Livingston
Email	klivingston@indianarha.org

Network Description

The Indiana Transfer of Care (InTOC) Network is in the process of being formed under the umbrella of the Indiana Rural Health Association (IRHA) to address gaps in interfacility transfers. Interfacility transfers are when a patient is transferred from one setting to care to another, like in the situation of needing a higher level of care. The network has established a partnership between three rural organizations to plan for and improve interfacility transfers.

Current partners in the InTOC Network are three Critical Access Hospitals (CAHs): Sullivan County Community Hospital serves Sullivan County, Putnam County Hospital serves Putnam County, and Union Clinton Hospital serves Vermillion County. The network plans to add a transportation provider to the network. The identified rural partners are included due to their Health Professional Shortage Area status and willingness to contribute to planning and, hopefully, dissemination across the state.

Program Description

The InTOC program seeks to build a network of stakeholders that will address barriers to interfacility transfers between care settings, thus improving health system efficiencies. The network created this program area as a response to all three communities' community health needs assessments identifying transportation as a critical barrier. For example, a patient may need to be transferred to a higher level of care, but the health care facility does not have an available vehicle for transfer, as the priority of emergency medical services (EMS) vehicles is emergent trips. This is further complicated if the vehicles must leave the county for a transfer. In addition, a shortage of EMS workers and paramedics is compounding the transportation issue at hand.

The InTOC Network will conduct needs assessments with three partner hospitals, as well as various EMS providers in the state for planning and best practices. The partners will form a collaborative network through sharing data, evaluating transfer protocols, identifying deficiencies, and creating a business plan for a shared, regional ambulance motor pool for interfacility transfers among partners and tertiary transfer locations. Network meetings are organized according to existing collaboration models: EMS7 Tabletop exercises as maintained by the Indiana Department of Homeland Security, collective impact planning, and the National Highway Traffic Safety Administration's Guide for Interfacility Patient Transfer.

Region Covered by Network Services

- Putnam County, IN
- Sullivan County, IN
- Vermillion County, IN

Network Partners

Organization	City, State	Organization Type
Putnam County Hospital	Greencastle, IN	Critical Access Hospital
Sullivan County Community Hospital	Sullivan, IN	Critical Access Hospital
Union Hospital Clinton	Clinton, IN	Critical Access Hospital

Good Samaritan Hospital

Good Samaritan Hospital Network

Grant number:
P10RH45767

Primary focus area:
Care Coordination

Other focus areas:
Health System Efficiencies, Mental/Behavioral Health, Telehealth

Organization type:
Hospital

Grantee Contact Information

Organization	Good Samaritan Hospital/Samaritan Center
Address	520 South 7th Street
City/State/Zip	Vincennes, IN 47591
Telephone No.	812-882-5220
Website	www.gshvin.org
Project Director	Kim Everett
Email	keverett@gshvin.org

Network Description

The Good Samaritan Hospital Network consists of four partners located in Indiana that serve 11 counties across Indiana and Illinois. Partners convened in 2022 to implement planning activities addressing local behavioral health, primary care coordination, and care integration needs. Each entity in the network has achieved success on an individual basis and has proven its long-standing commitment to public health through longevity and public acceptance.

While the members had always worked together tangentially, this network is the first formal collaboration of the entities and the first attempt at focusing on a single subject matter — that of a stated commitment to a health network. The partners were selected based on their individual access and attention to a wide variety of patients and their needs.

Program Description

Community health needs assessments in the service area indicate a need for increased access to primary care services. The assessment revealed many residents within the rural four-county service area are more than 30 minutes away from a primary care option. Good Samaritan Hospital (GSH) Network will examine the possibility of expanding the GSH Mobile Wellness Unit (MWU) to further health service delivery integration within the existing system. The network will explore the use of shared technologies such as telehealth services as another strategy to expand access to care for persons with co-occurring behavioral and mental health and primary care needs. With a shortage of behavioral health workforce capacity and high poverty rates in all counties of the service area, an improved health care service delivery model is needed. Studying the use of the mobile wellness unit, recruiting medical staff, and integration of health services, such as MWU services, into non–English-speaking communities will be priorities for the network.

Special Populations Being Served

- Migrant

Region Covered by Network Services

- Knox County, IN
- Pike County, IN
- Daviess County, IN
- Marion County, IN

Network Partners

Organization	City, State	Organization Type
Good Samaritan Hospital/Samaritan Center	Vincennes, IN	Behavioral Health
Knox County Department of Health	Vincennes, IN	Public Health
Good Samaritan Physicians' Network	Vincennes, IN	Physicians Clinic
Family Health Center	Vincennes, IN	Federally Qualified Health Center

Union Hospital Inc.

Illiana-Survivor Milestones Improving Lives Everyday

Grant number:
P10RH45775

Primary focus area:
Cancer Care

Other focus areas:
Health System Efficiencies

Organization type:
Hospital

Grantee Contact Information

Organization	Richard G. Lugar Center for Rural Health/Union Hospital
Address	1606 N. 7th Street
City/State/Zip	Terre Haute, IN 47804
Telephone No.	812-238-7479
Website	www.lugarcenter.org
Project Director	Daniel Hardesty
Email	dhardesty@uhhg.org

Network Description

The Illiana-Survivor Milestones Improving Lives Everyday (I-SMILE) network was formed in 2022 to identify the obstacles that lead to poor health care and quality-of-life outcomes for cancer survivors in rural areas in West Central Indiana and Eastern Illinois. The network will be the first of its kind for the area that focuses on identifying methods and initiatives that will increase quality of life for cancer survivors and their support system.

The I-SMILE network plans to identify obstacles to health care and opportunities for health care coordination by conducting multiple information-gathering activities, including focus groups with cancer survivors and cancer survivor support systems, listening sessions with community members, and primary data collection from local primary care sites. To accomplish these strategies and goals, I-SMILE is strategically composed of network partners in the targeted rural areas that have access to the targeted population and trust within their communities. The type of organizations represented across the network (seven partners, including the applicant) include rural institutions such as public libraries, local primary care sites, a health department, a cancer philanthropy organization, and the area's largest acute care hospital.

Program Description

The programmatic focus of the I-SMILE network is on cancer, specifically cancer survivorship. Cancer survivors are often described as any individual who has been diagnosed with cancer regardless of their journey to remission or their fight to battle the disease. This subset of the rural population faces many obstacles in receiving their treatment, recovering from the treatment (regardless of the success of the effort), and paying for the treatment. Research shows the rural cancer survivors are more likely to have poor health outcomes and quality of life compared to urban counterparts.

The I-SMILE network partners plan to execute multiple information-gathering strategies within the targeted area to identify gaps in health care coordination and opportunities to improve the quality of life of cancer survivors. Efforts include facilitated focus groups, listening sessions, interviews, and primary data collection from rural primary care sites. The primary data collected will inform the network of the current landscape for cancer survivors in the targeted communities and how their health needs are being addressed. This data will inform the development of a strategic action plan that will detail interventions necessary to improve the quality of life and health care coordination for cancer survivors in rural communities. I-SMILE will be governed by an advisory board that comprises leadership from network partners who will help make decisions and provide guidance to help the network build the strategic plan. I-SMILE will also break up into working groups that are needed to help address more specific issues. The network and program director will use available best practices from the Rural Health Innovation Center and the National Rural Health Resource Center's Strategic Planning Guide.

Region Covered by Network Services

- Parke County, IN
- Sullivan County, IN
- Clark County, IL

Network Partners

Organization	City, State	Organization Type
Union Hospital (Applicant)	Terre Haute, IN	Hospital
PINK of Terre Haute	Terre Haute, IN	Philanthropy/Foundation
Clark County Health Department	Martinsville, IL	Public Health
Marshall Public Library	Marshall, IL	Other
Sullivan County Public Library	Sullivan, IN	Other
Cork Medical Center	Marshall, IL	Rural Health Center
Union Family Medicine Rockville	Rockville, IN	Rural Health Center

Thrive Allen County

Southeast Kansas Social Isolation and Suicide Prevention Network

Grant number:
P1045774

Primary focus area:
Mental/Behavioral Health

Other focus areas:
Telehealth

Organization type:
Nonprofit Community Health Development Organization

Grantee Contact Information

Organization	Thrive Allen County
Address	9 S. Jefferson Avenue
City/State/Zip	Iola, KS 66749
Telephone No.	620-365-8128
Website	www.thriveallencounty.org
Project Director	Jessica Thompson
Email	jessica@thriveallencounty.org

Network Description

Thrive Allen County is a prominent rural health advocacy organization in Kansas that was established in 2007. Thrive Allen County focuses on bike and walking trails, community engagement, economic development, health care, healthy lifestyles, and education and advocacy for Allen County areas and the state of Kansas.

In 2017, the Robert Wood Johnson Foundation awarded Allen County the nation's top honor, naming it a Culture of Health Prize Winner. Many of the things that Thrive has put into motion have laid the foundation for a sustainable culture of health in Allen County.

Thrive Allen County is partnering with the Community Health Center of Southeast Kansas, Southeast Kansas Mental Health Center, Resource Center for Independent Living, Hope Unlimited, and Southeast Kansas Area Agency on Aging. Thrive has chosen to work with these organizations because their scope covers working with the target populations for this grant. Thrive Allen County has an existing Rural Health Initiative group that includes these partners. These organizations meet to discuss ongoing projects to update and to see how as a group they can work together to meet goals.

Thrive is also collaborating with new partners for this planning grant that bring new capacity and expertise in the areas of trauma-informed care and technology. The mission of University Behavioral Health's Center for Trauma Informed Innovation is to advance resilience, compassion, and well-being. The Center for Trauma Informed Innovation will provide multiple training opportunities for Thrive's staff, Thrive's Rural Health Initiative group, and other organizations throughout the five counties. Training will include topics such as building trauma awareness and sensitivity and compassion.

In the areas of technology, Thrive is collaborating with three partners. Akesa Health is using technology to turn effective therapies into digital health interventions, more specifically an application to turn trauma into resiliency. Televada is a group that will help connect people who may be experiencing social isolation to people who enjoy similar interests such as yoga or cooking classes. Finally, a tech company called PursueCare provides telehealth services focusing mainly on mental health services.

Program Description

The programmatic focus for this grant is to increase capacity in Southeast Kansas to address social isolation and suicide risk factors by increasing the prevention, intervention, and management training of behavioral health, school personnel, primary care physicians, and other community members. The focus community populations for this grant are farmers, LGBTQ+, and people who are homebound due to various factors.

The initial plan in reaching the farmer population is to meet with local farmers, residents, and professionals who work alongside farmers. The network will create a survey that is targeted toward farmers and is designed to identify social isolation factors and help the network members understand how to raise awareness about and prevent suicide risk factors among farmers. When this data has been gathered and assessed, Thrive will attend farmer-focused events and engage farmers to deliver materials and resources that help in the grant's mission. To reach the LGBTQ+ population, the network will create a local peer-led support group for this community. The network will work with social welfare professionals at the University of Kansas to understand the LGBTQ+ community members who have attempted suicide, experienced substance misuse, are older, or have left the Mormon faith. Gathering information from these sources will allow Thrive to gain information on how best to engage with the LGBTQ+ population.

Thrive will use the Akesa Health trauma-resiliency app to translate effective therapies into digital health interventions that can be easily accessed remotely. Trauma-informed care training will be provided for grant partners, Thrive staff, and surrounding areas to encourage building trauma awareness and sensitivity. Televada services will help link people who may be homebound to other people with the same interests. Telehealth from PursueCare will help connect people who are experiencing social isolation to services and resources focused on mental health.

Special Populations Being Served

- Agricultural
- Elderly
- Homebound
- LGBTQ+

Region Covered by Network Services

- Allen County, KS
- Neosho County, KS
- Bourbon County, KS
- Crawford County, KS
- Anderson County, KS

Network Partners

Organization	City, State	Organization Type
Community Health Center of Southeast Kansas	Iola, KS	Physicians Clinic
Southeast Kansas Mental Health	Iola, KS	Behavioral Health
Resource Center for Independent Living	Iola, KS	Area Health Education Center
Southeast Kansas Area Agency on Aging	Chanute, KS	Area Agency on Aging
Hope Unlimited	Iola, KS	Nonprofit Organization
Allen County College	Iola, KS	College/University
Neosho County Community College	Chanute, KS	College/University
Allen County Sheriff's Department	Iola, KS	Law Enforcement
PursueCare	Middletown, CT	Home Health
Center for Trauma Informed Innovation	Kansas City, MO	Behavioral Health
Akesa Health	San Ramon, CA	Behavioral Health
Televada	Phoenix, AZ	Other

Louisiana Rural Health Association

Rural Telehealth Network

Grant number:
P10RH47172

Primary focus area:
Health Information Technology

Other focus areas:
Care Coordination, Telehealth

Organization type:
Nonprofit Organization

Grantee Contact Information

Organization	Louisiana Rural Health Association
Address	P.O. Box 387
City/State/Zip	Napoleonville, LA 70390
Telephone No.	337-366-5915
Website	www.lrha.org
Project Director	Denaé Hebert
Email	dhebert@lrha.org

Network Description

The network comprises the Louisiana Rural Health Association (LRHA), the Louisiana Public Health Institute (LPHI), and Louisiana Tech University. LRHA has long-standing relationships with both Louisiana Tech and LPHI, and LRHA brought both partners together specifically for the Rural Health Network Development Planning Program grant to improve the coordination of care of rural residents across the state.

An LRHA representative serves as an advisory partner in the LPHI project, called Delta Center: Advancing Racially Equitable Telehealth Care and Payment in Louisiana and Mississippi. LPHI and LRHA also both participate with other rural stakeholders in a monthly rural health collaborations group to facilitate collaboration and communication among rural stakeholders across the state of Louisiana. LRHA and Louisiana Tech are partners in a HRSA Outreach Grant to implement a data dashboard and performance improvement analysis related to chronic care management in rural health clinics. LRHA is a nonprofit membership organization with more than 500 members, including 150 rural providers, with a mission to provide leadership on rural health issues. LRHA membership consists of a diverse collection of individuals and organizations that share a common interest in ensuring that all rural communities have access to quality, affordable health care. LRHA serves as an advocate and resource hub for rural providers across the state of Louisiana.

LPHI is a statewide 501(c)(3) nonprofit public health institute that has proudly served the residents of Louisiana for over 25 years. As a statewide, community-focused nonprofit, it is committed to ensuring all Louisianans have fair and just opportunities to be healthy and well. Underneath LPHI sits the Partnership for Achieving Total Health (PATH) health information exchange. LPHI is currently working to integrate larger health systems into the PATH exchange and is committed to working with the network partners to advance and enhance rural provider engagement in a statewide health information exchange.

Louisiana Tech's mission includes a commitment to quality in teaching, research, creative activity, public service, and workforce/economic development. Louisiana Tech will aid in the identification of research questions that will contribute to a sustainable program throughout the state by utilizing both quantitative and qualitative analysis. Louisiana Tech's role will also specifically identify health equity gaps across the state and how they intersect with continuity and coordination of care. These types of performance-improvement activities are critical to a sustainability plan that addresses racial and ethnic-based health disparities as well as social determinants of health.

Program Description

Over 80% of Louisiana is designated as a Health Professional Shortage Area (HPSA). With these limited resources, patients often must travel to larger metropolitan areas to receive care at multiple health care facilities. Especially in cases of long-term or chronic conditions, such as cancer or kidney failure, it is vital that all providers responsible for a patient's care have access to the most up-to-date information about treatment plans.

PATH is a health information exchange network dedicated to advancing the health of Louisiana's communities to ensure that every person has fair and just opportunities to be healthy and well. PATH provides timely, actionable data to empower care teams to deliver the best care possible. PATH's mission is to improve population health across Louisiana through an equitable data-service infrastructure that equips care teams with the right information at the right time. This project seeks to integrate rural providers into the PATH statewide health information exchange to ensure coordination of care.

Region Covered by Network Services

- Statewide, Louisiana

Network Partners

Organization	City, State	Organization Type
Louisiana Tech University	Ruston, LA	College/University
Louisiana Public Health Institute	New Orleans, LA	Nonprofit Organization
Louisiana Rural Health Association	Napoleonville, LA	Nonprofit Organization

Citizens Memorial Hospital

Mobile Integrated Healthcare Network

Grant number:
P10RH45763

Primary focus area:
Integrated Health Services

Other focus areas:
Community Paramedicine

Organization type:
Hospital

Grantee Contact Information

Organization	Citizens Memorial Hospital
Address	1500 N. Oakland Avenue
City/State/Zip	Bolivar, MO 65613
Telephone No.	417-328-7571
Website	www.citizensmemorial.com
Project Director	Christina Bravata
Email	christina.bravata@citizensmemorial.com

Network Description

The Citizens Memorial Hospital Mobile Integrated Healthcare Network comprises Citizens Memorial Hospital, Ellett Memorial Hospital, the Dallas County Health Department, and the Washington County Mobile Integrated Health Network, which includes Great Mines Health Care, Mineral Area College, and Washington County Ambulance District. Citizens Memorial Hospital, Ellett Memorial Hospital, and the Dallas County Health Department serve adjacent rural populations across several counties in Southwest Missouri. These organizations have collaborated over the past 40 years to bring medical resources and support services to underserved communities through highly trained medical providers, emergency medical services, specialty services (including oncology, addiction treatment, ophthalmology, OB/GYN, and other specialties), ancillary care, educational public health resources, and support for individuals and families. In fall 2021, the Mobile Integrated Healthcare Network began collaborating with Citizens Memorial Hospital to offer community paramedicine consultation and training to the Citizens Memorial Hospital Emergency Medical Services Department. This collaboration resulted in a formalized Mobile Integrated Healthcare network of partners that will plan and strategize to implement a Mobile Integrated Healthcare program through the implementation of a community paramedicine strategy.

All partners within the Mobile Integrated Healthcare Network are experts in rural population health. The partners represent different sectors of the health care system: a medical provider (Great Mines Federally Qualified Health Center), emergency medical service provider (Citizens Memorial Hospital Emergency Medical Services Department, Washington County Ambulance District), sole community hospitals (Citizens Memorial Hospital and Ellett Memorial Hospital), and a public health organization (Dallas County Health Department). These organizations provide care across the life span as well as supportive services to address social determinants of health in individuals and their families. The Mobile Integrated Healthcare Network has developed trust within the underserved rural communities of Southwest Missouri. They have offered the highest standards of reliable care within the same region where their providers and employees live and work. As they continue to evolve to meet the needs of this area, offering a Mobile Integrated Healthcare strategy will effectively provide services to individuals who might not otherwise receive them and create a stronger safety net for individuals at risk of falling through the cracks. The Mobile Integrated Health Network of Washington County will provide mentorship for planning, strategizing, and project onboarding through their experience of developing a robust community paramedicine program within a rural area.

Program Description

The programmatic focus of the Mobile Integrated Healthcare Network will be integrative care coordination. This focus area was chosen in order to meet expanding needs of rural populations who are not receiving services due to barriers such as transportation and health literacy. The purpose of the network will be to integrate services for these at-risk individuals through a community paramedicine program that will provide on-site treatment services, social determinants of health assessments, and integrating specialized care access to those individuals who may not otherwise receive intervention or treatment. Strategic planning will include identifying high-risk population subsets such as pregnant women and those living in poverty.

The expertise of the Mobile Integrated Health Network of Washington County will provide guidance on a best/promising practice model of integrative care through community paramedicine. Through mentorship and training, the network will be able to replicate tried-and-true methods of an integrative care approach that has been proven effective within a similar rural region and demographic makeup. Throughout the planning process, this consultation group will offer expertise, lessons learned, and strategies to bring effectual, integrative care to the region without “reinventing the wheel.”

Region Covered by Network Services

- Polk County, MO
- St. Clair, MO
- Dallas County, MO
- Cedar County, MO
- Hickory County, MO

Network Partners

Organization	City, State	Organization Type
Citizens Memorial Hospital	Bolivar, MO	Hospital
Ellett Memorial Hospital	Appleton City, MO	Hospital
Dallas County Health Department	Buffalo, MO	Public Health
Great Mines Health Center	Great Mines, MO	Federally Qualified Health Center
Washington County Ambulance District	Great Mines, MO	Emergency Medical Services
Mineral Area College	Great Mines, MO	College/University

Missouri Alliance of YMCAs

Northeast Missouri Rural Health Services Network

Grant number:
P10RH45759

Primary focus area:
Network Organization/ Infrastructure Development

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

Organization type:
Nonprofit Organization

Grantee Contact Information

Organization	Missouri State Alliance of YMCAs
Address	525 Ellis Boulevard
City/State/Zip	Jefferson City, MO 65101
Telephone No.	573-230-7811
Website	www.missouriymcas.org
Project Director	Patricia A. Miller
Email	patty@moymca.org

Network Description

The Northeast Missouri Rural Health Systems Network is a group of community organizations that have existing relationships but are now coordinating to provide outreach, education and preventive health services. The network is made up of community-based nonprofit organizations, Federally Qualified Health Centers, and hospital systems, as well as school systems and local public health departments. The network is newly formed and includes key organizations that can implement and sustain health programs. The network plans to build organizational and governance structures to provide long-term advancement of health outcomes in the service area.

Program Description

The goal of the Northeast Missouri Regional Health System Network is to strengthen the community's health care system through increased care coordination in Marion, Pike, and Ralls counties. The network partners are collaborating to form a structured network to develop preventive health and wellness programs with the intent of reducing health disparities for residents within the three counties.

The network partners will begin by examining community need and working together to identify and develop an integrated system of care providing evidence-based health intervention programs. This will include a plan to develop screening, referral, communications, governance, funding, and technology, as well as intentional outreach in the community to address health disparities and equity.

Region Covered by Network Services

- Marion County, MO
- Pike County, MO
- Ralls County, MO

Network Partners

Organization	City, State	Organization Type
Missouri State Alliance of YMCAs	Jefferson City, MO	Nonprofit Organization
Hannibal YMCA	Hannibal, MO	Nonprofit Organization
Twin Pike Family YMCA	Louisianna, MO	Nonprofit Organization
Blessing Health System	Hannibal, MO	Hospital
Gateway Region YMCA	St. Louis, MO	Nonprofit Organization
Hannibal Regional Hospital	Hannibal, MO	Hospital
Hannibal School District	Hannibal, MO	School System
Missouri Rural Health Association	Jefferson City, MO	Nonprofit Organization
Pike County Health Department	Bowling Green, MO	Public Health
Preferred Family Healthcare	Hannibal, MO	Federally Qualified Health Center
Pike County Memorial Hospital	Louisianna, MO	Hospital

Sullivan County Memorial Hospital

Sullivan County Health Improvement

Grant number:
P10RH45773

Primary focus area:
Network Organization/Infrastructure Development

Other focus areas:
Health System Efficiencies, Integrated Health Services, Transportation

Organization type:
Critical Access Hospital

Grantee Contact Information

Organization	Sullivan County Memorial Hospital
Address	630 W. 3rd Street
City/State/Zip	Milan, MO 63556
Telephone No.	660-265-4212
Website	www.scmhospital.org
Project Director	Jason Chrisman
Email	jasonchrisman@scmhospital.org

Network Description

The Sullivan County Health Improvement Network is in its infancy and is just beginning its work. The network's members include Sullivan County Memorial Hospital, Northeast Missouri Health Council, Sullivan County Health Department, Sullivan County Ambulance District, and Northeast Regional Medical Center.

The partners of the network were chosen because they encompass the entirety of the health care landscape in Sullivan County; Northeast Regional Medical Center is actually in an adjacent county but is the primary regional health care facility to which transfers from Sullivan County are sent. Each network partner has a desire to increase health care services as well as the efficiency of those services. Together, the entirety of the network has the power to overcome the obstacles that are present in a very rural part of the country.

Program Description

The Sullivan County Health Improvement Network focus is to develop a comprehensive plan to improve the overall health care system in rural underserved Sullivan County, Mo. To accomplish this goal, the network will develop a strategic system and facility improvement plan inclusive of business and sustainability strategies that will streamline services of all health care–related organizations in a way that improves access and quality of care.

Several objectives are included in the approach to meeting the focus of the network. These include completing a comprehensive analysis of the feasibility of implementing a micro hospital, examining the long-term feasibility of maintaining Critical Access Hospital status in the absence of structural changes, and examining how a Mobile Integrated Healthcare model would benefit the county in partnership with the local Federally Qualified Health Center, ambulance district, and public health. Also, the possibility of integrating Federally Qualified Health Center services into the hospital setting in a shared facility model will be explored.

Special Populations Being Served

- Migrant

Region Covered by Network Services

- Sullivan County, MO

Network Partners

Organization	City, State	Organization Type
Sullivan County Memorial Hospital	Milan, MO	Critical Access Hospital
Northeast Missouri Health Council	Milan, MO	Federally Qualified Health Center
Sullivan County Health Department	Milan, MO	Public Health
Sullivan County Ambulance District	Milan, MO	Emergency Medical Services
Northeast Regional Medical Center	Kirksville, MO	Hospital

University of Montana

UM Health Extension Office Network

Grant number:
P10RH45776

Primary focus area:
Network Organization/ Infrastructure Development

Other focus areas:
Care Coordination, Integrated Health Services, Social Determinants of Health

Organization type:
College/University

Grantee Contact Information

Organization	University of Montana Health & Medicine
Address	32 Campus Drive
City/State/Zip	Missoula, MT 59812
Telephone No.	406-243-7946
Website	www.umt.edu/umhm/
Project Director	Lily Apedaile
Email	Lily.apedaile@umontana.edu

Network Description

The University of Montana (UM) Health Extension Office Network will consist of a core team of organizations serving communities in western Montana. The organizations making up this network have been collaborating since the early 2010s to develop and implement the Western Montana Family Medicine Residency Program. Since the original formation of this collaborative team, the University of Montana has worked with these organizations to develop and implement health care career awareness programming, train behavioral health professionals through Behavioral Health Workforce Education and Training Program grants, and offer continuing education programs for health care providers.
The University of Montana will serve in the facilitator role for the network to provide resources and project management to help with the development of a health extension office model. The other five partner organizations were chosen for this network due to the geographical areas they serve in western Montana and because of their dedication to serving rural Montana residents using innovative approaches.

Program Description

The UM Health Extension Planning Project will focus on developing an implementation plan for a health extension office (or offices) in western Montana. Montana is a rural/frontier state with limited health care resources in many parts of the state. This lack of access and resources dramatically impacts the health of Montanans. The establishment of a health extension office will help rural health care and public health providers increase access to health care and resources to improve health outcomes. Since the overall goal of the planning project is the development of a health extension office model, the network will focus on (1) care coordination, (2) integrated health systems, (3) network organization/infrastructure development, and (4) social determinants of health.

For this planning project, the network will initially base its work on the University of New Mexico Health Extension Regional Office (HERO) model. The HERO model is a nationally recognized health extension office model that serves communities like the communities in Montana, making it an ideal model to use for developing a health extension office model that will meet the needs of Montanans.

Special Populations Being Served

- American Indian
- Children/Adolescents

Region Covered by Network Services

- Flathead County, MT
- Lake County, MT

Network Partners

Organization	City, State	Organization Type
University of Montana	Missoula, MT	College/University
St. Luke Community Healthcare	Ronan, MT	Critical Access Hospital
Logan Health	Kalispell, MT	Hospital
Confederated Salish Kootenai Tribal Health	St. Ignatius, MT	Tribal Health Clinic
Lake County Health Department	Polson, MT	Public Health
Flathead City-County Health Department	Kalispell, MT	Public Health

New Mexico

Rio Arriba County

Northern New Mexico Rural Health Network

Grant number:
P10RH45764

Primary focus area:
Housing

Other focus areas:
Health Equity, Social Determinants of Health, Substance Abuse Prevention and/or Treatment

Organization type:
Public Health Department

Grantee Contact Information

Organization	Rio Arriba County Health and Human Services
Address	2010 Industrial Park Road
City/State/Zip	Espanola, NM 87532
Telephone No.	505-753-3143
Website	www.rio-arriba.org
Project Director	Amber Leichtle
Email	ALeichtle@rio-arriba.org

Network Description

The Northern New Mexico Rural Health Network (NNMRHN) is a collaboration of service providers and community organizations to collectively address substance use disorder in the region. The proposed project focuses on incorporating new organizational partners into NNMRHN to address housing issues in Rio Arriba, Taos, and Santa Fe counties.

The proposed project will expand NNMRHN to include a focus on increasing access to and improving the quality of supportive housing opportunities for the target population. An existing operational referral network, the Opioid Use Reduction (OUR) Network, composed of housing providers and case management agencies that refer to housing, will collaborate with NNMRHN to discuss and implement ways to improve referrals using existing resources to pair housing opportunities with case management, medication-assisted treatment, and harm reduction for individuals seeking recovery. The second network, HOPE (Housing Opportunities for the Pueblos and Española) is in formation and will discuss ways to overcome jurisdictional barriers to create housing and care opportunities through new development and capital projects. The Network Development Planning Program grant will support a network collaboration coordinator to staff meetings and coordinate activities, as well as staff time for a housing development expert to provide technical assistance to the network to better utilize and share existing resources toward exploring new opportunities for housing.

Grant funding will also help cover the costs required for data collection, training, field trips, shared information infrastructure, and evaluation. The network's efforts will build on the city of Española's Affordable Housing Plan adopted by the city council as well as the Rio Arriba Housing Plan, which is under review.

Program Description

The network for housing will be expanded to include all players — government, tribal, and nonprofit agencies — to collectively address jurisdictional and other barriers on the continuum of housing needs such as for affordable housing and for recovery and transitional housing. All will work in tandem with the existing NNMRHN members toward establishing a comprehensive system of care for people experiencing substance use disorder/opioid use disorder and support for their families.

The target population for the proposed project is people experiencing or at risk for substance use disorder/opioid use disorder and their families who are experiencing homelessness, in unstable or unsafe housing, or at high risk for homelessness. The service area covers people who reside primarily in Rio Arriba and northern Santa Fe Counties, as well as three Native American pueblos in the region. The population will also include towns in Taos County that are immediately adjacent to Rio Arriba.

Special Populations Being Served

- Homeless
- Justice Involved
- Low Income

Region Covered by Network Services

- Rio Arriba County, NM
- Northern Santa Fe County, NM
- Pueblo of San Ildefonso, NM
- Pueblo of Santa Clara, NM
- Ohkay Owingeh Pueblo, NM
- Taos County, NM

Network Partners

Organization	City, State	Organization Type
Rio Arriba County Housing Authority	New Mexico	Nonprofit Organization
Santa Fe Connect Program	New Mexico	Government
County of Taos	New Mexico	Government
Santa Fe Civic Housing Authority	New Mexico	Nonprofit Organization
Santa Fe Community Housing Trust	New Mexico	Nonprofit Organization
The Mountain Center	New Mexico	Nonprofit Organization
Pueblo of Santa Clara	New Mexico	Tribal Nation
Pueblo of Santa Clara Housing Authority	New Mexico	Tribal Nation
Pueblo of San Ildefonso	New Mexico	Tribal Nation
Ohkay Owingeh Pueblo	New Mexico	Tribal Nation
Help New Mexico Inc.	New Mexico	Nonprofit Organization
Espanola Pathways Shelter	New Mexico	Nonprofit
City of Espanola	New Mexico	Government

Garnet Health Medical Center–Catskills

Sullivan Transportation Health Access & Reliability Taskforce

Grant number:
P10RH45762

Primary focus area:
Transportation

Organization type:
Hospital

Grantee Contact Information

Organization	Garnet Health Medical Center–Catskills
Address	68 Harris Bushville Road
City/State/Zip	Monticello, NY 12701
Telephone No.	845-333-2632
Website	www.Garnethealth.org
Project Director	Moira Mencher
Email	mmencher@garnethealth.org

Organization	Garnet Health Medical Center
Address	707 East Main Street
City/State/Zip	Middletown, NY 10940
Telephone No.	845-333-2397
Website	www.Garnethealth.org
Project Director	Royce Pilkington
Email	rpilkington@garnethealth.org

Network Description

The Sullivan Transportation Health Access & Reliability Taskforce (STHART) network was formed to improve access to health care transportation in Sullivan County, N.Y. The first accomplishment of this emerging network was the receipt of the Rural Health Network Development Planning Program grant. The five core network partners were selected as subject matter experts in the areas of health care, community resources, and transportation services. They are Garnet Health Medical Center–Catskills, Garnet Health Medical Center, Sullivan County Division of Community Resources, Rolling V Bus, and Garnet Health Doctors.

As the primary hospital in Sullivan County, Garnet Health Medical Center–Catskills is serving as the lead organization for the Network Development Planning Program grant activities. Garnet Health Medical Center is Garnet Health system's flagship institution and provides administrative oversight and expertise regarding HRSA reporting requirements and the development of communication materials. Sullivan County Division of Community Resources is the manager of existing public transportation in Sullivan County, utilizing the services of Rolling V Bus. Serving as a subject matter expert to the network, Rolling V Bus is a full-service transportation company based in the Catskills region that provides regional charter services to area residents. Garnet Health Doctors is a primary care and multispecialty practice that is part of Garnet Health's network of care.

Program Description

STHART will develop a strategic, comprehensive plan for a more coordinated and accessible transportation system focused on increasing health care access in Sullivan County, N.Y. A lack of transportation has been determined to be an exacerbator to the region's already low access to health care. This is a significant burden for those seeking to maintain good health and live a healthy lifestyle, particularly for those living under or just above the federal poverty level.

STHART will engage a strategic planning firm specializing in transportation to analyze and derive solutions that can be successful and sustainable in our rural community. STHART's goal is to develop a strategic plan that addresses gaps in access to care modalities in preparation for program implementation following the conclusion of the grant year.

Region Covered by Network Services

- Sullivan County, NY

Network Partners

Organization	City, State	Organization Type
Garnet Health Medical Center–Catskills	Sullivan County, NY	Hospital
Garnet Health Doctors	Sullivan County, NY	Nonprofit Organization
Sullivan County Division of Community Resources	Sullivan County, NY	Government
Rolling V Bus	Sullivan County, NY	Transportation
Garnet Health Medical Center	Orange County, NY	Hospital

North Country Healthy Heart Network Inc.

North Country Chronic Disease Prevention Coalition

Grant number:
P10RH45770

Primary focus area:
Network Organization/ Infrastructure Development

Other focus areas:
Chronic Disease Prevention/ Management

Organization type:
Nonprofit Organization

Grantee Contact Information

Organization	North Country Healthy Heart Network Inc.
Address	132 Bloomingdale Avenue, Suite 2
City/State/Zip	Saranac Lake, NY 12983
Telephone No.	518-891-5855, ext. 5501
Website	www.heartnetwork.org
Project Director	Ann Morgan
Email	amorgan@heartnetwork.org

Network Description

The North Country Chronic Disease Prevention Coalition (the network) is a collaborative group of health care providers, community-based organizations, and other chronic disease–prevention program stakeholders located in northeastern New York state. Formed in 2019, the network aims to expand access to, coordinate, and improve the quality of chronic disease prevention in its region by building a community integrated health network with capacity to sustain ongoing, regular delivery of evidence-based chronic disease prevention and self-management services. To date, the network has defined its product (a network of chronic disease and self-management service delivery organizations), developed a closed-loop referral process that health care providers can use to connect their patients to the regional network of programs, established a governance and committee structure to guide network development, defined the data collection plan needed to monitor system performance and build the network's value statement, and begun putting formal partner and service agreements in place.

The network was formed with a shared-services model in mind, where each participant has a role or contributes resources to help the network meet common goals and objectives. In order to expand access to, coordinate, and improve the quality of chronic disease prevention in its region, the network includes the participation of 15 organizations able to deliver chronic disease prevention and self-management education (CDPSME) programs (program delivery partners), a CDPSME training partner to train program delivery partner staff and volunteers to be program leaders and support the organizations hosting them, 15 health care provider organizations interested in referring patients to these lifesaving programs, an organization with capacity to accept provider referrals and assist patients with program selection and

enrollment (seven NY Connects programs), seven stakeholder organizations with capacity to inform or support data collection so that the network can monitor progress and begin building its value statement, and a team of 29 regional chronic disease–prevention stakeholders with an interest in helping to identify a model for sustainability (called the Integrated Network Development Committee).

Program Description

The network's program focus is chronic disease prevention and self-management. Chronic disease prevention and self-management was identified as a program priority because chronic disease rates across the network's region are high, especially diabetes. Further, until recently, the availability of evidence-based CDPSME opportunities in community settings was sporadic, at best.

The network's approach to addressing the need for regular, ongoing availability of evidence-based CDPSME is to build an army of CDPSME program leaders and delivery partners that collectively have capacity to offer programs continuously. This network approach to program delivery addresses the need for increased access to evidence-based chronic disease prevention and self-management services and goes a step further: it will ultimately facilitate contracting with health care payers so that these efforts can be sustained over the long term.

Special Populations Being Served

- American Indian
- Elderly

Region Covered by Network Services

- Clinton County, NY
- St. Lawrence County, NY
- Essex County, NY
- Franklin County, NY
- Hamilton County, NY
- Warren County, NY
- Washington County, NY

Network Partners

Organization	City, State	Organization Type
Adirondack Health	Saranac Lake, NY	Hospital
Adirondack Health Institute	Glens Falls, NY	Other
Adirondacks ACO	Plattsburgh, NY	Other
Claxton-Hepburn Medical Center	Ogdensburg, NY	Hospital
Community Health Centers of the North Country	Ogdensburg, NY	Federally Qualified Health Center
Clinton County Office for the Aging	Plattsburgh, NY	Area Agency on Aging
Franklin County Public Health	Malone, NY	Public Health
Hudson Headwaters Healthcare Network	Glens Falls, NY	Federally Qualified Health Center
Irongate Family Practice	Glens Falls, NY	Physicians Clinic
Northwinds IPA	Plattsburgh, NY	Behavioral Health
St. Lawrence County Health Initiative Inc.	Potsdam, NY	Nonprofit
St. Regis Mohawk Tribe	Hogansburg, NY	Tribal Health Clinic
UVM-Champlain Valley Physicians Hospital	Plattsburgh, NY	Hospital
UVM-Elizabethtown Community Hospital	Elizabethtown, NY	Hospital
Washington County Office for the Aging	Fort Edward, NY	Area Agency on Aging

Westchester-Ellenville Regional Hospital Inc.

Ellenville Regional Rural Health Network

Grant number:
P10RH45779

Primary focus area:
Telehealth

Other focus areas:
Community Paramedicine, Elder Care, Network Organization/ Infrastructure Development

Organization type:
Critical Access Hospital

Grantee Contact Information

Organization	Ellenville Regional Hospital
Address	10 Healthy Way
City/State/Zip	Ellenville, NY 12428
Telephone No.	845-647-6400, ext. 205
Website	www.Erhny.org
Project Director	Brandon Bogert
Email	bbogert@erhny.org

Network Description

The Ellenville Regional Rural Health Network is a consortium of partners that provide services in Ellenville, N.Y. The core partners are Ellenville Regional Hospital, a 25-bed Critical Access Hospital; the Institute for Family Health, a Federally Qualified Health Center; and the Ulster County Department of Health. The purpose of the network is to promote the improved health and health equity of our rural community through increasing access to services and enhancing the local health and human service workforce. Since its inception, the network has grown to include partners from five counties and currently focuses on the prevention and management of chronic disease and the reduction and prevention of overdoses and other substance use related to negative health outcomes.

For the Network Development Planning Program grant, the network has brought together 13 partners, some existing and some new, including local offices for the aging, hospice agencies, more social service agencies, and community-based nonprofits to ensure there is sufficient reach to serve our intended audience of elderly persons in Wawarsing, Mamakating, and Crawford, N.Y. These partners are spread out around the project's service area, have an existing focus to serve our preferred population, and are leaders in the area when it comes to enhancing the lives of the communities they serve.

Program Description

With this Network Development Planning Program grant, the network will grow its structure to include subcommittees, including a data-focused committee and a healthy aging committee, to provide better structure for two areas that are important for the success of the network and the health of the community. These subcommittees will work to enhance the accessibility of services to seniors in Ellenville Regional Hospital's service area. This includes primary care, mental health care, and other health and wellness services. With the effects of the COVID-19 pandemic still looming in rural America, it is apparent that a large portion of the population, and seniors especially, are unable to receive adequate care due to issues with scheduling, transportation, and geographic isolation.

The project will improve these areas by developing a strategic plan for tele-wellness hubs in the three towns within the hospital's service area. These hubs will provide closer access to isolated individuals who need better access to primary, mental health, and preventive care, and can be utilized to improve the number of other wellness services made available to this population. This can be done through telemedicine or in-person services that can be offered at sites already frequented by seniors in each town. Additionally, a plan will be created for a community paramedicine program within each town to create a system of coordinated follow-up care to seniors who require emergency medical services.

Special Populations Being Served

- Elderly

Region Covered by Network Services

- Orange, NY
- Sullivan, NY
- Ulster, NY

Network Partners

Organization	City, State	Organization Type
Westchester-Ellenville Hospital Inc.	Ellenville, NY	Critical Access Hospital
Alzheimer's Association Hudson Valley Chapter	Poughkeepsie, NY	Nonprofit
Catholic Charities of Orange, Sullivan, and Ulster	Monticello, NY	Nonprofit
Ellenville First Aid and Rescue Squad	Ellenville, NY	Emergency Medical Services
Hospice of the Hudson Valley	Poughkeepsie, NY	Hospice
Jewish Family Services of Orange County	Middletown, NY	Nonprofit
Jewish Family Services of Ulster County	Kingston, NY	Nonprofit
Orange County Department of Health	Goshen, NY	Government
Orange County Office for the Aging	Goshen, NY	Area Agency on Aging
Rondout Valley Growers Association	Rondout, NY	Nonprofit
Sullivan 180	Liberty, NY	Nonprofit
The Institute for Family Health	Ellenville, NY	Federally Qualified Health Center
Ulster County Community Action Committee Inc.	Kingston, NY	Nonprofit
Ulster County Office for the Aging	Kingston, NY	Area Agency on Aging

North Carolina

Foundation for Health Leadership & Innovation

Bertie County Integrated Behavioral Health Network

Grant number:
P10RH45766

Primary focus area:
Network Organization/ Infrastructure Development

Other focus areas:
Mental/Behavioral Health, Substance Abuse Prevention and/or Treatment

Organization type:
Nonprofit Organization

Grantee Contact Information

Organization	Foundation for Health Leadership & Innovation
Address	2401 Weston Parkway, Suite 203
City/State/Zip	Cary, NC 27513
Telephone No.	919-821-0485
Website	www.Foundationhli.org
Project Director	Amelia Muse, Ph.D., LMFT
Email	Amelia.muse@foundationhli.org

Network Description

The Foundation for Health Leadership & Innovation (FHLI), Access East, Albemarle Regional Health Services (ARHS), Greater Wynns Grove Baptist Church, and East Carolina University (ECU) established partnerships in early 2022 to plan the Bertie County Integrated Behavioral Health Network. FHLI is a nonprofit organization deeply rooted in community, committed to elevating the voices of the people who live there, envisioning healthy communities where all people flourish. FHLI's strong connections with rural health organizations, local officials, and state legislators, and its expertise in integrated care, place FHLI in a unique position to serve Bertie County, N.C., to pursue the goal of planning an integrated behavioral health network. Access East serves as a whole-person care management entity for rural Eastern North Carolina, including Bertie County, and is a key support for primary care and specialty providers in the community. ARHS is the district health department serving several counties and provides core and essential public health services, including healthy communities programming, behavioral health care, and preventive health care. Greater Wynns Grove Baptist Church will serve as a faith-based partner in the network, helping to connect the provider and health system work to community residents. ECU is a public research university in Greenville, N.C., and is a leader in training health professionals serving rural North Carolina.

These partnerships are being used to elevate community voice in Bertie County to plan and build a network to address unmet behavioral health needs of county residents. The initial network partners will conduct outreach to critical voices that represent a broad spectrum of providers and community-based organizations. Outreach will include Bertie County residents with lived experience, local health providers, local public and community school systems, local government, faith-based organizations, small-business owners, and community-based organizations that support the aging population, as well as others. This array of partners will ensure that as many voices as possible are represented in the network to be able to plan a network to improve access to and quality of integrated behavioral health services in the community.

Program Description

The Bertie County Integrated Behavioral Health Network will focus on improving access to behavioral health care, including mental health and substance use treatment. Behavioral health access is a priority need in the community of Bertie County, where there are significant health disparities and difficulty accessing care. Options for accessing behavioral health services in Bertie County are limited, especially considering health care coverage in the community and provider availability. Intentional collaboration among provider organizations, community-based organizations, and community residents will inform how to address the gaps in behavioral health care. Network partners are interested in preventing over- and misuse of emergency services and organizing and planning better strategies to serve the Bertie community experiencing rural health care challenges. Filling this gap related to behavioral health will involve Bertie County provider organizations and partners working together to design coordinating strategies to expand their capacity to handle behavioral health care.

Through community convenings, bringing health provider and community voices together about behavioral health for the first time in this county, this network will collect ground truths concerning the root causes for existing access and quality issues, and foster a sense of hope and commitment to addressing long-standing inequities and challenges that have plagued this rural community for decades. The network will provide additional capacity for existing and new providers and community-based programs to spend time creating effective solutions, action plans, and changes as a network team instead of as individual, competing agencies. The network will also enhance provider support and acceptance of evidence-based models of integrated behavioral health care, including the beneficial outcomes of wraparound care management and coordination of treatment planning between primary care and behavioral health providers, ultimately resulting in meeting more behavioral health needs of the community.

Special Populations Being Served

- Black or African American
- Children/Adolescents
- Elderly

Region Covered by Network Services

- Bertie County, NC

Network Partners

Organization	City, State	Organization Type
Access East	Windsor, NC	Public Health
East Carolina University	Greenville, NC	College/University
Albemarle Regional Health Services	Windsor, NC	Public Health
Greater Wynns Grover Baptist Church	Colerain, NC	Other

North Dakota

University of North Dakota

North Dakota Rural Health Clinic Network

Grant number:
P10RH45777

Primary focus area:
Network Organization/ Infrastructure Development

Organization type:
University Center for Rural Health

Grantee Contact Information

Organization	University of North Dakota
Address	4201 James Ray Drive, Stop 8367
City/State/Zip	Grand Forks, ND 58202-6026
Telephone No.	701-330-3264; 701-213-5336
Website	Ruralhealth@und.edu
Project Director	Nicole Threadgold; Anna Walter
Email	Nicole.threadgold@und.edu; anna.walter@und.edu

Network Description

The North Dakota Rural Health Clinic (ND RHC) Network was established in 2021 through the Center for Rural Health at the University of North Dakota School of Medicine & Health Sciences to provide a platform of support and resources to the RHCs in North Dakota. The first part of the year was spent reaching out to all the RHCs across North Dakota to sign a memorandum of understanding agreeing to participate in the ND RHC Network, which achieved 100% participation. The remainder of the year was spent offering technical assistance, identifying statewide needs, and providing educational webinars.

The four partners chosen to support the Network Development Planning Program grant activities were selected based on (1) the expertise they bring from both small and large rural health systems, (2) being in rural counties and geographically located across North Dakota, (3) their experience participating in an Accountable Care Organization, and (4) having multiple years of experience in the health care industry.

Program Description

The programmatic focus of the ND RHC Network is to promote the development of statewide relationships among North Dakota RHCs and identify statewide needs. Discussions with North Dakota Critical Access Hospital (CAH) CEOs and other state partners identified the need for an RHC statewide support system, as one did not exist.

Through the University of North Dakota Center for Rural Health, the ND RHC Network is modeled after its ND CAH Quality Network, which has successfully provided support to North Dakota CAHs for over 15 years. Input from RHC contacts has been and will continue to be sought through the development of an RHC Advisory Committee, various network meetings, and surveys.

Region Covered by Network Services

The ND Rural Health Clinic Network is a statewide effort that covers all rural counties in the state and the rural portions of Morton, Burleigh, Grand Forks, and Cass counties.

Network Partners

Organization	City, State	Organization Type
Northwood Deaconess Health Center	Northwood, ND	Critical Access Hospital
Jacobson Memorial Hospital	Elgin, ND	Critical Access Hospital
Tioga Medical Center	Tioga, ND	Critical Access Hospital
First Care Health Center	Park River, ND	Critical Access Hospital

UPMC KANE

Chronic Illness Care Redesign Project

Grant number:
P10H45778

Primary focus area:
Chronic Disease Prevention/ Management

Other focus areas:
Mental/Behavioral Health, Substance Abuse Prevention and/or Treatment, Telehealth

Organization type:
Nonprofit Orgnization

Grantee Contact Information

Organization	Kane Community Hospital Foundation/UPMC Kane
Address	4372 U.S. Route 6
City/State/Zip	Kane, PA 16735
Telephone No.	814-837-4781
Website	www.UPMCKANE.com
Project Director	Lisa Keck
Email	Keckl@UPMC.edu

Network Description

The UPMC Kane Chronic Illness Care Redesign Services project will provide a planning strategy to integrate services for identified gaps in the target population of 109,726 in the Kane service area. The network consortium has loosely existed in the Kane service area for decades. Resources are extremely limited in this remote area of northwestern Pennsylvania; collaboration and networking are vital for service delivery. The network partners have identified key areas that can be improved upon by collaborating and sharing resources.

The six network partners included in this planning process are nonprofits currently providing services to the greater service area, but most importantly to the focus population of aged community members. The network has a particular focus on behavioral health and chronic illnesses (e.g., chronic obstructive pulmonary disease, lung disease, and heart disease). These conditions impact both the general population and the elderly in managed care and long-term care environments. Each collaborator included in the planning process will be more efficient by having a formalized process for regularly sharing services being provided and addressing barriers to connecting the senior population with health care. Several barriers have been identified, and activities are directed at measuring the current systems of care available, access, and interventions to overcome those barriers.

Program Description

The overarching focus for Network Development Planning Program grant activities is to improve the continuum of care and eliminate barriers to accessing health care for seniors in the UPMC Kane service area. Initial meetings with network collaborators indicate that a major gap in the service area for each participant is availability of inpatient service for mental health patients. Each participant is experiencing continued difficulty in providing psychological evaluations and placement for patients. Other gaps identified include preventive care, screenings for COVID-19, wellness screenings (including immunizations), primary care visits, emergency care, disease management, coordinated care among our senior care programs, and behavioral health. There has been increased demand in all aspects of health services at UPMC Kane. The need for planning includes a chronic disease care redesign to increase access to services and plan for effective community-based collaboration to reduce chronic disease and reduce barriers to improved community health. The goal is to reduce deaths due to chronic illnesses and substance abuse.

A collaborative approach to sharing services presents as the best solution. Implementing a telepsychology program to evaluate patients at both UPMC Kane and the Lutheran Home will provide the biggest impact for patients. The network identified a need to collaborate and share procedures, policies, and equipment to provide immediate relief for the patient population.

Special Populations Being Served

- Elderly
- Low Income and Underserved

Region Covered by Network Services

- McKean County, PA
- Warren County, PA
- Elk County, PA

Network Partners

Organization	City, State	Organization Type
UPMC Kane	Kane, PA	Hospital
UPMC Home Health	Kane, PA	Home Health
Lutheran Home of Kane	Kane, PA	Skilled Nursing Facility
Kane Area Community Center	Kane, PA	Other
Kane Senior Center	Kane, PA	Senior Center
Single County Authority for Alcohol and Drug Abuse	Port Allegany, PA	Other

Rural Health Association of Tennessee

Tennessee Rural Health Clinic Coalition

Grant number:
P10RH45771

Primary focus area:
Network Organization/ Infrastructure Development

Other focus areas:
Quality Improvement

Organization type:
Nonprofit Orgnization

Grantee Contact Information

Organization	Rural Health Association of Tennessee
Address	P.O. Box 656
City/State/Zip	Decaturville, TN 38329
Telephone No.	615-907-9707
Website	www.tnruralhealth.org
Project Director	Jacy Warrell
Email	jacy@tnruralhealth.org

Network Description

The Rural Health Association of Tennessee (RHA of TN) is in the process of building a Rural Health Clinic (RHC) Coalition. While many other states have either a stand-alone RHC association or a strong representation in their state rural health association, Tennessee has neither. Consequently, Tennessee RHCs do not have access to any centralized source for regulation updates, educational opportunities, or peer learning.

With more than 200 RHCs statewide, the development of an RHC Coalition will expand cross-organizational collaboration, improve the quality of basic health care services, and strengthen the rural health care system in Tennessee. Network partners include representatives from West, Middle, and East Tennessee. The current coalition advisory committee includes independent RHCs, provider-based RHCs, and a nonprofit/charitable clinic with RHC designation, as well as some other statewide partners.

Program Description

The goal of this project is to engage local RHC leaders in Tennessee's three "Grand Regions" in the development of a shared mission statement, decision-making structure, and an assessment of the network's sustainability and viability. RHA of TN seeks to understand the critical needs of Tennessee's RHCs to identify strengths, opportunities, and threats; interest in a RHC network and the essential roles and responsibilities of network partners; opportunities for cross-organizational collaboration and leadership development suited to Tennessee's RHCs; and resources needed to ensure the long-term sustainability and viability of the RHC Coalition.

Region Covered by Network Services

All rural Tennessee counties with RHCs

Network Partners

Organization	City, State	Organization Type
Three Rivers Hospital/St. Thomas	Waverly, TN	Critical Access Hospital
Servolution Health Services Inc.	Speedwell, TN	Nonprofit
Hometown Health Clinic	McKenzie, TN	Physicians Clinic
Saint Thomas–Accension	Nashville, TN	Hospital
East Tennessee State University–Rural Research	Johnson City, TN	College/University
University of Tennessee College of Pharmacy	Knoxville, TN	College/University
Cumberland Family Care	Spencer, TN	Physicians Clinic
Tennessee Department of Health, Office of Rural Health	Nashville, TN	Government

Jamie's Place

Methow Valley Community-Based Long-Term Care Network

Grant number:
P10RH45765

Primary focus area:
Health System Efficiencies

Other focus areas:
Care Coordination,
Long-Term Care,
Network Organization/
Infrastructure Development

Organization type:
Nonprofit Adult Family Home

Grantee Contact Information

Organization	Jamie's Place
Address	109 Norfolk Road
City/State/Zip	Winthrop, WA 98862
Telephone No.	509-996-5964
Website	www.Jamiesplace.org
Project Director	Rana Clarke
Email	jamiesplaceafh@gmail.com

Network Description

In 2020 the Jamie's Place board launched the Senior Assessment Support for Housing (SASH) committee to assess the current and future needs of the aging population in our rural community. The SASH steering committee consisted of representatives from the relevant social service agencies in our community.

The SASH report revealed the need for 28 additional facility-based beds to support the aging community, and data suggests that within the next five years more than 200 residents will be seeking caregivers to support aging at home. The report also found that a multipronged approach to the crisis is the only way to attain a sustainable eldercare solution. Quality care will require additional skilled nursing beds and caregivers to care for those requiring care in a facility or aging in place.

With this grant, a new network has been established, the Methow Valley Community-Based Long-Term Care Network, including three members: Jamie's Place, Family Health Centers (FHC), and Methow At Home (MAH). Based on the research found in the SASH report, the network members analyzed the significant needs and gaps in community-based long-term care services, facilities, and supports in the valley and initiated the process of identifying solutions. Together the network members will specifically address the infrastructure needs and gaps in services impacting access to community-based long-term care services in the valley.

Program Description

The network's aim is to expand access to, coordinate, and improve the quality of essential health care services by analyzing current systems and finding areas in need of improvement. The network is focusing on identifying ways to improve local long-term care supports through collaboration, access to additional services, and developing efficiencies to provide better outcomes. Additionally, the network is identifying ways to build workforce, facility-based, and in-home supports, and an infrastructure to manage the aging community. Network members have already made good progress:

1. The Workforce Development Team has initiated a program with Liberty High School to certify high school seniors as health care aides so they can move directly into jobs at Jamie's Place or in the community when they graduate. Training has begun, and the first group will graduate in May 2022.
2. Methow At Home has been working on many of the aging-in-place and fall-prevention programs.
3. The Facilities Team led to an Expansion Taskforce, which is currently doing a feasibility study to expand Jamie's Place by 28 beds.
4. The Housing Solutions Network and Methow Housing Trust is researching solutions for caregiver workforce housing.
5. The Grant Readiness Team has been working to identify grants that could further support the network. Thanks to a grant from the Methow Valley Fund of the Community Foundation of NW Washington, the network was able to hire a grant writer to assist in applying for the HRSA Rural Health Network Development Planning Program Grant.

Network members are focused on ways to enhance community and partner relationships to promote involvement and participation in network planning activities, aiming to strengthen the local valley and the entirety of Okanogan County.

Special Populations Being Served

- Elderly

Region Covered by Network Services

- Okanogan, WA

Network Partners

Organization	City, State	Organization Type
Methow At Home	Twisp, WA	Nonprofit
Family Health Centers	Twisp, WA	Physicians Clinic
Jamie's Place	Winthrop, WA	Skilled Nursing Facility

St. Clare Memorial Hospital

Northland Telehealth Network

Grant number:
P10RH45765

Primary focus area:
Telehealth

Other focus areas:
Health Equity,
Health System Efficiencies,
Network Organization/
Infrastructure Development

Organization type:
Critical Access Hospital

Grantee Contact Information

Organization	Prevea Health
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Telephone No.	920-429-1723
Website	www.Prevea.com
Project Director	Shane McMullen
Email	Shane.mcmullen@prevea.com

Network Description

The Northland Telehealth Network (NTN) is a collaborative of 11 health care partners at 14 sites (including eight Critical Access Hospitals and two opioid/substance use disorder treatment centers) that began conversations around telehealth connections in 2017. These discussions and planning expanded during the COVID-19 pandemic and the increased need for telehealth services.

This renewed effort will serve rural service areas that include 11 Wisconsin and Michigan counties with a total population of 326,000. The network's mission is to promote the capacity of members to improve access to health care in rural, underserved, and disadvantaged communities through the application of telehealth and telemedicine solutions. The vision is to connect and share resources, strengthen rural health care, and save lives.

Program Description

The programmatic goals for NTN are to (1) plan, formalize, and develop an integrated and sustainable telehealth network; (2) identify and leverage volume discounts to secure better price points to reduce member costs; (3) identify and improve efficiencies by eliminating unnecessary transfers; (4) increase the number of telehealth services; (5) expand the number of rural telehealth sites; and (6) increase rural patients' access to health care to improve outcomes and save lives.

Working relationships are already in place for tele-stroke and tele–neonatal intensive care unit with five out of the 11 members, which allows for best practices and improved efficiency.

Region Covered by Network Services

- Delta County, MI Marinette County, WI
- Oconto County, WI
- Door County, WI
- Jackson County, WI
- Buffalo County, WI
- Dunn County, WI
- Chippewa County, WI
- Rusk County, WI
- Barron County, WI
- Washburn County, WI

Network Partners

Organization	City, State	Organization Type
HSHS St. Clare Memorial Hospital	Oconto Falls, WI	Critical Access Hospital
Cumberland Healthcare	Cumberland, WI	Critical Access Hospital
OSF HealthCare St. Francis Hospital	Escanaba, MI	Critical Access Hospital
Indianhead Medical Center	Shell Lake, WI	Critical Access Hospital
Spooner Health	Spooner, WI	Critical Access Hospital
Prevea Health	Rice Lake, WI	Rural Health Center
Prevea Health	Ladysmith, WI	Rural Health Center
Prevea Health	Cornell, WI	Rural Health Center
Prevea Health	Mondovi, WI	Rural Health Center
LE Phillips Libertas Treatment Center	Chippewa Falls, WI	Behavioral Health
Libertas Treatment Center	Marinette, WI	Behavioral Health
Door County Medical Center	Sturgeon Bay, WI	Critical Access Hospital
Advent Health Durand Hospital	Durand, WI	Critical Access Hospital
Black River Memorial Hospital	Black River Falls, WI	Critical Access Hospital

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