U.S. Department of Health and Human Services

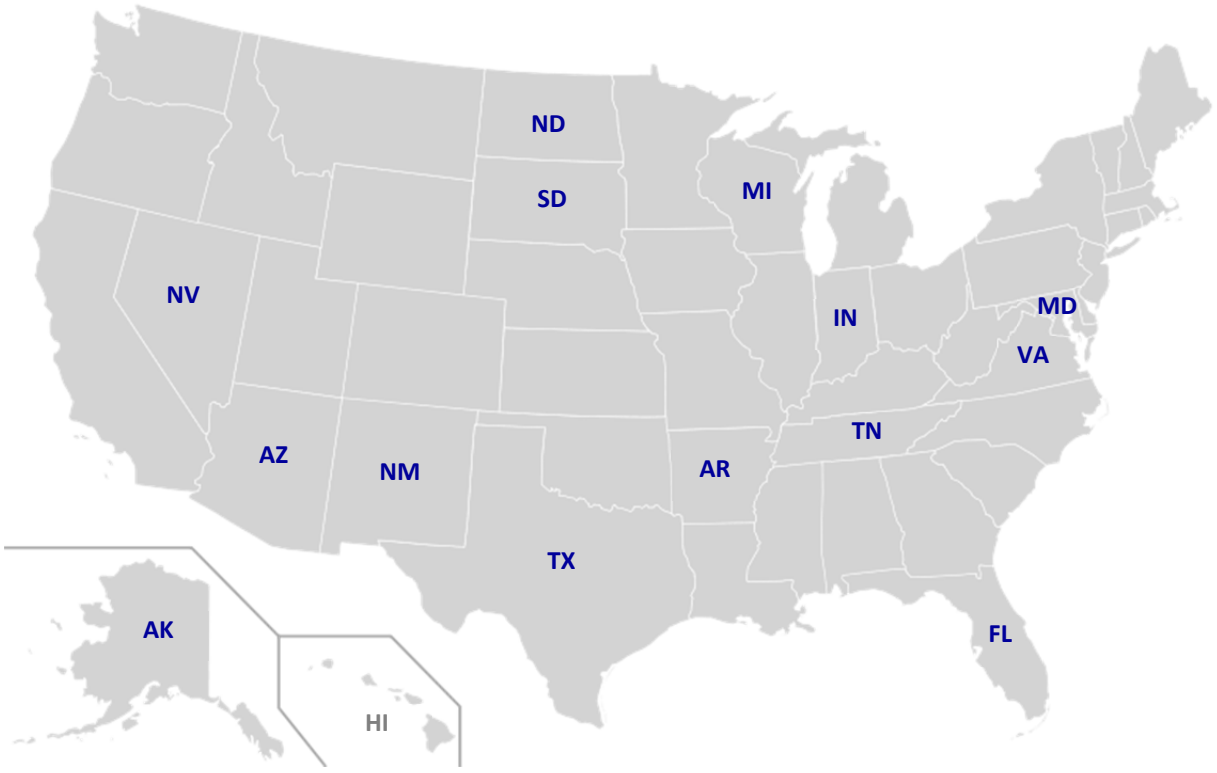
HRSA

Health Resources and Services Administration

Source Book

Rural Health Network Development Grant Program

2011 - 2014



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2011 – 2014 Rural Health Network Development Grant Program

The Rural Health Network Development Grant Program is authorized by the Public Health Service Act, Section 330A (f) (42 U.S.C. 254(c)(f)), as amended. For the 2011 grant year, the program is a three-year grant program with individual grant awards limited to a maximum of $180,000 per year. Its purpose is to expand access to, coordinate and improve the quality of essential health care services, and enhance the delivery of health care in rural areas. These grants support rural providers who work in formal networks, alliances, coalitions or partnerships to integrate administrative, clinical, technological, and financial functions. Funds provided through this program are not used for direct delivery of services. The ultimate goal is to strengthen the rural health care delivery system by 1) improving the viability of the individual providers in the network, and/or 2) improving the delivery of care to people served by the network.

Networks must consist of at least three separately owned entities, and each must sign a memorandum of agreement or similar document. Upon completion of the grant program, a network should have completed a thorough strategic planning process, be able to clearly articulate the benefits of the network to its network partners/members and to the community it serves, and have a sound strategy in place for sustaining its operations. Some anticipated outcomes of supporting the development of rural health networks include:

1) Achieving economies of scale and cost efficiencies of certain administrative functions by increasing the financial viability of the network;
2) Enhancing workforce recruitment and retention;
3) Sharing staff and expertise across network members;
4) Enhancing the continuum of care;
5) Providing services to the underinsured and uninsured;
6) Improving access to capital and technologies;
7) Ensuring continuous quality improvement of the care provided by network members;
8) Enhancing the ability of network members to respond positively to rapid and fundamental changes in the health care environment.

The Network Development program supports HRSA's goals of improving access and quality of health care, improving health outcomes, and improving public health and health care systems. The Program also supports U.S. Department of Health and Human Services' goals to improve the safety, quality, affordability and accessibility of health care, and to promote the economic and social well-being of individuals, families, and communities.

This Source Book provides a description of the 20 initiatives funded under the Rural Health Network Development Grant Program in the 2011 – 2014 funding cycle. The following information for each grantee is included: Organizational Information, Network Partners, Community Characteristics, Program Services, Outcomes, Challenges & Innovative Solutions, Sustainability, and Implications for Other Communities.

2011 - 2014 Rural Health Network Development Grant Recipients

(Listed by State)

2011 - 2014 Rural Health Network Development Grant Recipients

(Listed by Focus Area)

	Access to Care	
State	Grant Organization Name	Page
Alaska	Ketchikan General Hospital	1
Michigan	McKenzie Memorial Hospital	51
Michigan	Northern Michigan Hospitals, Inc.	60
New Mexico	Clayton Health Systems	72
Tennessee	Hickman Community Health Care Services, Inc.	88
Virginia	Giles Free Clinic	100
	Adolescent Wellness	
State	Grant Organization Name	Page
Arizona	Mariposa Community Health Center	12
	Aging	
State	Grant Organization Name	Page
Arizona	Tohono O'odham Nursing Care Authority	19
	Behavioral Health	
State	Grant Organization Name	Page
Alaska	Ketchikan General Hospital	1
Arkansas	Siloam Springs Rural Health Cooperative	24
Indiana	Affiliated Service Providers of Indiana, Inc.	34
Michigan	Alcona Citizens for Health	48
North Dakota	Coal County Community Health Center	80
Tennessee	WestCare Tennessee Inc. / WestCare Kentucky, Inc.	92
	Community Health Workers	
State	Grant Organization Name	Page
Arizona	Eastern Area Health Education Center	7
Maryland	Western Maryland AHEC	41
	Emergency Medical Services	
State	Grant Organization Name	Page
Alaska	Ketchikan General Hospital	1
Michigan	Michigan Rural EMS Network	54
South Dakota	Pioneer Memorial Hospital	85

2011 - 2014 Rural Health Network Development Grant Recipients

(Listed by Focus Area)

	Health Information Technology	
State	Grant Organization Name	Page
Indiana	Affiliated Service Providers of Indiana, Inc.	34
Texas	Southeast Texas Hospital System	96
	Health Promotion & Wellness	
State	Grant Organization Name	Page
Arkansas	Siloam Springs Rural Health Cooperative	24
New Mexico	Clayton Health Systems	72
	Oral Health	
State	Grant Organization Name	Page
Maryland	Western Maryland AHEC	41
Virginia	Giles Free Clinic	100
	Tele-Health	
State	Grant Organization Name	Page
Michigan	McKenzie Memorial Hospital	51
North Dakota	Coal County Community Health Center	80
Tennessee	Hickman Community Health Care Services, Inc.	88
South Dakota	Pioneer Memorial Hospital	85
	Women's Health	
State	Grant Organization Name	Page
Arizona	Eastern Area Health Education Center	7
	Workforce Development	
State	Grant Organization Name	Page
Florida	North Florida Community College	29
Nevada	Humboldt General Hospital	64
New Mexico	Clayton Health Systems	72

Alaska

PeaceHealth DBA Ketchikan Medical Center

Organizational Information	
Grant Number	D06RH21678
Grantee Organization	PeaceHealth DBA Ketchikan Medical Center
Organization Type	Hospital
Address	3100 Tongass Ave., Ketchikan, AK 99901
Grantee organization website	www.powhealthnetwork.org
Name of Network	Prince of Wales Health Network
Network Director	Name: Gretchen M. Klein
	Title: Project Director
	Phone number: 907-617-7635
	Fax number: N/A
	Email address: info@powhealthnetwork.org
Project Period	2011 – 2014
Funding level for each budget period	May 2011 to April 2012: $180,000
	May 2012 to April 2013: $179,902
	May 2013 to April 2014: $180,000

Network Partners		
Partner Organization	Location	Organizational Type
Southeast Alaska Regional Health Consortium	Klawock, Prince of Wales Island, Alaska	Tribal Health Consortium and Community Health Center
PeaceHealth	Craig, Prince of Wales Island, Alaska	Hospital System Primary Care Clinic
Alaska Island Community Services (Community Health Center)	Wrangell, Alaska	Community Health Center
State of Alaska Craig Public Health Center	Craig, Prince of Wales Island, Alaska	Public Health Center
Community Connections	Craig, Prince of Wales Island, Alaska	Behavioral Health Non-Profit Organization

Community Characteristics

A. Area

Coffman Cove, Craig, Edna Bay, Hollis, Hydaburg, Kasaan, Klawock, Naukati, Point Baker, Port Protection, Thorne Bay, and Whale Pass

B. Community description

Prince of Wales Island (POW) is a remote island in southern Southeast Alaska. The third largest island in the US, POW encompasses 2500 square miles and twelve distinct communities ranging in size from 15 to 1200 residents. Travel in this part of Alaska is challenging due to large distances, lack of roads, and inclement weather. It is time-consuming and financially unrealistic for most residents to travel off-island for higher levels of care. Travel off-island is by small plane or boat only, as there is no commercial jet service and no roads connecting the island to the mainland. Monthly unemployment ranges from 10.5 – 20.2%. The population is decreasing due to declines in the Island's main economic industries, logging and commercial fishing, and shortages of health care workers and resources are ongoing challenges.

C. Need

The greatest need entering this project was to establish and build a structure to facilitate communication and collaboration between healthcare providers on POW to order to improve access and service delivery to the island population. The Rural Health

Network Development grant became the conduit to establish a collaborative leadership framework with the overall goal "to build a strong and sustainable network of healthcare organizations, collaborating to strengthen the healthcare system on Prince of Wales Island and increase access to quality healthcare for all island residents far into the future."

The POW Health Network established the forum, structure and roles for the key health care providers of POW to come together 1) to act as a catalyst for improving healthcare and the supporting infrastructure for POW; 2) to share information and facilitate communication between stakeholders in healthcare on POW; 3) to initiate discussion about healthcare needs for POW and explore the feasibility of providing additional services; and 4) to leverage our members' collective influence to improve the quality of and access to healthcare services on POW Island. The Network itself did not pursue the direct delivery of care but rather focused on supporting the health care providers in their role and in the development of a collaborative infrastructure to support the Island's needs.

Program Services

A. Description

Over the years, the POW Health Network has led and participated in a wide array of activities including:

- Establishing and building a collaborative leadership team of health care providers and representatives that has and continues to hold quarterly meetings on POW.
- Providing staff support through the POW Health Network Director and assistant to further POW Health Network initiatives and activities.
- Leveraging collective support to:
    - Augment the Emergency Medical Services resources on POW through additional Southeast Regional EMS Council staff
    - Assist in the development of and funding for HOPE (Helping Ourselves Prevent Emergencies), a POW-based non-profit
    - Help change policies within agencies and within the State of Alaska for transferring patients who are under a court-ordered involuntary commitment (Title 47) off the island for care.
- Supporting and expanding behavioral health services on POW by securing additional State grant funding for the POW Behavioral Health Planning Project resulting in:
    - A comprehensive needs assessment and strategic plan to improve the behavioral health system on POW
    - A community coalition to oversee the implementation of the strategic plan and continue to advise the Network on behavioral health issues for the island into the future
    - The launch by HOPE of a domestic violence education and prevention pilot program, GreenDot Alaska.
- Facilitating the planning, development and implementation of island-wide and community-based health care education for:
    - 18 community and island-wide outreach health care forums
    - Distribution of the POW Healthcare Resource Guide to 4,000 residents
    - Distribution of the POW Youth Activities Guide to 2,000 residents
- Identifying and implementing an initiative to increase immunization rates for POW residents resulting in a 13% increase in 9 months.
- Supporting CME training for healthcare providers by sending them to various trainings such as: telemedicine, Southeast Region EMS Council symposium, veterans' telemedicine, veterans' PTSD, chronic pain management, Living Well Alaska, Gate Keeper Suicide Prevention, and SART (Sexual Assault Response Team) trainings.
- Assisting in improving outreach and care delivery to over 100 local veterans through the training of volunteers and creating a Veterans Center for communication and advocacy, resulting in their ability to receive benefits and access care and services.

B. Role of Network Partners

The Network is governed by a 9-member Steering Committee. The Steering Committee is comprised of one clinical and one administrative level representative from each member organization. The exception is Craig Public Health Center which contributes two clinical representatives due to staff limitations and organizational structure. The Steering Committee meets in-person quarterly, and members communicate with the Network Director between regular meetings. Decisions for the Network are made by consensus of the Steering Committee.

All Network members provide Steering Committee members' in-kind time to the project, as well as additional in-kind resources relative to achieving Network goals and objectives. In addition, PeaceHealth Ketchikan Medical Center (f/k/a Ketchikan General Hospital) serves as the fiscal agent for the Network and provides additional administrative and fiscal support to the project in-kind.

Outcomes

A. Outcomes and Evaluation Findings

One of the greatest contributions of the POW Health Network has been the creation of a venue for dialogue among health care providers, communities and residents as it relates to access, delivery and support of health care services on and for the Island. Though the Network itself does not provide direct services, there are significant benefits to the community from Network activities. Improved relationships between Network members result in better coordination of services between providers. Through regular face-to-face meetings, Network members can better identify and address unmet healthcare needs in the community. The Network has also provided increased communication to the community about services offered on POW via newspaper ads, social media, seminars, flyers and a website. Additional visiting specialists (psychiatry, orthopedics, women's health, colonoscopy, and optometry) see an average of 15 patients per day once/month. There has been a 20% increase in local patient visits overall, resulting in saving Island residents time and money as they do not have to travel off-island for services, and making those services accessible to some who otherwise could not afford to travel off Island for care.

In addition, by leveraging its collective influence, the Network has brought additional resources to POW, further improving the local infrastructure for care. Through advocacy of the Network, an EMS coordinator was hired by Southeast Region EMS Council (SEREMS) to better coordinate POW's EMS system. In addition, a behavioral health planning project carried out by the Network assured that the individual behavioral health providers on POW were collaborating to replace a critically needed recently lost service and providers. Out of this project, a strategic plan to improve the entire behavioral health system on POW was also created. Finally, through the infrastructure developed by the Network and the support it is able to continue to provide, HOPE (Helping Ourselves Prevent Emergencies), a small, local non-profit agency was established which was able to secure state funding to develop and implement a domestic violence prevention program on POW.

Other key outcomes of the POW Health Network include:

- Support in securing funding for the Network Behavioral Health (BH) Planning Project resulting in improvement of behavioral health structure on POW and enabling polices through the State of Alaska to improve transfers for Title 47 patients. (involuntary commitments).
- The launch of a state-wide pilot program called GreenDot Alaska and Coaches as Men from the BHC assessment, and community readiness.
- Training of 4 certified volunteer providers to facilitate the operation of SART (Sexual Assault Response Team). They work directly with patients who have been victims of assault. They are also key in the implementation of the policies and procedures relating to SART services.
- The launch of an immunization initiative to improve internal systems, access for patients, and education and awareness. This effort improved rates by 13%, and providers and patient dialogue across the region. It became a model for others in the state to follow.
- Increased access to physician and provider specialists on the island allowing patients to stay on the island to receive this care. These specialists on average see 15 patients monthly. These visiting clinics were not on POW 5 years ago.
- Assisted in establishing a centrally located Veterans Resource Center on Prince of Wales Island, staffed by volunteers to help enroll, and support the 400 veterans on the island. Though this project has just been initiated, it has already increased the number of veterans who are able to access wellness, behavioral health, and primary care services, and benefits.

B. Network Collaboration

The main goal of the POW Health Network is to achieve a higher level of service and increased accessibility to care through the collaboration of health care providers delivering care to POW residents, businesses and visitors. Though the providers of POW had attempted to initiate a forum for discussion and collaboration for close to 15 years, it was not until the HRSA Network Grant project that this was truly accomplished. It has taken years of building trust, both among the providers as well as with the communities, to achieve the outcomes of success enabled through this grant project.

During the grant period, the number of POW Health Network members increased in both number and scope. The Steering Committee now includes 5 separate organizations with representatives from PeaceHealth, SEARHC, Community Connections, Public Health and Alaska Community Services. The Network itself became the conduit for collaboration among key participants by providing a structure for sharing information through its Steering Committee and regularly scheduled meetings, and staff to support and implement the activities and actions to accomplish initiatives set by the Steering Committee.

As the Network developed, members realized the importance of:

- Providing a safe and continuous forum for sharing of ideas
- Having the right people at the table – both in organizational authority and experience as well as interpersonal skills
- Reinforcing the benefits of collaboration by choosing short-term achievable projects as well as working on more complex needs
- Putting in the effort to recruit, retain and grow staff and volunteer support
- Recognizing that it is a continuous process requiring on-going focus and work

Challenges & Innovative Solutions

Trust between Network members was the greatest initial barrier to success of the project. Due to the contentious history, it was necessary for Network members to display a mutual willingness to put aside past differences and move towards a new future of collaboration in order for the project to succeed. This was accomplished in a variety of ways. Values and roles for the Network and its members were identified early on in the project. These values played, and continue to play, a significant role in guiding Network activities and functions. In addition, the Network Director formed strong relationships with all Steering Committee members as well as additional support and administrative personnel at member organizations, further aiding the trust-building process. Regular face-to-face meetings of Network members initially occurred on a monthly basis. These meetings were essential to build stronger relationships between the Steering Committee members themselves, as well as extending these improved relationships further into the member organizations. The Steering Committee continues to meet face-to-face quarterly because of the mutually recognized value of these personal interactions.

Another challenge was the ability to recruit and retain qualified staff to support the Network. It was critical that one member agency serve as the fiscal agent for the Network and employ the Network Director so benefits and retirement could, and can continue to be offered, thereby encouraging the long-term commitment of a director. It has been essential for the Network and the Director to establish an independent identity, but everyone in the partnership understands without a fiscal agent it would not be cost effective or realistic for a director of this level to continue. In-kind contributions also were important, demonstrating network member commitment to the program as well as being good stewards of dollars of each of the members, and working toward collaboration in sharing and maximizing resources. An example of this has been the provision of office space for the Network staff by one of the member organizations. This collaboration through shared services and donations of in-kind marketing, travel, and office support for the continuation of the Network has shown the importance and value of the POW Health Network in this region.

Development of shared information technology was removed from the work plan for this grant period, due to unforeseen challenges with one agency's newly implemented electronic medical record system, as well as limited IT staff at two of the members' organization. Unfortunately, there was not enough staffing available among Network members to address this issue. However, it is anticipated that development of shared information technology can still be addressed in the future as Network members' IT staff become more available.

Sustainability

A. Network Structure

The POW Health Network will continue its work on the island. A sustainability strategy for the Network has been identified and implemented. In 2014, an agreement with the Alaska Community Foundation to accept donated funds on behalf of the POW Health Network was established, thereby allowing the POW Health Network to pursue another type of fundraising. PeaceHealth will continue to be the fiscal agent for the Network, including providing the management and human resources oversight for the POW Health Network staff. As part of the sustainability strategy, the 5 partnering agencies of the POW Health Network have committed $36,000 in cash per year for the next 3 years, and another $87,000 in-kind, to support the continuation of the POW Health Network in 2014. We are proud of the work and collaboration of the partners, and their willingness to commit funds and resources to ensure the on-going operations of the POW Health Network. This speaks volumes about their recognition of the

value of the Network in supporting the members and the health care delivery system to deliver the highest level of care and services accessible locally as feasible. The Network Director also has a fund development plan to fundraise another $24,000 from local donors and corporate sponsors in 2014.

B. On-going Projects and Activities/Services To Be Provided

Though the Network does not provide direct services, there are significant benefits to the community from Network activities. The Network future goals are to continue to improve immunization rates and behavioral health by integrating systems and processes. Partners are committed to continuing to collaborate to improve health outcomes and the over-all health of the residents of Prince of Wales.

C. Sustained Impact

One of the greatest long-term effects of the POW Health Network has been the creation of a forum for health care providers to come together to work collaboratively to solve problems and improve health care for POW residents. These partner agencies have stepped forward with cash and in-kind contributions, demonstrating their sense of value of and commitment to the Network to ensure that this forum continues.

One of the greatest accomplishments of the Network to date has been the creation of the Prince of Wales Behavioral Health Planning Project. In 2009, the primary provider of behavioral health services on POW abruptly and unexpectedly closed its doors, leaving a significant gap in substance abuse and mental health services. Although the Network did not have behavioral health in its goals and objectives at that time, members recognized this was exactly the type of situation the Network was formed to address. Due to the collaborative structure already in place, the State of Alaska Division of Behavioral Health awarded the Prince of Wales Health Network a 2-year grant to provide an island-wide needs assessment and strategic plan to improve the behavioral health system on Prince of Wales. A comprehensive needs assessment and strategic plan were developed through this project, and a community coalition has been formed to oversee the implementation of the strategic plan and continue to advise the Network on behavioral health issues for the island into the future. Through this project, behavioral health providers came together to develop a coordinated plan to improve the system on Prince of Wales. Furthermore, through the foundation laid by this project, Helping Ourselves Prevent Emergencies (HOPE), a local non-profit agency, was able to secure additional state funding to develop a domestic violence prevention program, a key area of need identified by the Network through the needs assessment process. The Network worked closely with HOPE to continue to provide support and resources in the development of this program. HOPE now has an Executive Director, and through philanthropy and state funding, has been able to continue to deliver services on the Island.

The Network has been able to leverage its collective influence in other ways also. In 2009, Network members collectively recognized a need for increased support to POW's fragmented EMS system. The Network advocated to Southeast Region EMS Council (SEREMS) for increased support to POW EMS. There has been a full-time staff person for SEREMS, improving education opportunities and trainings for the last 4 years. There have been over 40 classes and trainings given to help support EMS in the communities. In addition, as a result of collaboration, the Network Director is able to advocate for POW as a whole to local, regional and state agencies, and provide continuing education for many of the providers from 20011-2014.

The Network and its strong volunteers and partnering agencies have been critical for ensuring regular communications on the island. Health outcomes improved for chronic pain management, immunization rates, behavioral health services, and an increase in availability of specialists on the island. In addition, a significant portion of Network meetings is dedicated to sharing operational issues and organizational updates. Without these face-to-face meetings, a forum for these important discussions would not exist. Network members recognize that relationships and communications are, and will continue to be, the foundation for all other successes.

The ability to accomplish many of these things was a result of communication, advocacy, and commitment of many partners coming together to improve health outcomes and quality of services and programs through this region.

Implications for Other Communities

It is critical for the Network members and their representatives to demonstrate a high level of commitment to project success. This project was successful because Steering Committee members were committed to active participation at meetings, followed through on goals, and thereby initiated change. Additionally, Steering Committee members made funding commitments, gave marketing support, and provided other adequate support from their respective organizations for participation in Network activities. A community could

easily struggle with a similar project if members did not display an equal level of commitment. It is equally essential for the right people to be at the table. Member representatives must have enough decision making authority, yet also understand the lower level operational issues of local clinics.

The Network Director serves as a coordinator of information and driver to get people together. This person should be highly skilled at facilitation, a strong leader, and possess excellent communication and interpersonal skills. In the case of the POW Health Network, the Network Director from 2012-2014 was a life-long resident of Southeast Alaska, and knew the complexity of working with 12 different communities, each having its town tribal council / government body. The Director must work with everyone to help strengthen and support collaboration, regardless of differences of opinion. On POW it became a team effort to bring positive outcomes and wonderful collaborations. The Network Assistant helped assure that meetings and partnerships could be met and continued. Various partners stepped up in 2012 - 2014 to assist in identifying resources, and to partner with state, federal, tribal, and local agencies. Consultants, grant-writers, and educators were utilized to expand our resource base and to assure Network sustainability after HRSA grant funding expired.

Finally, it is essential for communities to recognize that the Network truly is a partnership of everyone and to see the value in the Network's work and accomplishments. When developing a network, it is important to be open to building a structure that engages the patients and the family members for their insight and understanding of the area. However, the true weathervane for success will come from the partners, communities, residents, area businesses, and agencies recognizing the value of the Network and what it can accomplish. On POW, this wide array of entities and individuals came together to help make initiatives happen and projects succeed.

Arizona

Eastern Area Health Education Center

Organizational Information	
Grant Number	D06RH21669
Grantee Organization	Eastern Area Health Education Center
Organization Type	AHEC
Address	5860 South Hospital Drive, Globe, AZ 85501-9449
Grantee organization website	www.azrwhn.org
Name of Network	Arizona Rural Women's Health Network
Network Director	Name: Kimberly Zill
	Title: Network Director
	Phone number: 602-288-7544
	Fax number: 602-252-3620
	Email address: kimberlyz@aachc.org
Project Period	2011 - 2014
Funding level for each budget period	May 2011 to April 2012: $180,845
	May 2012 to April 2013: $179,961
	May 2013 to April 2014: $178,649

Network Partners		
Partner Organization	Location	Organizational Type
Eastern Arizona Area Health Education Center	Globe/Pinal, Gila & Graham/AZ	AHEC
Northern Arizona Area Health Education Center	Flagstaff/ Northern Yavapai, Apache, Navajo & Coconino/AZ	AHEC
Greater Valley Area Health Education Center	Phoenix/Maricopa, Southern Yavapai and Pinal/AZ	AHEC
Western Arizona Area Health Education Center	Yuma/Yuma, Mohave & LaPaz/AZ	AHEC
Southeastern Arizona Area Health Education Center	Nogales/Santa Cruz, Pima, Greenlee, Graham & Cochise)	AHEC
Center for Rural	Tucson/All Counties/AZ	State Office/University
Arizona State Office of Rural Health Programs	Tucson/All Counties/AZ	State Office/University
Arizona State University	Tempe/Maricopa/AZ	University
Regional Center for Border Health, Inc.	Yuma/Yuma/AZ	Non-Profit
Inter Tribal Council of Arizona (ITCA)	Phoenix/All Counties/AZ	Non-Profit
North Country Healthcare (NCHC)	Flagstaff/Coconino, Gila, Mohave, Navajo & Apache/AZ	FQHC
Mariposa Community Health Center	Nogales/Santa Cruz/AZ	FQHC
Time Out, Inc.	Payson/Gila/AZ	Non-Profit
Mogollon Health Alliance	Payson/Gila/AZ	Non-Profit
Arizona Department of Health Services	Phoenix/All Counties/AZ	State Department of Health Service
Payson Amnesty International	Payson/Gila/AZ	Non-Profit
Arizona Alliance for Community Health Centers	Phoenix/All Counties EXCEPT LaPaz County/AZ	Non-Profit/Primary Care Organization

Community Characteristics

A. Area

The Arizona Rural Women's Health Network serves all 15 counties of Arizona:

Gila	Greenlee	LaPaz	Mohave	Coconino	Apache	Cochise
Maricopa	Santa Cruz	Yuma	Pinal	Pima	Graham	Yavapai
Navajo						

B. Community description

In Arizona, diversity compounds the challenges of traditional rural women's health issues. Rural Arizona is not a uniform landscape environmentally, socially or culturally. The diversity of rural areas ranges from international borderlands to Indian reservations to areas classified as frontier. Population composition varies greatly among regions, and includes large percentages of Hispanics and American Indians. Consequently, rural women in Arizona face an array of health care issues, and multiple agencies in different regions have developed specialized responses for the communities they serve. Despite continuous and concerted efforts, however, significant gaps in services for rural women persist in all areas of the state.

C. Need

The Arizona Rural Women's Health Network was formed to address health challenges and adverse outcomes affecting rural women and their families primarily through providing health care provider training and continuing education programming. These programs were conducted through Network member partnerships/collaborations. The intent of AzRWHN is to address the fundamental problem that there is a lack of health care information, services, and accessibility in Arizona's rural areas specifically designed to reach women, who are the key conduits for health care and wellness within their families. As a result there are health disparities among rural women themselves and associated family members.

Program Services

A. Description

Over the past three years the Network has conducted activities to build the partners' capacity to cultivate and promote innovative policies and practices that improve the health of women in rural Arizona. These activities include: network development, growth and retention; efforts to raise awareness and influence policy around issues concerning rural women's issues in the state; and opportunities to improve health information, services and data for health care providers and rural women and their families. The Network has partnered with members to produce workshops around women's health, perinatal care, trauma informed care, heart, breast and oral health, domestic and sexual violence and other issues affecting rural women's health. AzRWHN has participated in numerous community meetings, health fairs, workshops, and community meetings. The Director and members have represented the Network at various community, state and national workshops, meetings and conferences.

B. Role of Network Partners

Having these organizations working together as a coordinated, collaborative network has had significant benefits for rural Arizona. Each of these organizations is doing substantial work to promote women's health in rural communities. Although there have been various successful initiatives and task forces and special projects that have attempted to meet the needs in rural communities, it is especially difficult to address the availability and timely delivery of health- related services for women living in rural/frontier communities on an on-going basis. This problem is often exacerbated by the lack of funds to ensure sustainability. By working together as a network, the programmatic assets and expertise held by each partner can and has been shared and leveraged to overcome the unpredictability of available services, resources and education.

Outcomes

A. Outcomes and Evaluation Findings

The full benefits and long-term impact of the Network's efforts in the counties it served will not be known for many years. As part of the network's evaluation efforts, an analysis/evaluation to measure and monitor connectivity of the related partnerships was conducted. This was accomplished using a tool called PARTNER (Program to Analyze, Record, and Track Networks to Enhance

Relationships). PARTNER is a social network analysis program that includes a survey that can be administered online and an analysis tool that reads the data gathered from the survey and provides options for social network analysis. Social Network Analysis is a method used to identify the members of a network and the relationships between those members. Members of a network can be visually represented as nodes (often as circles/squares) and the relationships between them are visualized as lines connecting those nodes (See Diagram). In addition to visualizations, network "measures" can indicate who the key players in a network are for example, centrality shows who has the most number of connections or who is a bridge between subsets of the network.

Participants in this survey included:

1.	Eastern Arizona Health Education Center	EAHEC
2.	North Country Healthcare	NAHEC
3.	Regional Center for Border Health, Inc.	RCBH
4.	Inter Tribal Council of Arizona	ITCA
5.	Mariposa Community Health Center	MCHC
6.	Time Out, Inc.	Time Out
7.	Mogollon Health Alliance	MHA
8.	Arizona Department of Health Services	ADHS
9.	Payson Amnesty International	PAI
10.	Western Area Health Education Center	WAHEC
11.	Center for Rural Health-MEZCOPH	CRH-MEZCOPH
12.	Greater Valley Area Health Education Center	GVAHEC
13.	Inter Tribal Council of Arizona	ITCA
14.	Arizona Association of Community Health Centers	AACHC

Utilizing the PARTNER tool, Network members were asked to share their opinions about the collaborative's most important outcome. Reducing health disparities was considered by 25 percent of the members as the most important outcome of the Network, followed by public awareness and improved health outcomes at 17 percent respectively. Other outcomes identified by members were health education services, improved services, improved resource sharing, increased knowledge sharing and community support.

When asked how successful the Network has been at reaching its goals, 67 percent of members said somewhat successful and 33 percent said successful. Members were then asked to identify what aspects of their collaboration contribute to their success. Twenty-one percent of members identified the exchange of information and knowledge as a contributor to success. Other contributors include: sharing resources (17 percent), having a shared mission, goals (17 percent), meeting regularly (14 percent), bringing together diverse stakeholders (12 percent), informal relationships created (12 percent) and collective decision-making (seven percent).

In addition to the network map, the connections between the members are described in whole network scores that represent the network at the aggregate level. That is, the whole network members' responses comprise these scores (see below). Each one is a percentile.

Network Scores

Density	43.30%
Degree Centralization	34.30%
Trust	78.10%

Whole network scores offered by PARTNER include density, degree centralization, and trust. Density measures the concentration of individuals who are connected to each other in a network. An increase in connections means an increase in density. This Network is well on its way to becoming a highly dense network through an increase in membership and connections.

Centralization measures the extent to which a network is dominated by one or a few very central hubs. In a highly centralized network, these central hubs represent single points of failure, which if removed or damaged, quickly fragments the network. Since the Network did not score very high in this measure, it must strive to be a less centralized network in order to have fewer points of failure and exhibit greater resilience.

Trust as measured here is the amount of reliability, support for the mission, and willingness to engage in frank, open, and civil discussion, considering a variety of viewpoints that an organization is described as having. In this measure, the Network scored very high indicating a mature network that is supportive, engaged and willing to be honest in a respectful manner.

B. Network Collaboration

Contributions members make to the Network include:

- In-Kind resources
- Paid staff
- Volunteers
- Data resources including data sets, collection and analysis
- Specific health expertise
- Expertise other than health
- Community connections
- Fiscal management (e.g. acting as fiscal agent)
- Facilitation/Leadership

An important lesson learned by the Network, and critical to its success, was learning to maximize the time spent together collaborating. As the Network matured and the scope of the work began to solidify it was necessary to focus the group's planning efforts and help the group reach specific conclusions and objectives. In this Network's experience, utilizing a skilled facilitator was important for leading the meetings and helping the group define its goals.

Another important lesson that the Network has learned is the value of engaging community stakeholders, learning about their work and identifying how the Network's resources and expertise can address community concerns. Through said communication this Network was able to identify a very specific project --sexual violence prevention and treatment -- that was necessary in Arizona and that has had great community acceptance.

Challenges & Innovative Solutions

During the three-year grant period, the Network decided the overarching goal of rural women's health could be broad in terms of garnering evaluation data and outcomes. While women's health remained the focus of the Network, a needs assessment undertaken by the Network resulted in the development and implementation of a more targeted pilot program. The pilot program was developed for Community Health Workers/Promotoras and Community Health Representatives around sexual violence in rural Arizona. This curriculum and training program was developed to address the culturally specific needs of the diverse populations residing in Arizona and the Southwest.

The Network experienced staffing changes related to resignation of the former network director and evaluator. The Network experienced a few months in 2012 without staffing in both of these roles, but was able to continue with 1) structure and guidance of the Leadership Team and 2) the overall members working together ensuring sustainability. Lastly, the Network did lose two members, but acquired five additional new members in this grant cycle.

Sustainability

A. Network Structure

The AzRWHN is a mature network formed in 2006. The Network expects to retain all partners after the termination of funding from this award. Arizona Alliance for Community Health Centers is the current subcontractor housing the Network Director and will remain so after this grant funding cycle ends. Other revenue streams will be pursued including promotion of training education activities for healthcare professionals. The Leadership Team will remain intact and provide insight and guidance for the Network. Monthly teleconferences will continue as well as quarterly face-to-face Network meetings. The current MOU partners are:

Northern Arizona Area Health Education Center (NAHEC)
Arizona Alliance for Community Health Centers (AACHC)
Greater Valley Health Education Center (GVAHEC)
Eastern Arizona Area Health Education Center (EAHEC)
Mariposa Community Health Center (MCHC)
Western Arizona Area Health Education Center (WAHEC)

B. On-going Projects and Activities/Services To Be Provided

AzRWHN will continue providing women's health education, health care provider training, resources and services to rural Arizona. This will take place through collaboration with current and future members along with other partnerships throughout the state. It is expected from preliminary evaluation data, the sexual violence pilot program will be expanded and offered to other lay health professionals, public health nurses and other appropriate audiences, including other states.

Preliminary evaluation data from this pilot program is very promising. Please see below:

Question	% Who Agree
1. The training met my expectations	89.3
2. The learning objectives for each topic were met	85.7
3. The content was well organized and easy to follow	89.3
4. The materials were relevant and useful	82.1
5. The trainer was knowledgeable and effective	92.9
6. Adequate time was provided for questions and discussion	60.7
7. My time in this training was well spent	82.1
8. I would recommend this training to others	96.4

C. Sustained Impact

AzRWHN's project efforts has increased the capacity of Network members and partners to create and promote policies and linkages that will result in enhanced overall health for Arizona's rural women. Specifically, the Network has and will continue to provide training to rural providers and other stakeholders on rural women's health issues, emphasizing sexual violence; advance policy through increased awareness and advocacy; foster collaboration among key stakeholders to bridge gaps in care, resources, and service provision; increase the use of Community Health Workers/ Promotoras and Community Health Representatives; while collaborating and networking with community, state and national partners.

The AZRWHN has an opportunity to partner with the Arizona Department of Health Services, Bureau of Women's and Children's Health to ensure women living in rural and frontier communities have an opportunity to provide input to the Title V needs assessment by coordinating listening and prioritization sessions in rural communities. This input will help identify Maternal and Child Health priority areas for Arizona which will in turn drive funding decisions for the following five years.

Implications for Other Communities

The Arizona Rural Women's Health Network is a statewide rural health network consisting of both horizontal and vertical organizations. AzRWHN experiences would benefit other networks that propose a similar structure. The Network has been able to leverage resources, utilize members' expertise and collaborate to produce effective and essential public health programming and education for underserved rural women and their families living in Arizona.

The sexual violence curriculum and training program created by the AzRWHN for Community Health Worker/Promotoras and Community Health Representatives has been very successful to date. Since this program was specifically designed for the culturally diverse needs of women in Arizona, we believe this program would benefit similar populations across the country.

Arizona

Mariposa Community Health Center (MCHC)

Organizational Information	
Grant Number	D06RH21674
Grantee Organization	Mariposa Community Health Center (MCHC)
Organization Type	Federally qualified health center
Address	1852 N. Mastick Way, Nogales, AZ 85621
Grantee organization website	www.mariposachc.net
Name of Network	Santa Cruz County Adolescent Wellness Network (AWN)
Network Director	Name: Cassalyn David
	Title: Network Director
	Phone number: 520-375-6050
	Fax number: 520-761-2153
	Email address: cdavid@mariposachc.net
Project Period	2011 - 2014
Funding level for each budget period	May 2011 to April 2012: $180,000
	May 2012 to April 2013: $180,000
	May 2013 to April 2014: $180,000

Network Partners		
Partner Organization	Location	Organizational Type
Southeast Arizona Area Health Education Center	Nogales, Santa Cruz County, AZ	AHEC
University of Arizona Cooperative Extension-Santa Cruz County	Nogales, AZ	University extension service
Santa Cruz County Superintendent of Schools	Nogales, AZ	County education authority
Circles of Peace	Nogales, AZ	Non-profit domestic violence and youth substance abuse prevention
Community Intervention Associates	Nogales, AZ	Behavioral Health Provider
Pinal Hispanic Council	Nogales, AZ	Behavioral Health Provider
Nogales Unified School District #1	Nogales, AZ	Public School District
Santa Cruz Valley Unified School District #35	Rio Rico, Santa Cruz County, AZ	Public School District
Patagonia Elementary and Union High School Districts	Patagonia, Santa Cruz County, AZ	Public School District
University of Arizona Mel & Enid Zuckerman College of Public Health	Tucson, Pima County, AZ	Academic Evaluation Partner

Community Characteristics

A. Area

AWN serves all of Santa Cruz County, Arizona, including the county seat, Nogales, and the communities of Rio Rico, Tubac, Tumacacori, Patagonia, and Sonoita.

B. Community description

Santa Cruz County is the smallest county in Arizona (1,238 square miles) with a population of 47,420 (US Census 2010). Being contiguous with the international border with México, its way of life—history, people, culture and economy—are linked to its neighbors in the state of Sonora, México. As the largest community in the county, Nogales serves as the primary source of employment and public services for the entire county. It shares deep ties with Nogales, Sonora, its neighbor just across the border. Nogales, Arizona is home to two very active ports of entry that welcome a steady flow of people and commerce. The border also poses challenges in terms of illegal trafficking of drugs, goods and people. The county population is 82.8 percent Hispanic, compared to 29.6 percent across Arizona. One third (32.7 percent) of Santa Cruz County residents are foreign born, and 79.7 percent speak a language other than English at home, compared to 27.1 percent statewide. In 2012, the adolescent population of Santa Cruz County (aged 12-25) was 9,086. Santa Cruz County is a low-income community, with a median household income of $42,948 compared to $50,752 for Arizona. According to the Annie E Casey Foundation, 37.5 percent of Santa Cruz County children under 18 lived in poverty in 2011, compared to 22.9 percent statewide. Only 71.2 percent of county adults attain high school graduation, compared to 85.2 percent in Arizona. The unemployment rate was 20.3 percent in August 2013 compared to 8.7percent for Arizona.

C. Need

Youth service providers in Santa Cruz County face complex adolescent health issues with limited resources. The roots of these health issues are in social and economic factors that no single organization can confront alone. A partnership was needed to allow organizations to collaboratively identify and address the local needs and maximize local assets.

Health Care Access and Insurance Coverage - In the 2012 BRFSS, 21 percent of Santa Cruz County respondents reported they could not see a doctor in the past six months due to cost, compared to 14 percent in Arizona. In 2011, 18 percent of Santa Cruz County children were uninsured, compared to 13 percent across Arizona. The 2013 Santa Cruz County Community Health Assessment included a survey of 201 residents. Respondents echoed this data by selecting lack of health insurance as the most important health problem in our county (56percent). Lack of insurance coverage and confusion about eligibility often preclude or delay diagnosis and treatment. In many cases, residents who are uninsured or underinsured seek alternate care in México which can lead to challenges in terms of continuity of care. Santa Cruz County is a medically underserved area. The U.S. Department of Health and Human Services designates SCC as a Health Personnel Shortage Area (HPSA), a Medically Underserved Population (MUP) and a Medically Underserved Area (MUA) and a Dental HPSA.

Adolescent Health Literacy - The immigrant and Spanish-speaking nature of the community influence communication and literacy, and therefore health literacy. AWN partners gathered data directly from local youth via focus groups (n=9) and a survey (n=223 middle school students) in 2009. The following results and needs were identified:

- *Seeking health information and treatment:* The majority of survey respondents sought medical treatment from western providers, while many receive medical advice from grandmothers and treatment across the border in México.
- *Comprehension of health information:* Many of the students demonstrated some proficiency at reading food labels; however, further education is needed to ensure all youth can access the full benefit of available health information.

These findings are consistent with the literature on rural and Mexican/Mexican-American healing practices and health literacy. They demonstrate opportunities for AWN to improve access to health care and information through collaboration and integration among the local, culturally competent service providers.

Adolescent Education - Santa Cruz County has six high schools (four public, one charter and one private) serving over 3,200 students for the 2013-2014 school year. In Santa Cruz County in 2011 the four-year graduation rate for all students was 81.1 percent, but just 23.5 percent for students with limited English proficiency (Annie E. Casey Foundation). AWN works to support the schools' efforts to serve the "whole child," providing the health and wellness services that can help students succeed.

Nutrition and Physical Activity - A Youth Risk Behavior Survey was administered to high school students in Santa Cruz County in 2007. Nearly 13 percent of students were overweight and 15 percent were at risk of becoming overweight. Almost a third (28 percent) is at risk for overweight and its lifelong health implications. This is consistent with nationwide disparities among rural, low-income, and Hispanic residents.

Adolescent Pregnancy - Santa Cruz County consistently has higher teen pregnancy rates than most Arizona counties, with 27.9 pregnancies per 1,000 females ages 19 and under, compared to 23.0 for the state in 2011. Santa Cruz County has the fourth lowest percentage of pregnant women who receive prenatal care in their first trimester, 68.9 percent compared to 81.7 percent for the state in 2011.

Program Services

A. Description

The Santa Cruz County Adolescent Wellness Network carried out the following activities during the Rural Health Network Development (RHND) Grant Program.

Network Infrastructure and Sustainability: AWN established a robust network structure during the RHND grant period through development of operating procedures (described in Part VI), strategic planning, and by convening monthly meetings. The activities were carried out collaboratively by partners under the leadership of the full-time Network Director and the Leadership Team, an elected Chair and Vice-Chair. The Network Director executed and renewed contracts with network partners and consultants and established MOAs with new members. The AWN sustainability planning process was based on the Georgia Health Policy Center (GHPC) Sustainability Framework and included two retreats to involve all members. In response to evaluation outcomes that indicated a need for expanded membership, the network engaged in outreach to new partners that is described in more detail in Part VI. The network also created and fulfilled a Communications and Marketing Plan through print, electronic, and in-person outreach including developing and maintaining website and Facebook pages and email newsletters.

Increased capacity and integration of school and community services for adolescents: In order to assess and respond to adolescent wellness needs in the county, AWN produced a number of reports, surveys, and trainings.

- Funding Scan – To establish a baseline of existing resources and funding sources of the various adolescent-serving organizations in Santa Cruz County, the Funding Scan provides an overview of both school-based and community-based adolescent programs in Santa Cruz County. This was completed in October of 2011. AWN plans to update the report in the future to measure change and potential impact form AWN efforts to promote these programs.
- School Health Profiles – In November 2011, AWN initiated a local inventory of school health services and policies. The CDC School Health Profiles surveys were sent to all schools in the county and results were used to compare local policies and practices to state and national results and best practices, identify gaps and areas for improvement, and assess family and community involvement in school health.
- Trainings – In November 2011 AWN conducted a Training Needs Assessment which allowed teachers and other adolescent service providers in the county to identify gaps in skills and knowledge they felt required trainings. Thanks to participation from the diverse network members (described in section B. Roles below), AWN was able to provide trainings for 446 service providers on eight topics specifically tailored to an adolescent development perspective. Topics included bullying, teen dating violence, asthma, suicide prevention, identifying and referring youth with emotional risks, improving parent-teen communication, and current trends in street drugs.

Social, environmental, and policy changes that favor services for adolescents: AWN understands youth health issues through the socio-ecological model and sought to create organization and system-level improvements during the RHNDG period.

- Coordinated School Health (CSH) – Under the leadership of the County Superintendent of School's Office, the network worked to support schools' efforts to improve their CSH policies and practices. AWN provided technical assistance to school health advisory councils, promoted best practices, supported continuing education for CSH leaders in the schools, and raised awareness and understanding of the importance of CSH.
- School-Linked Health Care (SLHC) – AWN members brought state and national resources to the county to promote school-linked health care, a system of referral and follow-up that would improve access to care for the students our members serve. AWN members hosted a forum, researched past school-based health centers in the area that were unsustainable, and worked with providers in neighboring counties to create a plan for sustainable SLHC. AWN was able to negotiate Memoranda of Agreement with the three major school districts in the county and applied to HRSA for funding to support the system's development and implementation.
- Youth Involvement – AWN values youth involvement in the programs and decisions that affect them as well as quality opportunities to learn and lead. The UA Cooperative Extension developed a Youth Involvement Toolkit on behalf of AWN that brings together research, tools, and best practices to help any organization develop its youth program. Following a process that included youth focus groups, self-assessment, and a forum on youth involvement with 16 other local organizations, AWN began a pilot group of 4 local high school students who are helping develop a full-fledged youth program. The teens are implementing youth board governance, updating operating procedures, and creating outreach and training plans. Meanwhile, AWN is advocating for more youth input into decisions and more quality youth leadership opportunities in organizations across the county.

B. Role of Network Partners

AWN manages the roles and responsibilities of its partner organizations through the operating procedures, contracts, and MOAs.

Mariposa Community Health Center (MCHC) is the lead agency and grant applicant, housing the Network Director. MCHC is a federally-qualified health center, and the major provider of primary care, dental, and public health services in Santa Cruz County.

Santa Cruz County Superintendent of Schools (SCCSS) provides all school districts in Santa Cruz County with administrative assistance, connection to the Arizona Department of Education, and partnerships for the implementation of US Department of Education grants. AWN contracts with SCCSS to provide Coordinated School Health promotion and technical assistance as well as serve as a liaison with schools.

University of Arizona Cooperative Extension-Santa Cruz County (UACE) connects communities to University resources and faculty. AWN contracts with the UACE to utilize the organization's experience in developing and administrating youth advocacy and leadership training curricula, as well as strategic and business planning expertise and resources. The current Network Chairperson represents UACE.

Southeast Arizona Area Health Education Center (SEAHEC) mission is to improve the recruitment, diversity, distribution, and retention of culturally competent personnel in three rural and medically underserved Arizona counties. SEAHEC delivers high-quality continuing education trainings through its contract with AWN, meeting the documented needs of a diverse group of youth service providers.

Pinal Hispanic Council (PHC) and Community Intervention Associates (CIA) provide licensed outpatient clinical behavioral health services in Santa Cruz County. Each has an MOA with AWN to represent youth behavioral health resources and needs in the network. The current Network Vice-Chairperson represents CIA.

Circles of Peace (COP) provides treatment and prevention programs for domestic violence and underage substance abuse. COP signed a partnership MOA with AWN to strengthen connections with their prevention and youth leadership programs.

Nogales Unified School District, Santa Cruz Valley Unified School District, Patagonia Elementary and Patagonia Union High School Districts are public school districts that together serve 87 percent of the Santa Cruz County student population. AWN signed MOAs with the districts to jointly explore school-linked health care and other programs and services that would improve student well-being.

Outcomes

A. Outcomes and Evaluation Findings

The following summary represents an overview of preliminary AWN outcome and evaluation findings. More complete findings will be available with the completion of the AWN Evaluation Report (May 2014), Performance Improvement Measurement System report, and Final Closeout Report. Throughout the RHND program, AWN evaluation activities have been carried out by a third-party contractor, Rebecca Drummond, MA. Ms. Drummond is the Program Director for Family Wellness at the University of Arizona Mel an Enid Zuckerman College of Public Health.

Network Infrastructure and Sustainability: To assess network collaboration, the Evaluator has conducted a Wilder Collaboration Factors Inventory and analysis three times during the RHND grant (2011, 2013, and 2014). The survey helps the network inventory its strengths and weaknesses on factors that research has shown are important for the success of collaborative projects. In March 2014, mean scores for 17 of the 20 factors of collaboration (85%) were ranked 'strength,' 3 (15%) were borderline and should be discussed by the group, and 0 received a low 'needs to be addressed' score. Results showed improvements throughout the grant period. In the 2011 survey, 7 factors (35%) were ranked 'strength,' 12 (60%) were 'borderline,' and 1 (5%) was considered a 'concern.' Alongside the Wilder survey, AWN assesses member responses to open-ended questions about mission, accomplishments, priorities, and outreach.

Increased capacity and integration of school and community services for adolescents: In the fall of 2013 the SCCSS, on behalf of the AWN, conducted key informant interviews with school health staff to assess attitudes and gather feedback about the needs and feasibility of school-linked health care and coordinated school health. Five interviews with Registered Nurses representing

seven schools and two districts identified four components of coordinated school health that are in need of the most attention: counseling and mental health services, nutrition services, family and community involvement, and health services. Results informed and prioritized the AWN coordinated school health initiative.

The AWN professional development trainings for adolescent-serving schools and organizations were carried out by SEAHEC. Each training event included an evaluation component. The results for the eight trainings have not yet been aggregated, but all received positive feedback from participants, scoring high on questions of meeting educational objectives, relevance, knowledge of speakers, and application to the practice setting.

Social, environmental, and policy changes that favor services for adolescents: In the fall of 2013, a Community Impact Survey was sent electronically to approximately 77 individuals who had participated in at least one AWN event. The 12-question survey was designed to evaluate the overall quality of AWN outreach and services, gauge community perceptions of the network, elicit feedback, and document impact. Twenty-three (23) surveys were completed, yielding a 30-percent response rate including school, community-based, health care, behavioral health, and governmental organizations. When asked about the quality of event(s) attended 67 percent rated these as "excellent" (5 on a 1-5 scale). Twelve participants (57 percent) responded that there had been a change in awareness; nine participants (43 percent) indicated a change in skills as a result of the training(s) they attended.

B. Network Collaboration

In Santa Cruz County, the issues and challenges youth face as they obtain their education and transition to healthy, productive adulthood reach across the health, education, and social service sectors. One organization or one field does not have the expertise, connections, or resources to affect change at the population health level. AWN members report that collaboration through the network allows them to address social determinants of health in ways they could not working alone. Only a mature network with its reputation as a credible, neutral partnership can convene partnerships among sometimes competitive organizations and school districts. AWN has demonstrated the value of collaboration to members and shown that partnership strengthens organizations.

The network employs an organic strategy of network development, as advocated by the Arizona State Office of Rural Health. This means embracing paradigm shifts, so structure can adapt to match function. The parts are connected in a way that nurtures the desired outcomes. This allows the network to support collaboration that improves the quality of health care services, reduces health disparities, and improves population health.

Examples of AWN collaborative activities and principles:

- Member organizations contribute to AWN funding initiatives, providing input and editing grant applications, setting aside potential competitiveness or territorial feelings.
- Collaborative decision making and planning for network infrastructure, strategic planning, youth involvement, and sustainability
- AWN members provide valuable in-kind contributions to the network in terms of staff time, expertise, meeting space, marketing and outreach and serving as a liaison in their respective fields and with community contacts
- Continuing to foster our shared understanding of the need for training and professional development among youth service providers
- Responding to that need through shared training resources
- Sharing connections and professional networks to optimize AWN outreach and communications activities

Challenges & Innovative Solutions

During the first year of the RHND program, the most significant challenge for AWN was the need for a governance structure. The Network Director was hired in July 2011 and led members through a systematic process of identifying and choosing between models for decision-making and governance. The network formally adopted the Operating Procedures and elected a leadership team in August 2011. Since then the network has maintained regular updates to the Operating Procedures and annual leadership team elections.

The network immediately recognized the need to diversify membership to include behavioral health and more school representation. It is a challenge to identify the right partners and orient and incorporate them into the network. The network documented gaps in membership, reviewed and updated the Operating Procedures to reflect a more formal process of member application, brainstormed

potential organizations and methods for outreach, hosted two forums with potential new members, and successfully added three school districts, two behavioral health providers, and one youth-serving nonprofit. Key strategies in the new member initiative:

- Working closely with GHPC Technical Assistance and our peer health networks through NCHN allowed AWN to identify and implement best practices for membership expansion.
- Transparency was key, as some member organizations have paid contracts with deliverables related to network activities, and new members were participating on an in-kind basis. AWN has developed a culture of openness that creates shared understanding of our model and leaves an open door to raise any concerns.
- To enhance outreach, the Network Director developed compelling value propositions communicating the benefits of membership. The lessons and tools were shared in workshops at the April 2013 NCHN Annual Educational Conference and the June 2013 RHND Grantee Meeting.

Local schools provide excellent education and services to their students despite facing limited time and resources. In order to provide the trainings that school faculty and staff need, it was necessary for AWN to navigate logistical and administrative barriers. The AWN determined that the most convenient format for trainings is to hold them at a central location, not on school grounds, and to work closely with the administrators to find the optimal times. This way, AWN was able to achieve excellent attendance from counselors, teachers, administrators, and school health staff from the majority of local school districts as well as other youth service providers.

Sustainability

A. Network Structure

The AWN Director and partner organizations collaborated on an extensive sustainability planning process. Using the Technical Assistance and materials provided by the Georgia Health Policy Center, the AWN Director conducted a sustainability retreat in February 2013. Members delved into preliminary business planning both during a day-long retreat during the November 2013 TA Site Visit and a brief session in a regular monthly meeting. This way sustainability and business planning were constant themes guiding decision-making and members were well-oriented on the topics.

The AWN structure will continue past the end of the 2011 RHND grant program, including monthly meetings and leadership. All partner organizations have committed to maintaining their participation. There are currently two scenarios for sustaining network structure.

1. AWN applied for the 2014 RHND Grant Program. If awarded, this three-year grant would allow the network to create a system of school-linked health care for the county, in addition to expanding its work to improve quality and integration of adolescent services. The application staffing plan includes support for the Network Director as well as a School-Linked Health Program Coordinator, Patient Navigator, Clinical/IT Coordination, and Administrative Assistant.
2. AWN applied to HRSA for a no-cost extension which would support the network for one year past the original end date of April 30, 2014. The no-cost extension would fund the network director position at .85FTE for the year as well as a consulting contract for feasibility study and business planning. Some network activities would continue on an in-kind and scaled-back basis. The focus for the year would be funding diversification such as program income, member dues, and other grant applications. All member organizations are committed to continuing monthly meetings, and supporting the network's efforts to secure long-term funding.

B. On-going Projects and Activities/Services To Be Provided

If the AWN is awarded a 2014 RHND Grant activities will continue and expand. The budget includes funding for professional development and other capacity building activities, support for environmental and system changes, and development of a school-linked health care system.

In the case that AWN does not receive a 2014 RHND Grant, many activities will continue in a variety of forms. The network director will be able to use the professional development and school connections AWN has developed to continue connecting service providers to training resources. With the identification of new and diverse funding sources AWN could also renew its contract with SEAHEC to provide continuing education. The director will continue to support the youth involvement program and use established contacts to promote youth leadership opportunities in the community. Following an April, 2014 Leadership and Advocacy training AWN is providing through the UA Cooperative Extension, the network will have a cadre of trained youth and service provider personnel who can identify and address systems and environmental changes for youth wellness. The director, MCHC, and AWN youth involvement team members can provide support for these efforts beyond the end of the 2011 RHND Grant Period. Student

interns will assist with maintaining the network website and social media as an information clearinghouse for adolescent resources in the area.

C. Sustained Impact

During the AWN Sustainability Planning process, which began with a retreat in February 2013, members identified the following sustained impacts from RHNDG activities.

Network Infrastructure and Sustainability:

- AWN is an established, highly functional group with up-to-date Operating Procedures that consistently scores highly on Wilder Collaboration Factors Inventory Survey
- AWN and the issues it represents are visible and known to the school districts, non-profits, and government agencies
- Created solid relationships among partners; members and others see that collaboration is possible and beneficial
- Improved cross-referral among organizations and fostered a culture of collaboration that has led to more cross-sector partnerships on a variety health topics
- Elevated the role of youth in partnering with the programs that serve them

Increased capacity and integration of school and community services for adolescents:

- Published a Funding Scan of Youth-Serving programs in the county
- Published the Training Needs Assessment of Santa Cruz County youth-serving professionals
- Over 400 local teachers and other youth service providers have been trained on adolescent development topics according to the Training Needs Assessment
- School and community-based organizations know who to go to for information, resources, training, and support

Social, environmental, and policy changes that favor services for adolescents:

- Created awareness of the need for and interest in school-linked health among stakeholders
- Created and disseminated the Santa Cruz County School Health Profiles Report, demonstrating to schools, districts, and the county where we stand in comparison to state and national counterparts in school health policies and practices
- The AWN created the Policy Scan and Strategic Directions for Policy Change documents to outline the current landscape of policy, system, and environmental factors affecting youth wellness and provide a foundation for improvements
- Published the Youth Involvement in Decision-Making Toolkit and trained 16 organizations on improving the quantity and quality of youth leadership opportunities in the community

The AWN Evaluation Report (due out May 2014) will provide a more comprehensive list of accomplishments and serve as a template for future annual reports.

Implications for Other Communities

Other communities interested in improving capacity and collaboration in youth services could benefit from the AWN model for network development. AWN is a horizontal rural health network that began in 2007, and was able to progress from 'developing' to 'mature' during the RHND grant program. The network owes its success to the diversity and quality of its partner organizations and the strength of its leadership team. AWN leveraged state and national resources both to enhance its own development and the programs and services it provides members and the community.

When creating a network of this type, it would be beneficial to consider the following indicators.

- Inclusion of a broad group of stakeholders such as AHEC, university cooperative extension, health care providers, public health, behavioral health, schools, and non-profit social service providers.
- Utilization of state and national resources for health networks, rural and public health organizations, school-linked health care, collective impact, youth development, and coordinated school health.
- Authentic youth partnership and leadership opportunities are key components to any program seeking to serve youth and address adolescent wellness issues.
- Another community would certainly have different needs and values, so local assessment and prioritization of needs, activities, and programs is important.

Arizona

Tohono O'odham Nursing Care Authority

Organizational Information	
Grant Number	D06RH21681
Grantee Organization	Tohono O'odham Nursing Care Authority
Organization Type	Skilled Nursing Facility
Address	HC01 Box 9100, Sells, AZ 85634 / Federal Route 15 Mile Post 9
Grantee organization website	http://www.toltc.org/
Name of Network	Tohono O'odham Nation Elder Care Consortium (ECC) www.tonelder.org
Network Director	Name: Rebecca Drummond
	Title: Project Director
	Phone number: 520-933-1141
	Fax number: N/A
	Email address: rebecca_drummond@outlook.com
Project Period	2011 - 2014
Funding level for each budget period	May 2011 to April 2012: $180,000
	May 2012 to April 2013: $180,000
	May 2013 to April 2014: $180,000

Network Partners		
Partner Organization	Location	Organizational Type
Tohono O'odham Nursing Care Authority	Tribal Nation / reservation	Skilled Nursing Facility
Tohono O'odham Department of Health and Human Services	Tribal Nation / reservation	Tribal Health Department
Tohono O'odham Community College	Tribal Nation / reservation	Tribal College
Indian Health Services	Tribal Nation / reservation Sells Service Unit	Federal government run health care services
Elder Advisory Council	Tribal Nation / reservation	Advisory Council

Community Characteristics

A. Area

The Tohono O'odham Nation is a federally-recognized tribe that includes approximately 32,000 members occupying tribal lands in southern Arizona along the U.S.-Mexico border and lies within Pima, Maricopa, and Pinal counties. The Nation is the second largest reservation in Arizona in both population and geographical size, with a land base of 2.8 million acres and 4,460 square miles. Tribal members live both on and off the reservation which is comprised of 12 administrative districts. Sells, Arizona functions as the administrative capital of the Nation.

B. Community description

Elders are socially isolated. Sixteen percent (16%) of Elders on the O'odham Reservation live and eat meals alone. Most Elders do not participate in clubs, organizations or attend meetings. Chronic disease and other health issues remain a serious problem. Over 60% of Tohono O'odham Elders reported they had diabetes and/or high blood pressure. In addition, self-reporting of arthritis, cataracts, depression and asthma were at significant levels. Transportation is limited and undependable. Transportation continues to be a major barrier to health care and access to all services. Non-medical transportation through the Division of Senior Services of the Tohono O'odham Department of Health and Human Services and through district offices cannot meet demands.

There are limited community transportation options for Elders to access community events, shopping for goods and services, and attendance at social and religious events. In-home and community based services are not readily available. Many Elders need help with basic activities of daily living - walking, getting in or out of bed, eating, and more complex activities such as preparing one's own meals, doing heavy housework, and shopping. Many Elders live in substandard housing. Programs and funding for rehabilitation and repair are very limited. Services provided in districts vary greatly from one district to the next. Meal programs for many elders are only offered once a week. Most of the Senior Centers need replacement or substantial repairs. There is a need for more options for long term care and supportive housing. The data indicates that more Elders will require long term care, including a range of services such as in-home care and assistance, adult day care, independent living, and assisted living. The sole facility, the Archie Hendricks Sr. Skilled Nursing Facility (AHSSNF) is currently unable to meet present and future needs. Service and health information is not widely available. There are numerous gaps in services to Elders and many Elders are not aware of the current services that are available to them within their communities or on the Tohono O'odham Nation. Families and caregivers need support. A high percentage of Tohono O'odham Elders live with family members (79%), who provide care and help with health needs. Caregiver training and respite care services need to be expanded.

C. Need

In 2011, the Elder Care Consortium (ECC), a body established in 2004 to analyze and address issues relating to elder health and quality of life, developed the report *Respecting our Past, Addressing Our Future: a Strategy for Improving Elder Care on the Tohono O'odham Nation.* This report made recommendations to address the needs of Elders. Subsequently the Nation commissioned the *Tohono O'odham Elder Care Comprehensive Strategic Plan* outlining 9 strategic directions and implementation steps. The ECC seeks to address many of these recommendations and strategic directions, but in particular works to address: 1) In-home and community based services, 2) senior services staffing and funding, 3) elder education, 4) ECC development and sustainability, 5) professional development for elder care workforce.

Program Services

A. Description

Through the Rural Health Network Development grant program, the Elder Care Consortium (ECC) worked to strengthen and formalize its partnerships. This formalization included the development of operating procedures, a 3-year strategic plan and an evaluation plan, as well as planning for communication /outreach and sustainability. Priorities were identified and the Home and Community Based Services (HCBS), Education and Training, and Information Technology Committees were created to focus on them.

B. Role of Network Partners

Through memoranda of agreements (MOA's), each partner has committed to support the ECC by including their respective leadership and staff in decision-making processes and project planning, including attending and chairing meetings, and leading committees.

ECC partners have unique and complimentary roles in the community which they bring to the ECC. The Indian Health Services provides primary care, social services and public health nursing and refers out for most specialty and tertiary care through Contract Health Services, while the Archie Hendricks Senior Skilled Nursing Facility (AHSSNF) provides skilled nursing, hospice, and assisted living, in addition to professional education in geriatrics. In addition, the AHSSNF has served as the fiscal agent for this Rural Health Network Development (RHND) grant and administrative oversight to grant personnel. The Tohono O'odham Community College provides CEUs at training program, conducts workshops for Elders, and training programs for Caregivers and Direct Care Workers. The Department of Health and Human Services (TODDHHS) represents the largest number of ECC participants as its services span community outreach and education, senior services including congregate meals, transportation, caregiver support, adult care, and social activities. The TODHHS also houses Adult Protection Services, Behavioral Health, Family Assistance, Special Needs, Healthy O'odham Promotion Program, Prevention, Child Welfare, Health Transportation and Community Health Services which includes the Community Health Representatives and the Home Health Programs providing in-home nursing care.

Additional partners that provide support to ECC include: 1) the Nation's Department of Information Technology, 2) the Tohono O'odham Utility Authority, 3) Tohono O'odham Ki:Ki Association (housing), and 4) the Nation's Planning and Economic Development Department. These partners participate in ECC meetings, presenting information as needed.

Outcomes

A. Outcomes and Evaluation Findings

Education and training has focused on professional development for ECC members, service providers, and the broader community.

- The ECC supported community events such as the forum on "Aging and Memory" in partnership with the TODHHS, TOCC and the Banner Alzheimer's Institute, which was attended by approximately 61 participants comprised of health professionals and family caregivers.
- The ECC sponsored 8 hours of training in "Case Management 101." Approximately 75 health and social service providers received certificates of attendance from Arizona State University and Continuing Education Units from the Tohono O'odham Community College. Participants included case managers, community health workers, public health nurses, behavioral health workers, social workers and other service providers.
- The ECC supported the TOCC Caregiver Program by promoting and disseminating the program, providing student support and materials for practicum. The program offers a Caregiver Certificate and a Direct Care Worker Certificate, which can lead to reimbursement for family caregivers or employment opportunities with caregiving agencies.
- The ECC began an O'odham audio translation project to develop health messages/concepts in O'odham recordings. The first audio translation included instructions for diabetes blood sugar check (kits). The recording was played for elders at a Elder Fun Day in Hickiwan and at Diabetes Day in Sells for feedback and impressions. This could potentially be included with kits distributed by diabetes programs and for use with home and community health workers or played in office rooms at the I.H.S.
- Through an United States Administration on Aging (AOA) Elder Abuse Prevention Intervention grant at the TODHHS, supported by the ECC Education and Training Committee, an elder abuse curriculum is being developed and will be offered to service providers and caregivers working with Elders. These workshops will be designed to raise awareness of elder abuse prevention, while addressing cultural considerations unique to the Nation.

The ECC has been able to engage in activities and advance issues relating to technology.

- At the May 2013 Elder Day, elders were surveyed about personal experience with and interest in a variety of technologies, such as internet, home computers, video games, cell phones and video conferencing. The ECC IT committee continues to conduct outreach at community events offering demonstrations. For example, Elder Fun Day, Sept. 26, in Hickiwan was video streamed to AHSSNF, where people at the nursing home see activities and people waving into camera from the Fun Day.
- The ECC purchased technology for wireless video conferencing in remote/rural areas, piloting caregiver education from TODHHS to communities where internet service is not available. The ECC IT committee continues to use community education and community events to test the feasibility and develop strategies to reach remote areas.

To address home and community based services and explore systems and models of care coordination, service delivery, and community access to information and services, the ECC initiated a resource mapping project.

- An inventory of elder services on the Nation has been conducted. Information is maintained in a database and local data management options are being explored. A resource directory will be produced and potentially accessed and updated on the internet. The primary purpose of the directory is a product for ECC partners and providers to use to connect elders to needed services and resources in a coordinated way.
- Complementing the inventory of services, qualitative data was collected through 1) stakeholder meetings, 2) focus groups with elders and caregivers, and participants from the CM101 training, and 3) interview with District Chairs or their representatives.
- Analysis of service inventory, supplemented with qualitative data will help the ECC identify gaps and duplication of services and make recommendations for improving a system/model of care.
- Information from the resource mapping project will provide an opportunity for the ECC to advocate with tribal leadership on next steps for improved elder care.
- Through the AOA Elder Abuse Prevention Intervention grant at the TODHHS, supported by the ECC Home and Community Based Services Committee, a screening tool will be developed to assess elder abuse and risk of abuse in a variety of settings, as well as assess caregiver burnout and potential abuse risk.

B. Network Collaboration

In the spring of 2013, 26 ECC members completed the Wilder Factors of Collaboration Inventory (WFCI). Results of the survey were shared at a regular meeting, which promoted discussion of collaboration and partnership. Strengths of the ECC collaboration highlighted that the 'time is right' for individuals and agencies to collaborate for elder care, and high mutual respect for one another. Areas of concern included open and frequent communication, appropriate pace of development, and development of clear roles and policy guidelines.

The ECC had a retreat with a local facilitator to encourage team building, improve communication, and build trust. It was an opportunity for individuals from distinct organizations and programs to discuss common values and vision for elder care, while getting to know one another better in a personal and professional way. The day concluded with ECC members writing letters to tribal and employment leadership summarizing what they gained from the day and what their vision is for elders on the Nation.

Challenges & Innovative Solutions

The ECC is predominantly a group of individuals representing service programs and entities that each provides similar but unique services, often guided by their respective funding sources but not exclusively as evidenced by its longevity. The entities are mostly funded through tribal government resources as well as some grant funding, except for IHS which is entirely federally funded. The notion of becoming self-sustaining, especially through alternative revenue streams, creating a business model or fee for service method of sustainability is challenging for many grantees. To this end, a grant that is to strengthen a partnership rather than provide program or services to elders directly is a challenging concept both to service providers and to the local community or leadership. Promoting and sustaining an advocacy group is always a challenge when its members and audience are service providers or clients.

Developing an evaluation plan and logic model, as well as conducting and summarizing a sustainability activity helped ECC members see and document its purpose and progress. Also, communication and marketing strategies such as developing a logo and website will help ECC promote its purpose and help increase visibility in the community.

Sustainability

A. Network Structure

The ECC will continue as an informal group of advocates and service providers and ECC meetings will be open to any community member or agency representative to participate. The ECC will continue to meet monthly, and is chaired by a representative of one of the original lead agencies. The ECC will be managed through in-kind leadership and resources. When possible, the ECC leverages its partnerships to seek out grant opportunities. Similarly, when individual ECC entities or programs receive new grants, they are able to access ECC leadership or committees for assistance, feedback and networking/collaboration to better reach its target audiences.

B. On-going Projects and Activities/Services To Be Provided

As an informal network, the ECC will continue to meet to exchange news, ideas and information about services, grant opportunities and advocacy needs around elder care and implementing the priorities outlined in the Tohono O'odham Elder Care Comprehensive Strategic Plan. Committees will meet as needed to move priorities forward, collaborate on funding opportunities and respond to requests by local leadership and community members.

C. Sustained Impact

In the fall of 2013 the ECC conducted a "Sustained Impact" activity and a report was subsequently submitted highlighting the results of the discussion activity:

New Capacities Created include:

- Caregiver Certificate
- AOA Elder Abuse Prevention Intervention Grant
- Resource mapping for improved continuum of care
- Shared vision
- Increased awareness of elder needs

- Enhanced community engagement
- Strategic plan, whitepaper, focus group data, needs assessment, mission/vision

New Ways of Serving include:

- Career development
- Enhanced collaboration and communication
- Contact list and division activities
- Sustaining commitment to elder welfare
- DHHS Senior Services Expansion Plan
- Addressing IT needs of tribal Elders

And, Policy/Systems/Environment Changes include:

- Investment of staff time by agency leadership
- Elders are part of the community conversation
- Investment in staff through Geriatric Nurse Leadership Academy
- Ongoing caregiver training program
- Elder Care Strategic Plan adopted under Nation's Executive Administration Plan
- Creation of Adult Protection Ordinance and services

Implications for Other Communities

Joining unique organizations dependent on different funding streams, missions, and mandates, through a shared vision can be a powerful tool for advocacy. Assessing capacity and priorities is key to making it work. Tribal Nations and rural communities continue to struggle with limited resources and high demand for services. Competition for limited resources can create challenges for successful collaborations. Collaborating and maintaining lines of communication open between and within organizations situates networks well for advocacy moments and funding opportunities. However, clear roles and responsibilities need to be defined beyond a common vision to gain traction and maintain momentum.

Assessing collaboration with an objective tool, such as the WFCI, and qualitative group discussion and team building activities can help boost morale and celebrate small and big wins. Evaluation processes can help define programmatic process, outputs and outcomes, and tools such as logic models provide visual aids. Evaluation is most useful when integrated from the onset of any project, as a guiding framework.

Arkansas

Siloam Springs Regional Health Cooperative dba Bridges to Wellness

Organizational Information	
Grant Number	D06RH21666
Grantee Organization	Siloam Springs Regional Health Cooperative dba Bridges to Wellness
Organization Type	Rural Health Network, 501c3 non-profit corporation
Address	116S. Broadway, Siloam Springs, AR 72712
Grantee organization website	www.bridgestowellness.org
Name of Network	Siloam Springs Regional Health Cooperative dba Bridges to Wellness
Network Director	Name: Emerson M. Goodwin
	Title: Executive Director
	Phone number: 479-549-3143
	Fax number: 479-549-3243
	Email address: egoodwin@bridgestowellness.org
Project Period	2011 - 2014
Funding level for each budget period	May 2011 to April 2012: $179,993
	May 2012 to April 2013: $179,993
	May 2013 to April 2014: $179,993

Network Partners		
Partner Organization	Location	Organizational Type
Community Physician's Group	Siloam Springs, Benton, Arkansas Gentry, Benton, Arkansas; Chouteau, Mayes, Oklahoma; Locust Grove, Mayes, Oklahoma; Westville, Adair, Oklahoma; Grove, Delaware, Oklahoma; Jay, Delaware, Oklahoma; Kansas, Delaware, Oklahoma	Primary and Specialist Medical Center
Ozark Guidance	Springdale, Washington, Arkansas Fayetteville, Washington, Arkansas Siloam Springs, Benton, Arkansas	Behavioral Health Center
Community Medical Clinic	Springdale, Siloam Springs, Washington & Benton, Arkansas	Federally Qualified Health Center (FQHC)
Benton County Health Department	Siloam Springs, Benton, Arkansas Rogers, Benton, Arkansas	State Health Department
Siloam Springs Regional Hospital	Siloam Springs, Benton, Arkansas	Hospital
Siloam Springs Chamber of Commerce	Siloam Springs, Benton, Arkansas	Chamber of Commerce
Simmons Foods	Siloam Springs, Benton, Arkansas	Food Producer
Ozark Electronics	Siloam Springs, Benton, Arkansas	Product Refurbisher
John Brown University	Siloam Springs, Benton, Arkansas	University
Siloam Springs School District	Siloam Springs, Benton, Arkansas	K-12 Primary Education

Community Characteristics

A. Area

The network serves the Arkansas communities of Siloam Springs, Gentry, Decatur and Gravette in Benton County and the community of Lincoln in Washington County. In Oklahoma, the network serves the counties of Adair, Cherokee and Delaware.

B. Community description

Siloam Springs is the hub of western Benton County with a population of approximately 16,000. Siloam Springs is on the Arkansas –Oklahoma boarder. It is the home of John Brown University, a private, Christian University. A number of manufacturing companies have plants or headquarters in the area, including Simmons Food, the area's largest employer with approximately 6,000 employees. The manufacturing job landscape has been shifting over the past five years with companies tightening their belts. While manufacturing forms a solid base for employment a significant number of residents travel to the Benton County and Washington County population centers of Bentonville, Rogers, Springdale and Fayetteville for job opportunities. These communities are 45 to 60 minutes away.

The community is fortunate to have a historically strong and committed medical community. In 2010, the city owned hospital was sold to a for profit group which opened a new hospital in 2012.

Approximately 25-30 percent of Siloam Springs residents are Latino/Hispanic. In Adair County Oklahoma 44 percent of residents are Native Americans. These demographics challenge the networks ability to reach out in a meaningful and culturally significant manner.

C. Need

Bridges to Wellness (BTW) serves medically underserved residents in Benton and Washington counties in northwest Arkansas and Adair, Cherokee and Delaware counties in northeast Oklahoma. In our service area, before the Affordable Care Act, 23,000 individuals (21%) lack health insurance, and more than 18,000 (16.5%) live in poverty. Unmet health care needs include: 1) a lack of access to care caused by lack of insurance and an inability to afford care and 2) a high prevalence of untreated chronic disease. Diabetes is the most prevalent, 20.9% of the service area suffers from diabetes, almost three times the national rate and more than twice the Arkansas state rate.

Program Services

A. Description

Bridges to Wellness was formed to address unmet health and wellness needs in the community. We are addressing the community norms formed around the promotion of physical activity and access to healthy foods. In addition, our network addresses the social norms around mental health issues. Our work involves a broad cross-section of our community in program development and implementation. Our network is one of the few in the country that involves medical providers and business leaders working together on solutions.

We divide our work into two buckets: Health System Integration and Health Promotion. Health Promotion is encouraging consumers to examine and change their health behavior by adopting healthy lifestyle strategies and working on strategies to create a more health-promoting community through policy and environmental (natural, built, social) change. Health System Integration is working on the issues that identify and close gaps in medical services and those that improve the quality of care.

Health Promotion:

BTW hosts WELLFEST!, a call to action for the community to get up and get active. We are in the process of planning WELLFEST! IV and we anticipate 700 participants from our community of 15,000 . The event is planned and implemented by more than 100 community volunteers. In one day, residents can participate in 15 different events from as simple as hula hoops to as challenging as a 50 mile bike ride.

BTW collaborated with the City of Siloam Springs and John Brown University to install an outdoor gym on the campus of John Brown University. The Outdoor Gym has been well received by the community. It is used by community members and students. Community members excitedly share with us that they see people using it all the time. In June it we will be celebrating its 1st anniversary.

BTW collaborated with MainStreet, a historic district preservation organization, to seek support to launch the Downtown Master and Connectivity Plan. Local foundation grant funding was obtained, a funding match was secured from the city and a planning process was conducted that included a five day series of community input. It is one thing to promote physical activity and another to improve the built environment in a way that supports residents' attempts to get more active. Currently Siloam Springs has 8.5 miles of disconnected trails and is not connected to any neighboring communities. It is the long range goal of the Downtown Master and Connectivity Plan to greatly improve the connectivity within in Siloam Springs and with its neighboring communities.

Bridges to Wellness developed Eat Better. Move More., a worksite/community wellness initiative encouraging individuals to join or form a team, keep track of their health behavior on an online dashboard and attend nutrition and other wellness classes. Currently 200 individuals are putting healthy in action. Bridges to Wellness has partnered with Siloam Springs Park and Recreation to host weekly Zumba and yoga classes. Weekly, approximately 100 people workout in these two programs. Eat Better. Move More is a fee for service program for individuals or as a worksite wellness program. There are several employers who are engaging with BTW to bring Eat Better. Move More. to the worksite. We look to the fees to begin developing an additional revenue stream to defray costs.

Bridges to Wellness is conducting a Latino/Hispanic collaborative physical activity and access to healthy nutrition research project to identify opportunities and barriers to the adoption of healthy lifestyles. The product of this research will be partnering with Latino/Hispanic communities to develop programs that have community input in the design and implementation.

Health System Integration:

Network partner Ozark Guidance and Bridges to Wellness teamed up to offer a series of Mental Health First Aid (MHFA) courses for medical personnel, human resource managers, first responders and school employees. The courses provided attendees with base line knowledge and tools to assists individuals experiencing a mental health episode. In addition, it formed a great opportunity for Bridges to Wellness to discuss support for greater identification of community mental health care needs.

BTW teamed up with the medical clinic of community's largest employer to provide diabetes education to the clinic's employees. It took us longer than we thought to put all the elements of this program together, but it is now in operation and is well accepted by the medical clinic and well attended by patients.

B. Role of Network Partners

The network members as a group provided the oversight and management of the grant funded program. They also engage in setting program goals, objectives and evaluation metrics.

Each network partner is involved in the planning of the work of the network. This is accomplished through monthly network board meetings and annual strategic planning meetings. During these meetings, program initiatives and interests by network members are identified. Staff is then tasked with bringing the relevant network members and other identified partners together. Network members also identify resources that will be necessary to move a project forward and either volunteer to help procure the resource or assist in developing a plan to secure the identified resource.

Network members participate on program committees, recruiting volunteers, designing, marketing and overseeing the programs implementation.

Outcomes

A. Outcomes and Evaluation Findings

BTW started unknown, little regarded and totally unsupported. Now, BTW is quoted in newspapers, hosting Chamber of Commerce events, participating in founding another community organization to work alongside our mission promoting physical activity and contemplating launching a major fundraising campaign to bring about a community wellness center.

However, we have not fully arrived. We have a long way to go. Evaluation findings show that while our name recognition has improved, knowledge of our work is lagging. When asked specifics about the issues BTW addresses, respondents agree that it is

important work to be done and that it needs to be made available to more people. In short, respondents believe we are working on issues they care about but that the programs need to be expanded and better marketed.

We have learned that getting the word out about our work is challenging and not inexpensive. We constantly try a variety of communications venues to reach intended audiences and our evaluation shows we need to continue to explore new communications channels and messages.

Evaluation also shows that BTW is being better received by the medical community and that we are not now seen as a threat to develop a medical reimbursement fee for service.

B. Network Collaboration

All the work of our network is done through collaborating with other organizations. We work to identify likely partners for any of our efforts. We try to understand what each potential partner contributes, what they stand to gain and what they put at risk. We want to grow the gain and minimize the risk. We meet with potential partners one on one and or bring multiple partners together. We discuss the issue we are addressing to get every organization's point of view and then move to develop goals, objectives and strategies. We then outline roles and responsibilities, metrics and timelines.

BTW Principles include:

1. Slow is over rated. It takes time to transform systems but it requires speed and the expectation that you can make change happen rapidly.
2. Persistence is required. While slow is over rated, change does not come overnight so you must persist until the change happens.
3. Real Change requires boots on the ground. Without grass roots and grass tops you can make a difference but not lasting impact.
4. Collaborate, collaborate and, when you don't want to, collaborate again. It is only through the collective leverage of everyone's assets can you make lasting change.

Challenges & Innovative Solutions

Momentum

There was a time when the network lost momentum and struggled to define its mission, vision and work. During this time the network would consider several different projects but, after considerable study, was unable to agree to move forward on any one project. In addition, the network members did not want the network to define its work in any way that could be perceived as providing competition to existing programs by a member of the network. In summary, the network believed there was value in working together but they could not readily agree on what they might work on.

To overcome this, the network went through a strategic planning session to identify areas of agreement. Each board member was interviewed separately and their comments without attribution where shared with the board of directors. The group learned that there was more consensus on proposed work then it believed to be true. At this session, the board of directors agreed on a new mission and vision and WELLFEST! as a work project. The rallying around WELLFEST! demonstrated to the group that it could work together to make a project happen.

Sustainability

Following the first WELLFEST!, the board of directors and the WELLFEST! planning committee asked the same question: "What happens after the one day call to action." That question lead to the development of a worksite/community wellness effort, Eat Better. Move More. Eat Better. Move More. challenges individuals to form or join a team, log onto an online dedicated fitness dashboard and get active and attend wellness classes. We reach individuals in the workplace and through community organizations. A per-participant fee is changed to begin building participant revenue support. Eat Better. Move More. has attracted grant support that also supports our sustainability.

The biggest challenge for our work is how to build supporting revenue streams to move initiatives forward when the grants stop. To that end, Bridges to Wellness is in the process of contracting with a fund development company to assist us on raising funds for a

project that has been a part of strategic thinking for seven years. In 2006, at the start of our network, the group had the vision of a destination wellness center. We have discussed it periodically as part of our strategic planning processes. We have now decided to conduct a campaign test to see if it is feasible. A successful fund raising effort will support the building project, building endowment and organizational operational costs for at least three years. We are at the beginning of the process and realize this is a high stakes endeavor.

Sustainability

A. Network Structure

It is our goal for our network to continue. We are now eight years old and are looking to develop a non-grant revenue stream. During this grant period, BTW initiated its first role as a 501c3 non-profit organization serving as its own fiduciary. Our current partners are poised to go forward with the network. The network is planning to keep its staff and network representatives will provide governance leadership for the network.

B. On-going Projects and Activities/Services To Be Provided

WELLFEST! is now in its fourth year and we will continue it as long as it is growing in participants and in funds raised. Eat Better. Move More. is continuing to gain attention in the community and with employers. We expect to grow the participation of this program and derive increasing revenue. BTW will continue to play a leadership role as a partner in the ongoing development of the Downtown Master and Connectivity Plan. Diabetes education will need a revenue stream, but in our community the need is there. We want to continue and expand our work in mental health support for the community. We are seeking regional grant funding for this.

C. Sustained Impact

1. The major impact of the network is tied to our collaborative role in driving the development of the Downtown Master and Connectivity Plan. This plan could double the amount of trails in our community. It could also increase the connection of sidewalks and number of parks. The plan's time horizon is 5-7 years and stands to improve the walkability score of Siloam Springs region by more than half.
2. The next major impact is a byproduct of our development grant. While looking to diversify our funding, we successfully competed for a grant from the Endeavor Foundation to conduct collaborative research and program development work within Latino communities. This research will have lasting impact on program design and implementation and will serve as a model not just for Latino outreach, but will influence all network health promotion programming.
3. BTW's influence in supporting the start of two organizations, whose missions align with BTW's. The two organizations include: Siloam Pedal'rs and PASS; Physically Active Siloam Springs.
4. The installation of the Outdoor Gym. For the next ten years residents will be able for free to work out on strength and agility equipment
5. BTW, as a result of its relationship with HRSA, has grown to the point where it is contemplating conducting its first capital campaign to establish a community Wellness Center. Residents could have a destination facility dedicated to assisting them in maintaining their health.

Implications for Other Communities

1. Realize that collaborating is easy to say, but not easy to do because everyone approaches the environment you are working in differently.
2. Get a clear, short and concise mission and vision statement and drive it into the network so that they bring it up in decision making for the network.
3. Think sustainability from day one.
4. Build a strong relationship with your TA provider for you and your board of directors.
5. Build relationships with other network directors so that you can learn what they are doing so that you can learn and grow.
6. Dream, plan, test, rework and evaluate.

Florida

North Florida Community College

Organizational Information	
Grant Number	D06RH21676
Grantee Organization	North Florida Community College
Organization Type	Post-Secondary Institution
Address	325 Turner Davis Drive, Madison, FL 32340
Grantee organization website	www.ruralhealthwork.com
Name of Network	North Florida Rural Healthcare Workforce Development Network
Network Director	Name: John-Walt Boatright
	Title: Executive Director
	Phone number: 850-973-1671
	Fax number: N/A
	Email address: boatrightj@nfcc.edu
Project Period	2011 - 2014
Funding level for each budget period	May 2011 to April 2012: $168,971
	May 2012 to April 2013: $175,063
	May 2013 to April 2014: $177,090

Network Partners		
Partner Organization	Location	Organizational Type
Florida State University (FSU) College of Medicine	Tallahassee, FL (Leon County)	University
North Florida Community College (NFCC)	Madison, FL (Madison County)	Community College
Madison County Memorial Hospital	Madison, FL (Madison County)	Hospital
Doctors' Memorial Hospital	Perry, FL (Taylor County)	Hospital
North Florida Medical Centers, Inc.	Tallahassee, FL (Leon County)	Hospital
CareerSource North Florida	Madison, FL (Madison County)	Workforce agency
Advent Christian Village	Dowling Park, FL (Suwannee County)	Retirement community
Suwannee-Hamilton Technical Center (SHTI)	Live Oak, FL (Suwannee County)	Technical school
Taylor Technical Institute (TTI)	Perry, FL (Taylor County)	Technical school
Covenant Hospice	Perry, FL (Taylor County)	Hospice
Big Bend AHEC	Tallahassee, FL (Leon County)	AHEC
Suwannee River AHEC	Gainesville, FL (Alachua County)	AHEC

Community Characteristics

A. Area

The North Florida Rural Healthcare Workforce Development Network services six counties in rural North Florida: Hamilton, Jefferson, Lafayette, Madison, Suwannee, and Taylor.

B. Community description

With an average population of 19,500 residents per county, all six counties in the service region are designated as rural and are listed as rural areas of critical economic concern by the Governor's Office of Tourism, Trade and Economic Development (OTTED). In addition, each of the six counties in the Network service area is designated by the U.S. Department of Health and Human Services, Health Resource and Service Administration, as a "Medically Underserved Area/Medically Underserved

Population" and a "Health Professional Shortage Area" for dental, primary medical care and mental health services. Madison and Hamilton counties are two of the four counties in Florida designated as persistent poverty counties. A more recent report out of the University of Georgia has proposed that all six counties will become proposed persistent poverty counties. The closest metropolitan area to any of the six counties is Tallahassee, approximately 30 miles east of Monticello in the center of Jefferson County.

All six counties have percentages of their residents covered by health insurance that are lower than both the state and national percentages. All six counties have percentages of their adult residents who are obese greater than both the state and national percentages. All six counties have percentages of their adult residents who smoke tobacco greater than both the state and national percentages. Other than Jefferson County, for which there is no data, the infant mortality rate of the remaining five counties exceeds both state and national rates (three of the counties have rates over two times greater). All of the county IMRs far exceed the Healthy People 2010 goal of 4.5 infant deaths per 1,000 live births. Finally, the mortality rates from heart disease in five of the six counties exceed the Healthy People 2010 goal and are higher than both state and national rates.

C. Need

As detailed in the response to the previous question, this rural North Florida area maintains a relatively low population, and of that population, there are higher percentages in the uninsured, obesity, and tobacco use than the state and national averages. A review of available data on health resources for the Networks' counties at the time of grant application submission reveals shortages in many areas far below the national average, demonstrating the need for a coordinated effort to address the health care workforce needs of these rural underserved communities. Furthermore, 2010-2011 data released by the Florida Center of Nursing highlights the healthcare workforce gaps in rural North Florida specific to the supply of LPNs, RNs, and ARNPs. In the Network's six-county service area has a potential RN workforce of 576, yet fills only 441 positions, which is 76 percent. In other words, 24 percent of all RN jobs are vacant. The LPN workforce is slightly better at a 14 percent deficiency. ARNP data for the six counties is virtually nonexistent because there are so few. Moreover, according to the HRSA's Health Resources Comparison Tool, each county in this service area averages four primary care physicians (PCPs); if one recognizes the widely recognized 50 PCPs per 100,000 residents, there is a shortage of six PCPs per county. The area's classification as 'medically underserved' and a 'health professional shortage area' denotes workforce numbers that are wholly deficient to serve the resident population.

As a result, due to the inherent challenges that rural communities face, the North Florida Rural Health Workforce Development Network was designed, and currently still seeks, to establish, cultivate, and maintain a collaborative effort amongst all regional stakeholders to facilitate enhanced training, recruitment and retention strategies that focus on healthcare professionals. Specifically in response to this need, the Network sought to achieve the following:

- Enhance the infrastructure available to support and coordinate health workforce development efforts.
- Develop both a network strategic plan and a plan for network sustainability that provides information, guidance, and support for workforce development activities in the six-county area.
- Expand the role and capacity of communities to effectively identify their health workforce needs, evaluate and modify recruitment and retention strategies

Program Services

A. Description

The following activities were conducted with the assistance of funds through the Rural Health Network Development grant program:

- During the first year, a combined effort of the Network and the FSU College of Medicine brought about 30 medical students to the Network's service area to tour and visit with healthcare providers, offering a glimpse into working in a rural setting. This provided valuable insight into rural healthcare for these medical students and led to a sustained partnership with FSU in facilitating these visits with rural providers in the six-county area.
- Along with students of NFCC's healthcare programs, the Network supported multiple community health fairs in the region to enhance greater public awareness. At a recent fair, over 30 booths were present, representing medical programs, healthcare providers, and related nonprofits from the service area.
- Not only has the Network supported and promoted health fairs for the public, but it has also maintained an assertive presence within local high schools in an attempt to cultivate a strong relationship with students by introducing them to the healthcare industry and its varied professional routes. This has been particularly successful at career fairs, engaging students in a friendly dialogue about their career choices and encouraging them to consider healthcare as one of those

options. The Network's presence at these events generates interest in the local healthcare industry and introduces students to the Network's purposeful role and interest in their success.

- In order to solidify the "Grow Our Own" philosophy adopted by the Network, staff allocated funds and coordinated health scholars summer camps on NFCC campus, in conjunction with NFCC personnel. One week (Monday-Thursday) during the summer, middle and high school students would take tours of medical facilities, learn about different professions within the healthcare industry, and meet and network with local professionals.
- In September 2013, NFCC was awarded a HRSA Health Information Technology (HIT) grant, based on regional needs and contingent upon the presence and operation of a rural health network. A Project Coordinator for the HIT grant has just been hired, and the groundwork is being laid for the non-degree program to begin training in August. This is in keeping with the Network's "Grow our Own" philosophy.
- Network staff lent their unwavering support to establish a collegiate organization known as CSSTRIDE (College Science Students Together Reaching Instructional Diversity and Excellence). CSSTRIDE remains a popular group on campus and is actively involved in numerous projects throughout the year.
- Presently, the Network is awarding some small scholarships to six students of various programs in healthcare, who intend to return to their rural communities to start their careers.
- Each year, the Network has hosted a regional summit that has garnered 100 or more participants. At this event, the Network hears from dynamic speakers on topics relevant to rural healthcare and workforce needs, connects with professionals and students throughout the region and state, and discusses emerging issues and how to collaboratively address them.

B. Role of Network Partners

Network partners had various roles in the planning and implementation of the Network and its activities including:

- North Florida Community College: Governing Board membership; Advisory Committee membership; houses Network offices; host site summer camps; site for meetings; serves as fiscal agent for the Network.
- FSU College of Medicine: Governing Board membership; Advisory Committee membership; hosts training and/or tours for medical students in the region; provision of data and potential funding opportunities for healthcare training needs.
- Doctors' Memorial Hospital: mentoring and work sites for healthcare trainees; Governing Board membership.
- Madison County Memorial Hospital: mentoring and work sites for healthcare trainees; participation in community events.
- North Florida Medical Centers, Inc.: Governing Board membership; provision of healthcare services to all communities; mentoring sites for medical students and participation in tours of rural communities for FSU medical students.
- CareerSource North Florida: Governing Board membership; partner in grant writing and leadership of the Network.
- Covenant Hospice: Governing Board membership; participant in all activities and strategic planning of the network.
- Area Health Education Centers (AHEC): Advisory Committee membership; participant in activities and strategic planning.
- Suwannee-Hamilton Technical Center: Governing Board membership; participant in activities and strategic planning; training site for multiple medical programs.
- Taylor Technical Institute: Participant in activities and strategic planning; prospective training site for nursing.

Outcomes

A. Outcomes and Evaluation Findings

Initially, the Network contracted with an NFCC evaluator to establish and coordinate a 2011-2013 monitoring and evaluation plan that tracked several focus areas: Communication, Training, Recruitment, Retention, and Sustainability. Several specific objectives were outlined under each focus area, as well as methods of measurement to assess each objective. An objective was determined to be "complete" if it had been achieved by the target date. An objective was determined to be "successful" if it had met its individually prescribed benchmark. The Governing Board would review and analyze certain components of the plan at each quarterly meeting.

- Communication objectives largely met their target dates.
- Training and Recruitment objectives were completed, but rates of success varied.
- None of the Retention objectives were completed at the culmination of the monitoring and evaluation plan due to an emphasis on long-term objectives with respect to this focus area, outside the timeframe of this report.
- Sustainability objectives remain "in progress" as of April 2013.

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B. Network Collaboration

The overarching principles that served as the foundation for the Network's collaboration centered on a system of open and unimpeded communication internally among members and active network partners. Providing updates on each represented organization's activities and finding ways to include others resulted in greater collaboration and translated to improved communication overall. Effective communication was on display during:

- Regular board meetings for planning and reporting on activities.
- Annual education and training summit focused on workforce needs of healthcare providers.
- Electronic correspondences, which proved to be more accommodating and inclusive of partners and members across the area.

Additionally, a structural staffing change from NFCC employees to contracted personnel reduced confusion in the reporting and accountability functions of the Network, thus contributing to more effective and simplified communication channels.

Challenges & Innovative Solutions

Several challenges presented themselves over the course of the three-year grant period:

- Turnover in Network staffing positions diverted time and resources from achievement of Network goals and missions toward extensive searches, interviews, and hiring processes for quality staff members. These events are largely unpredictable. Waning momentum has become a predictable side effect, yet new staff, when finally hired, brings fresh perspective and ideas. Nevertheless, lost time and resources are incurred. Incomplete information regarding sustainability efforts has also been a frustration, which identifies another challenge the Network has faced.
- Funding for sustainability continues to be an ongoing priority. The uncertainty has created problems in preparing and implementing activities, resulting in an inability to accurately forecast what the Network can foreseeably support financially. The Network board is aggressively seeking to address this problem by actively searching for sustainable funding that aligns with mission, goals, and values of the Network so that its efforts and presence remain constant. The HIT grant partnership has been a short-term progression toward said efforts.

Sustainability

A. Network Structure

For the next three years, the Network will foreseeably exist as a result of the partnerships that have been nurtured since the Network's inception. North Florida Community College, the grantee organization, has been instrumental in the overall success of the network, including ongoing sustainability efforts. The Network partnered with NFCC to apply for an HIT grant to provide high-skilled training and certification in health information technology, an emerging yet critical component of rural healthcare. While this will be a non-degree program, it will provide invaluable knowledge to a wide range of potential students and professionals in IT and healthcare backgrounds. The Network will utilize its extensive resources, human and financial capital to assist in the recruitment and training opportunities that NFCC continues to develop and eventually master specific to this rural health information technology initiative. The funding for this grant in particular will allow the Network to maintain its relevance and visibility in the six counties while looking for other avenues of funding that correlate with our overall mission of local industry cohesion.

An important structural change in the organization of the Network is the transition of staff from NFCC employees to contract employees. This has streamlined the process and clarified direction. A Personnel Committee has also been formed by the Network Board to directly oversee the Executive Director, Staff Assistant, and staffing-related issues. However, the lack of certainty regarding funding levels will affect staffing capabilities. As a result, the Network is actively seeking funds to ensure sustainability and viability.

B. On-going Projects and Activities/Services To Be Provided

A major focus of the Network moving forward will be providing the necessary support to the NFCC Health Information Technology program by way of recruitment, marketing, public relations, and utilizing the connections that the Network has developed and maintained. Other projects include, but are not limited to, the following:

- Health fairs coordinated among NFCC, SHTC, and TTI programs.
- Health Scholars camp

- Scholarships toward those who are enrolled or plan to enroll in a healthcare field and intend to return to their rural community to commence their careers, furthering the Network's "Grow our Own" philosophy
- Continuing cooperation and partnership with FSU College of Medicine students to visit providers and facilities in the North Florida service area

C. Sustained Impact

To articulate a couple of examples of sustained impact, the Network's annual summits have provided an extraordinary opportunity for all stakeholders, ranging from seasoned hospital CEOs to high school seniors who are aspiring nurses, to offer their perspectives, to connect with potential employees and employers, to discuss common problems in the industry, to grow personally and professionally, to instigate further cooperation and collaboration amongst each other, and to educate each other on new fields of study. Such interaction of depth and breadth molds greater understanding, working relationships, even friendships among the hundreds of participants attending these annual summits since 2010.

In addition to the tangible benefits that are evident from increased participation in Network-sponsored events, the community will also see new skills developed by service providers as a result of the rural health information technology initiative. By training IT and healthcare professionals in this emerging field, the HIT grant program will enable said professionals with transferrable skills when they enter or return to the workforce, vastly updating and improving the operations of our local healthcare providers and facilities, thus contributing to increased quality and access of services.

Furthermore, the North Florida Rural Healthcare Workforce Development Network has increased public awareness of availability about rural healthcare issues and access to healthcare due to its incessant efforts and promotional activities. More area residents are informed about the crucial need for healthcare professionals and the factors that contribute to the issue. Now that the problem has been widely recognized, our determination toward crafting a solution with input from all has only intensified.

The network has convened conversations, established new patterns of working together and pooled resources across the six-county service area, all to improve the economic environment for recruiting and retaining a trained, capable health workforce. It is expected that this increase in networking and shared resources will continue for years to come and eventually result in increased access to healthcare through a reduction in healthcare worker shortages.

Implications for Other Communities

The overall experience and outcomes generated from the North Florida Rural Healthcare Workforce Development Network has been an inarguably fruitful endeavor. The overwhelming community response in the past couple of years further hardens the Network's resolve to sustain the program, its activities, and develop more innovative methods to combat the inherent barriers of rural healthcare. Communities that wish to address similar needs would find this Network's experience useful in identifying methods and structures that worked marvelously, as well as finding some that have proven ineffective or unfeasible. In light of the lessons learned throughout this process, the Network certainly provides a good model to follow in seeking to train, recruit, and retain healthcare professionals in a rural setting.

In particular, other prospective programs similar to the North Florida Rural Healthcare Workforce Development Network should consider:

- Implementing clear and effective evaluation measures that will yield reliable and tangible information for accountability efforts.
- Identifying and engaging the right mixture and variety of partners.
- Establishing and, if needed, clarifying the functional role of individual member organizations.
- Developing and maintaining clear financial processes and lines of authority (organizational charts, instructions, etc.).

Indiana

Affiliated Service Providers of Indiana, Inc.

Organizational Information	
Grant Number	D06RH21664-03-00
Grantee Organization	Affiliated Service Providers of Indiana, Inc.
Organization Type	Behavioral Health Provider Network
Address	850 N. Harrison Street, Warsaw, IN 46581-0497
Grantee organization website	www.aspin.org www.ivbhn.org
Name of Network	Indiana Veteran Behavioral Health Network
Network Director	Name: Kathy Cook
	Title: CEO
	Phone number: 317-471-0000
	Fax number: 317-735-0019
	Email address: kcook@aspin.org
Project Period	2011 - 2014
Funding level for each budget period	May 2011 to April 2012: $179,700
	May 2012 to April 2013: $179,450
	May 2013 to April 2014: $177,510

Network Partners		
Partner Organization	Location	Organizational Type
Roudebush Veterans Administration Medical Center	Indianapolis, Marion, Indiana	Hospital and Community Outpatient Clinics-Government
VISN 11- Veteran Integrated Service Network (Regional Authority)	Ann Arbor, Washtenaw, Michigan	Government
Four County Counseling Center	Logansport, Cass, Indiana	Community Mental Health Center
Bowen Center	Warsaw, Kosciusko, Indiana	Community Mental Health Center
Hamilton Center, Inc.	Bloomfield, Greene, Indiana	Community Mental Health Center
Wabash Valley Alliance	Crawfordsville, Montgomery, Indiana	Community Mental Health Center
Centerstone of Indiana	Rushville, Rush, Indiana	Community Mental Health Center
Centerstone of Indiana	Columbus, Bartholomew, Indiana	Community Mental Health Center
Centerstone of Indiana	Bedford, Lawrence, Indiana	Community Mental Health Center
Community Howard Regional	Kokomo, Howard, Indiana	Community Mental Health Center
Indiana National Guard	Indianapolis, Marion, Indiana	Government
Indiana Department of Veteran Affairs	Indianapolis, Marion, Indiana	Government
Indiana Department of Labor	Indianapolis, Marion, Indiana	Government
Indiana Department of Mental Health & Addiction	Indianapolis, Marion, Indiana	Government
Purdue University Military Family Research Institute	West Lafayette, Tippecanoe, Indiana	University- Military Competency Training
Indiana Rural Health Association	Linton, Greene, Indiana	Hospital Association

Community Characteristics

A. Area

Indiana covers 35,867 square miles in the Midwest, with a (2012) estimated population of 6,537,334 people with 1,400,110 living in rural Indiana (USDA-ERS). Indiana is home to nearly 550,000 veterans. There are approximately 23,000 reserve component forces in Indiana: Army National Guard – 12,819, Air National Guard – 1,856, U.S. Army Reserve – 5,175, U.S. Air Force Reserve – 1,812, U.S. Marine Corps Reserve – 655, U.S. Navy Reserve – 475 and U.S. Coast Guard Reserve – 6.

Affiliated Service Providers of Indiana's Indiana Veterans Behavioral Health Network (IVBHN) is a statewide network that provides access to all service members and veterans that reside in the 92 Indiana counties. ASPIN behavioral health providers services can be accessed in 39 other clinics located in Indiana. The tele-health sites are located in Cass, Kosciusko, Rush, Bartholomew, Lawrence, Green, Howard, and Montgomery counties.

B. Community Description

Indiana has the 4th largest Army National Guard in the nation despite being the16th largest in population. Because its National Guard is primarily made up of Infantry soldiers, it has sent most of its troops to the frontlines of battle since 2003, many for multiple deployments. There are no active-duty military installations in Indiana that provide medical, behavioral or family support services for members of the Armed Forces. Indiana is also the 4th highest in the number of suicides of National Guard members. Indiana is 46th in terms of federal dollars received for veteran's benefits.

C. Need

Indiana is the fourth largest National Guard state with over 500,000 living veterans. Indiana is also the 4th highest in the number of suicides of National Guard members. ASPIN, a behavioral health network, identified that as a network it was serving around 1300 veterans annually and about one third of them with no insurance. The goal of creating the Indiana Veterans Behavioral Health Network was to create better access for veterans with behavioral health issues to seek help by connecting them utilizing telehealth equipment with their VA Medical Center without having to leave their rural communities. Because there are only two VA Medical Centers located in Indiana, there are significant behavioral health care access needs to reach the veteran in the rural areas.

Program Services

A. Description

The two primary goals of Indiana Veterans Behavioral Health Network were 1) to develop veteran cultural competency among providers of care and 2) to connect five selected Community Mental Health Centers as access sites to the Veteran's Administration Center tele-behavioral health hub. IVBHN has successfully met these goals.

Veteran Cultural Competency: In developing veteran cultural competency ASPIN Indiana Veterans Behavioral Health Network took a two prong approach. One, to train clinical providers on military culture and behavioral health issues post deployment, and two, to create a military ready designation system for behavioral health providers that allows the organization to be designated military friendly. IVBHN has successfully met these goals. Over the three year grant period, IVBHN directly trained 256 individuals via the live webinars. In order to expand the training opportunities, IVBHN established a learning management system, which allows individuals to view the archived IVBHN webinars. An additional 115 individuals have taken the online archived trainings via the IVBHN Learning Management System, bringing the total trained during the grant period to 371 individuals. During the grant period, six organizations have applied for, received, and maintained Military Ready designations. Three organizations have been awarded two star designations. Three additional organizations have received four star designations. These six organizations provide services across 28 of the 92 counties in Indiana, thus Designated Military Ready Behavioral Health Provider Organizations are available in over 30% of the State of Indiana.

Tele-Behavioral Health Network: IVBHN has placed teleconferencing units at eight rural community mental health centers to allow veterans' access to their VA clinical providers without leaving their local communities. The VA clinician connects with the veteran through the television monitor to conduct the scheduled appointment remotely. To utilize the tele -behavioral health network, veterans must be eligible for VA benefits and be scheduled by their VA clinicians.

B. Role of Network Partners

ASPIN, as the grant applicant agency played the lead role in all grant activities. As a network ASPIN brought the rural clinical providers to the table as a group and negotiated a group contract with the VA for facility fees. ASPIN also conducted most of the outreach and training, expanded the original network, purchased telehealth units, created policies and procedures, established the Military Ready Designation System, engaged veterans through community outreach, peer development, website, Facebook, and Twitter communication, and built community collaboration. It was also responsible for setting up a scheduling system.

Roudebush Veterans Administration Medical Center was an instrumental partner as they provided clinical therapists and the information technology knowledge on connecting the telehealth units with the VA. They also provided military subject matter experts for training civilian clinicians.

VISN 11- Veteran Integrated Service Network (Regional Authority) provided additional funding of approximately $900,000 during the grant period to support more therapists for the program and the purchase of three additional telehealth units.

Four County Counseling Center, Bowen Center, Hamilton Center, Inc., Wabash Valley Alliance, Centerstone of Indiana, and Community Howard Regional (all community mental health centers) each provided an office and staff in a rural site to support the program. These providers also helped the National Guard when there was a need for clinicians to conduct post deployment assessments. They regularly participated in partner meetings.

The Indiana National Guard linked the program to the veterans returning to Indiana. They gave the program access to yellow ribbon/seamless transition events to educate veterans on mental health issues that may arise after deployment. They also acted as subject matter experts to educate providers on military culture.

The Indiana Department of Veteran Affairs came under new leadership in the third year of the grant and became more active. They have partnered with ASPIN in a grant proposal from the Office of Rural Health on a Rural Veteran Coordination Pilot. ASPIN has trained over 35 veterans in the state peer certification program and this grant funding would focus on this population.

The Indiana Department of Mental Health & Addiction has been supportive of ASPIN IVBHN throughout the grant period. Over the last year ASPIN has been instrumental in helping them develop the Indiana Governors Veterans, Service Members and Families Coalition; and bringing together all the key players in the state delivering veterans services. They have included ASPIN in all aspects of creating a statewide strategic plan to address veteran needs. They have included ASPIN IVBHN in a statewide conference to provide program awareness.

Purdue University Military Family Research Institute has been an instrumental partner for all three years of the grant. They provided input when developing the Military Friendly designation criteria, as well as providing several military cultural competency trainings for clinicians across the state.

Indiana Rural Health Association has been supportive of the program by assisting with telehealth problems through the Upper Midwest Telehealth Resource Center. IVBHN has also presented military cultural training via webinars for their resource center. IRHA also supported presentations of the IVBHN grant at their statewide conferences.

The Indiana Department of Labor's partnership was minimal but it was seen as a key partner in re-integration for the returning veteran. In the future the network will use "Heroes to Hire" to advertise for open positions and to refer unemployed veterans for assistance in their job search.

Outcomes

A. Outcomes and Evaluation

The two primary goals of IVBHN were 1) to develop veteran cultural competence among providers of care and 2) to connect five selected Community Mental Health Centers as access sites to the Veteran's Administration Center tele-behavioral health hub. IVBHN has successfully met these goals.

In order to develop a veteran cultural competence among providers of care, IVBHN has successfully held 8 webinars. The webinars presented by IVBHN included: Veteran's Behavioral Health Issues Related to Deployment: PTSD; Provider Orientation to the IVBHN Network; Military Culture and Terminology; Behavioral Health Challenges for Veterans; Family Issues Facing Returning Veterans; From Helmets to Heels: The Physical and Behavioral Healthcare Challenges Facing Reintegrating Female Veterans; Remote PTSD: Drone Pilots and the Impact of Secondary Exposure, and Addressing Military Sexual Trauma in a Community Setting. In the second year of the grant, IVBHN began a collaboration project with the 8 regions of Indiana's Area Health Education Centers (AHEC) to develop and present webinars about veterans' issues. This collaboration helped the AHEC's (also funded by HRSA) achieve a goal given to them by their national office to provide educational information about veterans to healthcare workers in their regions, while significantly expanding the training base population and promotional efforts at IVBHN. This significantly increased the number of participants in the IVBHN training webinars from the first to second grant year. Over the three year grant period, IVBHN directly trained 256 individuals via the live webinars. In order to expand the training opportunities, IVBHN established a learning management system, which allows individuals to view the archived IVBHN webinars. An additional 115 individuals have taken the online archived trainings via the IVBHN Learning Management System, bringing the total trained during the grant period to 371 individuals.

To further IVBHN's mission to promote awareness of Veteran Behavioral Health issues, IVBHN has utilized social media. IVBHN has a web site (www.IVBHN.org), a Facebook Page (https://www.facebook.com/IVBHN) and a Twitter account (https://twitter.com/IndianaVeterans/@indianaveterans). Since its inception, the IVBHN website has had a total of 78,584 visits, with an average of 2,910 visits and 898 unique visitors per month. This has increased significantly during the last grant year, where the average is 6,200 visits with 1,736 unique visitors per month compared to 728 visits, 356 unique visitors per month in the two prior grant years. The IVBHN Facebook page has 90 Likes and the IVBHN Twitter account is followed by 545 individuals.

In addition to the direct training, marketing and outreach and social media activities, IVBHN developed The Military Ready Behavioral Health Provider Organization Designation program to further the goal of developing veteran cultural competency among providers of care. This program establishes a network of veteran friendly behavioral health providers through the IVBHN Network. For a provider to be designated as a Military Ready Behavioral Health Provider Organization, the agency must meet the requirements of either the one, two, three or four star levels as shown on the designation grid. The designation grid includes core requirements in the area of Access to Treatment, Organizational, Outreach and Marketing, Veteran and Family Support, Staff Development and Veteran Tracking. The four different star levels have increasing requirements across each level. Provider organizations must submit an application, and based on the review of that application the provider organization will receive notification of their designation status. Additionally, once an organization received Military Ready Designation, it must submit annual application to maintain that designation. During the grant period, six organizations have applied for, received, and maintained Military Ready designations. Three organizations have been awarded two star designations. Three additional organizations have received four star designations. These six organizations provide services across 28 of the 92 counties in Indiana, thus Designated Military Ready Behavioral Health Provider Organizations are available in over 30% of the State of Indiana.

IVBHN has successfully connected five selected Community Mental Health Centers to the Veteran's Administration Center tele-behavioral health hub at the Roudebush Veteran's Administration Hospital in Indianapolis, Indiana. Through grant funds, the equipment was purchased and installed at five different rural communities: Bloomfield (Hamilton Center), Crawfordsville (Wabash Valley), Logansport (Four County Counseling Center), Rushville (Centerstone) and Warsaw (Bowen Center). New policies and procedures were developed to ensure streamlined and safe access for the veterans served. As a result of the success of the IVBHN tele-behavioral health network, Roudebush has been awarded a pilot project to install additional tele-health units in three new locations: Columbus (Centerstone), Bedford (Centerstone), and Kokomo (Community Howard). This pilot project stems from an Executive Order issued August 31, 2012, in which President Barak Obama directed the VA, the Department of Health and Human Services, and the Department of Defense to work together to find ways to collaborate with community-based providers to assist veterans with easier access to behavioral health services.

IVBHN was selected for this initiative because of the tele-behavioral health services it had already established in Indiana. The three additional sites went online in February 2014. Due to challenges in connecting to the VA, appointments did not begin until the second grant year; however, since then a total of 328 appointments have been scheduled through IVBHN with 106 in the second grant year and 222 in the third grant year. The no show rate for IVBHN appointments is 20.7% which is comparable to VA data. Additionally, the winter of 2014 was extremely challenging and several appointments were cancelled due to poor weather conditions. An analysis of no show data indicates that there is an increase in no shows when a site is first established and new

patients begin using the service. After services have been established, the no show rates decline. IVBHN anticipates a continued decline in no show rates as sites are active for longer periods of time. Additionally with the activation of the three new sites and the increase in referrals to existing sites, it is expected that the volume of services provided through the IVBHN tele-behavioral health network will continue to grow.

The IVBHN tele-behavioral health network has had 328 completed visits during the grant period. The veterans using the tele-behavioral health sites saved 35,218 miles driven, by attending appointments in their home communities compared to traveling by car to the Roudebush VA in Indianapolis. This represents over 704 hours of drive time. At Indiana's current median wage of $15.26, the savings in drive time accounts for $10,749. Additionally at the federal mileage reimbursement rate ($0.555 for 2012, $0.565 for 2013 and $0.56 for 2014), the cost savings for miles driven is $19,834. With only 328 completed visits the IVBHN network, has realized a cost saving for veterans and their families in drive time and mileage of $30,583. An example of the impact on a veteran is demonstrated through the comments provided by the staff at the Rushville spoke site: "We had a new Veteran come in today. I gave him a folder with all of the information in it. He said he really appreciated our site because it saved him from driving to Indianapolis. I have to say also, the connection, audio and video is so much better at this location. No problems whatsoever. We also have a new veteran scheduled for next Thursday. It's really looking good here at Rushville."

In addition to the cost savings to veterans for drive time and mileage, IVBHN partners have been able to bill facility fees to the VA for the use of the tele-behavioral health services. During the second grant year, the total facility fees were $13,618. For the third grant year, the facility fees billed are $21,651. The total facility fees billed for the grant were $35,271, with $31,218 received to date. The ability to bill facility fees will help sustain the IVBHN network after the grant is completed.

B. Network Collaboration

IVBHN reached a successful collaboration with every one of its partners because everyone had a common goal: increase access of behavioral health services to veterans in Indiana. By establishing the consortium and meeting regularly partners were able to share events and create new ways to collaborate. A prime example is the VA Medical Center. They were a key part in the success of the IVBHN grant because their strategic goals aligned with the grant: 1. To increase access sites for veterans seeking services, 2. To develop partnerships with community providers, and 3. To reduce the amount of travel reimbursement paid to veterans traveling to the VA for services. Their regional authority, VISN 11 staff were regular attendees of the meetings and have duplicated the network in Michigan on a smaller scale. The VISN was also able to obtain additional funding for the VA in the amount of $900,000 to spend on hiring more therapists, and expanding the telehealth location by three sites.

Challenges & Innovative Solutions

Timeliness of Federal Contracting: From the ASPIN perspective, a challenge was obtaining a contract with the VA and invoicing. This has taken several months to complete through the Federal contracting processes. It also held up the implementation of the expansion sites.

Telehealth Unit Connectivity: Another challenge that was overcome was the establishment a new process to address the issue of the lengthy approval and re-approval process, the VA authorized the use of their cloud based Clinical Enterprise Video Conferencing Network (CEVN). This national platform supports the use of video technologies to perform clinical video conferencing on the VA's dedicated intranet. The VA "video expressway" provides access, through the VA firewall, to clinical video conferencing with non-VA sites. Using the video expressway, and the SIP protocol, ASPIN sites no longer have to obtain an EVTN System Security Plan (SSP) for these types of video interconnections. This new process allows easier access and avoids the long approval process.

Staff Turnover: Another challenge has been staff reassignment from both the VA and ASPIN. Both organizations has experience the change of key personnel during the three year grant period. Fortunately the staff that replaced them also have the same passion for the project to succeed.

Sustainability

A. Network Structure

The network will continue as part of ASPIN and the CEO will act as the network director. A five year contract was signed in January 2014 with the VA Medical Center and ASPIN to continue to provide tele-mental health connection to eight providers' sites in the ASPIN network. The contract will pay provider sites a facility fee for housing the telehealth equipment and providing the office space. ASPIN will centralize the provider invoices and collect the monthly VA payment and disburse it to providers. ASPIN current IT Director will oversee this function with the help of the office manager for scheduling and tracking. Peer Veteran volunteers will attend yellow ribbon events to outreach to returning veterans about behavioral health issues and the telehealth network.

B. On-going Projects and Activities/Services To Be Provided

The project will be sustained in several different ways.

The consortium members that the IVBHN grant pulled together three years ago now also attend an Indiana Governor Veterans, Servicemen, and Families Coalition that was just formed 10 months ago. ASPIN and IVBHN are active members in this new coalition so the quarter meeting will not be needed as information is dissemination and relationships are maintained through this new avenue. ASPIN was instrumental in helping the state identify key players to be on the coalition and has been actively involved in developing and implementing the state strategic plan for the Veteran coalition.

The telehealth network that has been created, linking ASPIN members with the Veterans Administration Medical Center will be sustained by existing ASPIN staff. The ASPIN IT Director will continue to host monthly connect calls to report usage and address any connectivity problems. The ASPIN Office Manager will continue to schedule and track telehealth appointments, as most of this is completed through an electronic scheduling website.

The marketing and outreach for the telehealth sites will be supported through the use of volunteer veteran peers. They will act in a volunteer capacity to be at yellow ribbon and seamless transition events to create awareness about behavioral health issues and the rural access sites.

The military cultural competency trainings will be sustained through the existing trainings that have been recorded and available for viewing on the ASPIN website. ASPIN will continue to offer at least two trainings annually on veteran related topics. ASPIN has also partnered with Purdue Military Family Life Research Institute and Military One Source to promote their competency a training as well.

The military designation program will sustain with its current six providers. During the grant period, six organizations have applied for, received, and maintained Military Ready designations. Three organizations have been awarded two star designations. Three additional organizations have received four star designations. These six organizations provide services across 28 of the 92 counties in Indiana, thus Designated Military Ready Behavioral Health Provider Organizations are available in over 30% of the State of Indiana. Active recruitment will depend on the State being supportive of the program.

C. Sustained Impact

Increased Utilization of Telehealth Network: The effect of war on our returning veterans in Indiana will last for over a decade. It is widely known that service members and veterans sometime do not exhibit the need for mental health services until 2-4 years after deployment ends; so it is anticipated these sites will be utilized even after the grant has ended. We also anticipate a growth in the number of service members and veterans served at each location due to increased awareness. Each site has now served veterans in their area, and it is projected to increase as the word -of -mouth marketing of the IVBHN project is circulated in each local community. Indiana continues to deploy National Guard units even though the number is decreasing. Indiana is also projected to receive large numbers of career military returning to rural Indiana communities due to the reduction of armed forces. Unfortunately, they will be returning to a state that does not have an abundance of jobs which will cause reintegration issues. By having a rural tele-mental health network established the VA and providers are ready to serve the returning veteran.

Continued Collaboration of Partners: The consortium members that the IVBHN grant pulled together three years ago, now also attend an Indiana Governor Veterans, Servicemen, and Families Coalition that was just formed 10 months ago. ASPIN and IVBHN are active members in this new coalition so the quarter meeting will not be needed as information is dissemination and

relationships are maintained through this new avenue. ASPIN was instrumental in helping the state identify key players to be on the coalition and has been actively involved in developing and implementing the state strategic plan for the Veteran coalition.

Military Cultural Competency: ASPIN has trained a total of 371clinical providers during the grant period on military cultural competency and other military behavioral health specialty topics. During the grant period, six organizations have applied for, received, and maintained Military Ready designations. Three organizations have been awarded two star designations. Three additional organizations have received four star designations. These six organizations provide services across 28 of the 92 counties in Indiana, thus Designated Military Ready Behavioral Health Provider Organizations are available in over 30% of the State of Indiana.

Mental Health Stigma in the Military: During the course of the grant there have been several situations in which returning veterans have been involved in criminal behavior because of untreated mental health issues. ASPIN created several print advertisements for its Network providers to use that softly prompts veterans to seek help. Providers have used these ads to outreach to veterans. ASPIN has also been present at a variety of veteran events to share the signs and symptoms of behavioral health issues. The goal is to provide veterans with an alternative source of treatment in their community, if they do not want to access VA services.

Implications for Other Communities

ASPIN's Indiana Veterans Behavioral Health Network /VA Roudebush tele-behavioral project was selected as one of 15 pilot projects in seven states where VA is working with community-based mental health providers to help Veterans access mental health services in a timely way. It is the first public/ private partnership between the VA and a private provider nationally. Because of the success of this project, this model of telehealth connection with local community mental health centers and the veterans' administration medical center has already been duplicated in Michigan on a smaller scale.

Maryland

Western Maryland Area Health Education Center

Organizational Information	
Grant Number	D06RH21682
Grantee Organization	Western Maryland Area Health Education Center
Organization Type	AHEC
Address	39 Baltimore Street, Suite 201, Cumberland, MD 21502
Grantee organization website	www.wmahec.org
Name of Network	Mountain Health Alliance
Network Director	Name: Susan Stewart
	Title: Executive Director, WMAHEC
	Phone number: 301-777-9150, ext. 147
	Fax number: 301-777-2649
	Email address: sstewart@wmahec.org
Project Period	2011 – 2014
Funding level for each budget period	May 2011 to April 2012: $180,000
	May 2012 to April 2013: $180,000
	May 2013 to April 2014: $180,000

Network Partners		
Partner Organization	Location	Organizational Type
Western Maryland Area Health Education Center	Cumberland, Allegany, Maryland	AHEC
Allegany Health Right	Cumberland, Allegany, Maryland	Non-profit
Workgroup on Access To Care	Cumberland, Allegany, Maryland	Voluntary membership
Allegany County Health Department	Cumberland, Allegany, Maryland	Local Health Department
Mineral County Health Department	Keyser, Mineral, West Virginia	Local Health Department
Healthy Mineral Coalition	Keyser, Mineral, West Virginia	Voluntary membership
Washington County Health Department	Hagerstown, Washington, Maryland	Local Health Department
Tri-State Community Health Center	Hancock, Washington, Maryland Cumberland, Allegany, Maryland	Federally Qualified Health Center
Mountain Laurel Medical Center	Oakland, Garrett, Maryland	Federally Qualified Health Center
Hyndman Area Health Center	Hyndman, Bedford, Pennsylvania	Federally Qualified Health Center
Garrett County Memorial Hospital	Oakland, Garrett, Maryland	Hospital
Garrett County Health Department	Oakland, Garrett, Maryland	Local Health Department
Western Maryland Health System	Cumberland, Allegany, Maryland	Hospital
Maryland AHEC Program Office	Baltimore, Baltimore City, Maryland	AHEC Program Office
Mineral County Family Resource Network	Keyser, Mineral, West Virginia	An agency of West Virginia Department of Health and Human Resources
County United Way	Cumberland, Allegany, Maryland	Non-Profit

Community Characteristics

A. Area

Mountain Health Alliance's (MHA's) service area is contained within Appalachia. The number of partners and service area outreach grew from its original group of three counties and two states to include five counties in three states, and is home to approximately 100,000 rural residents. The areas served are: Allegany, Garrett, and Western Washington counties in Maryland; Bedford County in Pennsylvania; and Mineral County in West Virginia. MHA's target population is low-income, uninsured and underinsured adult residents, close to 20 percent of the total population, or about 20,000 persons.

B. Community description

MHA's service area is comprised of about ninety percent Caucasians and ten percent Minority. According to County Health Rankings and Roadmaps, a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin's University Population Health Institute, the health outcomes of Allegany and Garrett counties rank in the lower fourth of the Maryland's twenty-four counties, with Allegany being 22nd out of 24. All five counties in MHA's service region are above their respective state incident rates for adult obesity, physical inactivity, uninsured residents, preventable hospital stays, unemployment, and children in poverty. The Maryland State Health Improvement Process (SHIP) 2012 found that the three Maryland counties are above state incidence rates for teen birth rates, child maltreatment, domestic violence, and deaths from heart disease as well. The percentage of persons living below the poverty level and/or uninsured in MHA's Maryland counties is nearly double that of the State of Maryland as a whole, while the entire state of West Virginia has high percentages of both. Allegany County has the lowest per capita income of any county in Maryland, and West Virginia, the only state entirely within Appalachia, is similarly impoverished. Forty percent of households in the Hyndman area of Bedford County, Pennsylvania have incomes below $25,000 according to census data. MHA's five counties, either through their FQHC partners or for "low income" residents, have HPSA designations in Primary Care, Dental, and Mental Health. Oral health care is not a mandated benefit for adults in plans offered by the Affordable Care Act (ACA), perpetuating disparities in MHA's service region that the ACA is targeted to overcome in other health areas. Residents of this area conduct their lives regionally by shopping, obtaining goods and services, including healthcare, and search for resources within a three-state area. Regionally, comprehensive and efficient public transportation is extremely limited. Given the mountainous topography and harsh winter conditions, transportation is often cited by residents as a barrier to care. In focus groups conducted in 2012, about 10% of respondents reported that transportation is a barrier to them seeking dental care, while partner surveys find that about 25% of their respondents reported missing a health care appointment (either dental or medical) within the past year.

C. Need

Given the low incomes of our residents, MHA's target population cannot afford either personal dental insurance, or out-of-pocket expenditures for their dental care. Twenty thousand uninsured/underinsured adults in the MHA service region are in need of access to oral health care. According to the *Maryland Behavioral Risk Assessment Survey 2008* report, Allegany County ranks first in complete tooth loss and last in the percentage of people who have kept all their teeth. The 2006 report of the *Maryland Behavioral Risk Assessment Survey* found that Allegany County ranked highest in total tooth loss with 10.3 percent of its residents having all their permanent teeth removed. In this same report, sixty-one percent of the people surveyed reported that they had never seen a dentist.

Poor oral health contributes to complications in cardiovascular disease and diabetes and increases the likelihood of stroke. In focus groups conducted in 2012, about 53% of respondents across all adult age groups (18-70+) reported that they suffered from one or more of the chronic conditions of diabetes, heart disease or high blood pressure. All participants in focus groups also stated the impact of poor oral health on one's self-esteem, and their ability to get a job due to poor appearance. Local Health Planning Coalitions have been established in Maryland. Maryland's MHA counties prioritize their efforts in rank order. Each of the three Maryland counties, Washington, Allegany and Garrett, cited access to care, including dental within their top three priorities.

During the grant period, the Mountain Health Alliance supported the efforts of two Western Maryland Missions of Mercy, two-day emergent free dental care clinics, as Network partners work to increase dental care access points. Each Mission of Mercy conducted pre- and post-treatment surveys in an effort to profile the characteristics of those seeking care, and presented those findings to partners as well as Maryland's State Director of Oral Health and the Maryland Dental Action Coalition. While the average household income of the region's targeted population is about $40,000, approximately 80% of the 1,500+ recent Missions of Mercy participants reported household incomes below $30,000 and 32% indicated that they had not received dental care within the past four or more years. Sixty-two percent cited the major reason that they do not have oral health care is lack of insurance or cost of care.

MHA's targeted population also seeks help from charitable programs for urgent dental problems. Another access point for urgent dental pain has often been the hospital Emergency Department (ED). One partner hospital, in the last three years, has seen over 40 patients per month and provided over $350,000 in uncompensated care yearly (since these individuals have no means of payment). In such cases, patients are usually given a small dose of antibiotics and advised to seek care from a dentist within a few days.

Program Services

Description:

The Mountain Health Alliance is a regional network dedicated to increasing access to affordable, comprehensive, quality healthcare for all. The Mountain Health Alliance envisions that our region will achieve a culture of health where all residents have access to a seamless system of healthcare, regardless of rurality, income, or education. Mountain Health Alliance members have certain agreed upon values that guide the Networks efforts. These include:

- Quality- in working to increase access to health care, we believe that the care must be of good quality.
- Affordable- in working to increase access to health care, we believe that the care must be affordable
- Collaboration- we value the culture of collaboration that pervades our work and encourages progress

Activities of MHA benefit both Network partners and the community served by the Network. MHA's vision is to eliminate health disparities based on rurality, income, and education in the region it serves. For this grant, MHA identified oral health as the most pressing need for the region's low-income and uninsured funding cycle. Activities included:

- Provided in-kind support for fundraising, operations and implementation for two Western Maryland Missions of Mercy, which is supported by MHA partners until access is expanded through other resources.
- Funded dental equipment to all care delivery partners to enhance quality of care and expand access.
- Conducted inter-professional primary care/dental surveys and sessions.
- Conducted inter-professional cultural competence and primary care oral health exam readiness sessions with health professions students. The team included GAHWDN's Network Director, Western Maryland AHEC Clinical Education Program Coordinator, MHA's Network Director, and the Community Health Worker (CHW). Health professions from the fields of Medicine, Nurse Anesthetist, Pharmacy, and Physician Assistant participated.
- Conducted community based focus groups reporting on barriers to health care, and disseminated findings to partners.
- Developed data collection system for reporting requirements across all partners and to other stakeholders.
- Strengthened network by expanding geographical outreach and added new partners.
- Obtained an in-kind grant from the National Association of Counties to conduct studies on the economic impact that partners have in the region, and the impact that increased dental access (through the opening of additional clinics in Mineral County WV and Cumberland, MD area) will have on the service area.
- Supported fluoridation of water supply in partner community that was scheduled to cease fluoridation due to budget constraints.
- Partnered with an urban FQHC to bring dental van services to rural FQHC partner site twice monthly.
- Created innovative coordination and compensation agreements between a partner non-profit and private and public health providers.
- Hired and trained a Community Health Worker (CHW), the only oral health CHW in Maryland, through coordination with the Regional Oral Health Pathway grant obtained by partner Allegany Health Right (AHR). The over 164 hour training modules were obtained through agreements with the Central Massachusetts AHEC for oral health training and the Texas AHEC East for the full 160 hour CHW course. Additionally, CHW staff conducts community outreach to pregnant moms (linkages with Maryland Oral Health Literacy initiative), senior centers (caregivers and residents), GED classes, adult congregate housing, and disability services providers. She also presented to the Maryland State Director of Oral Health and led a roundtable session at the Maryland Oral Health Summit in December 2013 regarding the role of the community health worker in oral health.
- Created an emergency department (ED) referral/diversion program. Regional Oral Health Pathway created a referral system that diverts patients who present with oral health pain at the ED of one partner hospital (Western Maryland Regional Medical Center) to partner Allegany Health Right, which then facilitates getting those patients into the appropriate care for their oral health pain (Care is partially donated by private practitioners.) Also, the Network created a unique payment system for its local health departments and Federally Qualified Health Center partner.
- Partnered with FQHC and local private dentists to provide oral health care to diabetic patients.

- Partnered with local ministry to provide dentures to persons seen at a local health department.
- Provided technical /grant writing assistance for Mineral County Health Department to obtain renovation funds that would make their dental clinic operational.
- Combined with a Rural Health Workforce Development Network – Garrett Allegany Health Workforce Development Network (GAHWDN) – to align to meet future goals. In September 2013 both MHA and GAHWDN voted unanimously that GAHWDN move forward as the Workforce component of the Mountain Health Alliance Network. The aligned group is now exploring how to make this relationship work efficiently. GAHWDN and MHA Network Directors as well as several other partners attend both monthly meetings and each update and educate the group about issues, progress, and work activities.

A. Role of Network Partners

Western Maryland AHEC: Governing Board Member. Responsibilities include: Project Oversight; Review all contractual arrangements, Attend all meetings; Serve as Network liaison to Western Maryland AHEC Board of Directors on all project matters; Network throughout 200+ AHECs nationwide on project goal, objectives, activities, outputs, outcomes, and impact; Implement the Strategic Action Plan; Serve as liaison to outside evaluator and participate in developing evaluation plan; and Prepare program reports; Publicize Network activities; Responsible for all program reporting and facilitating communication with other programs and partners.

Western Maryland Health System: Governing Board Member. Responsibilities include: Coordinate and report on Emergency Department Diversion program, hire and coordinate training of hospital-based Community Health Workers.

Hyndman Area Health Center: Governing Board Member. Responsibilities include: Provide dental care, work with partners to develop and implement payment and service arrangements appropriate to FQHC sites.

Tri-State Community Health Center: Governing Board Member. Provide interprofessional PCP/dental education to providers and patients.

Local Private Dentist and Public Health and FQHC practitioners: Educate and advise on oral health issues in the practice setting.

Allegany County Health Department: Governing Board Member. Provide dental care and implement compensation agreements through coordination with partner Allegany Health Right.

Mountain Laurel Medical Center: Partner. Provide oral health linkages to public and private dentists to provide oral health care, especially for diabetic patients.

Allegany Health Right: Governing Board Member. Coordinate Business Plan, Facilitate ROHP's dental care pathway through Emergency Department, provider, community-based, and self- referrals, and negotiates compensation models. Report on ROHP outcomes. Supervise Community Health Worker and assist in providing CHW with networking opportunities with MHA partners.

Garrett County Memorial Hospital: Partner. Participate in Emergency Department Diversion program.

Garrett County Health Department: Partner. Provide dental care, work with partners to develop and implement service and payment arrangements through coordination with partner Allegany Health Right.

Mineral County Health Department: Partner. Work with partners to obtain funding to bring a three chair dental clinic operational.

Mineral County Family Resource Network: Partner. Work with families in their county to coordinate linkages the Network's dental care resources. Work on funding objectives for Mineral County Health Department's dental clinic renovation.

Healthy Mineral Coalition: Partner. Work with the professional community to promote and advise on funding objectives for Mineral County Health Department's dental clinic renovation

Outcomes

A. Outcomes and Evaluation Findings

Dental Van Partnership: Beginning in August, 2012, Tri-State Community Health Center, in Hancock, Maryland began a partnership with Walnut Street Community Health Center's mobile dental unit "Healthy Smiles in Motion" (an urban FQHC in Hagerstown, Maryland). The dental van travels twice monthly to Tri-State's site and has cared for about 300 adult patients during the course of the grant.

Regional Oral Health Pathway (ROHP): The Regional Oral Health Pathway (HRSA Grant Number: D04RH23556) was obtained by partner Allegany Health Right in 2012 and is a program of MHA. Since its beginning in May 2012, ROHP has seen a tremendous growth in the number of patients, dental visits and percentage of donated care. From its first year, the number of patients has increased 132% percent from 177 to a projected 426; the number of dental visits provided has increased 183% percent from 189 to a projected 921 for their current grant year, and the percentage of donated care has increased from 45% to 79%. The increase in donated care is the result of the use of public health dental providers (such as health departments and FQHCs) and the implementation of compensation agreements appropriate to each.

Focus Group Report: Seven focus groups totaling 63 participants were conducted regionally. Discussion was especially encouraged regarding periodicity of participants' dental and medical exams, presence of chronic disorders, the psychological and physical impacts of poor dental health, and barriers to care. Major findings are as follows:

- 17% reported using the hospital's Emergency Department for acute oral health issues.
- 64% did not have "regular" dentist visits, defined as every 6 months.
- 71% had incomes below $30,000.
- 53% across all age ranges (19 to 70+) experienced one or more of the chronic conditions of Asthma, Diabetes, High Blood Pressure, or Heart Disease.
- 100% of respondents expressed the need for a local dental health clinic for uninsured and underinsured adults citing that it would help them with regular dental care by being affordable, locally accessible, and providing flexible care hours that include evenings and weekends.

Oral Health Exams in Primary Care Settings: In 2013, the Network agreed upon a survey which sought information on the extent to which primary care providers – practitioners in internal medicine, family medicine, ob-gyn, and pediatrics conduct oral health exams as a part of their practice. The target group included eighty physicians, D.O.'s, nurse practitioners, and physician assistants. The response rate was 20%. Of the 20%,

- 43% said that they do not currently perform oral health exams on their patients.
- 50% preferred live instruction on how to do such an exam, while 39% preferred on-line or self-guided study packets. Six percent preferred a combination of learning methods.
- 53% said that it would be useful to have a five to six question oral health risk assessment tool for adult exams.

Mission of Mercy two-day free dental clinics: MHA provided in-kind support for the organization, fund raising and implementation of two Missions of Mercy during the grant, in an attempt to provide urgent dental care while partners develop more permanent dental access points. Over fifteen hundred adults received dental care valued at over 1.4 million dollars. Sixty-three percent of respondents cited "No Insurance," or "Cost of Care" as barriers to obtaining oral health care. Eighty percent reported household incomes below $30,000. Similarly eighty percent of those receiving care were of working age – ages 19 through 59. Seventy-six percent of the patients attending Mission of Mercy clinics were from MHA's five county, three state service area.

B. Network Collaboration

The basic principles of success include trust in partners, commitment to the goals, and taking action steps to achieve the goals. Our successful collaborations include:

Regional Oral Health Pathway: The Regional Oral Health Pathway (ROHP) is a direct services program of MHA, funded by the Office of Oral Health Policy. Successes include the following:

- New Compensation Model: ROHP negotiated new compensation models for local health departments and FQHC partners, resulting in a 79% discount from value of services to amount paid. Twice as many services are now provided per patient. The payment model is based on an hourly rate that meets the needs of each partner, not on procedures.
- Community Health Worker: AHR and Western Maryland AHEC collaborated to hire and train the state's first and only oral health specific CHW

- Emergency Department Referral/Diversion Program: MHA Network director and ROHP grant director met with Western Maryland Health System ED staff and their lead physician. WMHS's ED created a process, which presents referrals to patients, and directs patients to Allegany Health Right, where a CHW and dental case managers facilitate care to partner public health and private dental providers for income-qualified adults.

Training of Primary Care Providers: A partner Private Dentist, Western Maryland AHEC, and the Western Maryland Hospital System's Wellness Program Director collaborated to provide evidence-based primary care oral health education to a group of nineteen primary care providers.

Mobile Dental Van Services: Tri-State Community Health Center (FQHC) entered into an agreement With Walnut Street Community Health Center (FQHC Hagerstown, MD) to have Walnut Street's dental van go to Hancock to provide services to Tri-State patients, seeing about 15 patients a month.

Public Health Dental Clinic in Mineral County, WV: While it is not yet open, only $50,000 more are needed to complete renovations. This clinic will also serve Maryland residents.

FQHC Dental Clinic in Cumberland, MD: While this has not materialized yet, Tri- State (FQHC) is collaborating with Hyndman (FQHC) to bring a dental clinic to Cumberland. Hyndman is writing an expansion grant, and Tri-State is allowing Hyndman to proceed with operating a dental clinic in its service area. Their project officers have given preliminary approval.

Challenges & Innovative Solutions

The Network originally cited in its work plan that dental clinics would most likely be its "significant strategy" to increase access to oral health care in the region. Funding constraints for bricks and mortars projects necessitated that the Network look toward expansion of existing resources while still developing plans for actual clinics. Specifically, because of economic conditions, especially in the State of West Virginia, the Mineral County Health Department has experienced lengthy delays in obtaining funding for renovation of existing facilities to make their dental clinic operational. As well as vigorously pursuing private foundation and State of West Virginia governmental resources, the Mineral County Health Department is conducting a "home grown" fund raising approach as they await WV legislative action.

For the Cumberland area, the group aggressively sought State of Maryland, Appalachian Regional Commission, and private foundation funding sources for a bricks and mortars facility, including exploring a partnership with the Cumberland Housing Authority to utilize some of a disused vacant hospital site. Economic conditions affected the State of Maryland's funding process, stopping the Cumberland Housing Authority's site plans. Regardless of Network and local partnerships, any building/renovation project required matching grants.

The Network has successfully expanded access to existing public health resources and also continues to explore potential FQHC dental service expansion into the Cumberland area. As partners obtain additional funding, they share information and, when applicable, resources regarding programs that can assist qualifying residents. For instance, AHR obtained grants from the Stullman Foundation and Maryland's Community Health Resources Commission for oral health care for elderly and disabled adults and is incorporating its efforts with those of Allegany County Health Department's Maryland Senior Surveillance project for oral health.

The Network was faced with a key hospital losing hundreds of thousands of dollars yearly in uncompensated care through its Emergency Department for oral health diagnoses. In addition to the economic impact on this hospital, the hospital ED could not offer the appropriate care for dental emergencies. The creation of an emergency dental referral process and the establishment of a care pathway with partner Allegany Health Right have facilitated patients getting cost-effective, comprehensive care for their problems in a timely manner.

Sustainability

A. Network Structure

The Network structure will continue with all of the partners listed in Part II. Sustainable funding is needed for the Network Director's position, but the Network group will continue to meet and carry out its original objectives as well as explore other areas in which to increase access to health care. During the course of the grant, it became apparent that workforce development is an

integral part of the increase in access to care. To that end, partners include in every meeting, their workforce needs as well as obtain updates from the Garrett Allegany Health Workforce Development Network. The two voted to consolidate their efforts in September 2013 and seek additional funding based upon both health care access and workforce development. The Regional Oral Health Pathway will remain a program of MHA. A May 21, 2014 meeting is scheduled for the combined Network to determine work groups and meeting schedules.

B. On-going Projects and Activities/Services To Be Provided

- Continuation of Network partner meetings for planning, networking, and implementation purposes

- Continuation of the Regional Oral Health Pathway: Since healthcare is regional in the MHA service area, ROHP's model addresses health disparities and provides patient navigation among all partners in the three-state, five-county region. The Pathway can address and is expected to address other health priorities wherever the Network targets them.

- Greater integration of workforce needs into MHA's work. The partners of the Network have a longstanding history of working collaboratively, and assisting each other in meeting workforce demands in mutually beneficial collaborations. Western Maryland AHEC, through its clinical education, housing for health professions students and medical residents, and its continuing education programs adds connections and perspective to the process.

- Continued coordination and facilitation of compensation agreements. Efforts target both the care pathway of the patient and the compensation models needed to effectively bring public health providers, both health departments and FQHCs, into the care cycle. The burden on private dentists to provide pro bono has been greatly minimized. These dentists now provide care only for more complex cases. This model allows for patients to receive more procedures at lower costs, while having the assurance that more complex services are available in the community.

- Continued oral health inter-professional education for primary care and for health professions students. From the surveys of primary care providers, the one-on-one instruction with two pediatric groups, and the positive response from health professions students across several disciplines, this work is necessary to provide education about the health culture of the service region and develop a mouth-body connection within the professional community.

- Continue the development of data-driven materials that tell our story for local, state and federal stakeholders and legislators.

C. Sustained Impact

The Network has an improved care coordination and compensation mechanism that will allow access to continue and expand through the use of existing public-private resources. These efforts enhanced relationships between private and public providers, and encouraged partners to support each other's goals. This model is navigable to other health issues that the Network wishes to address. The Network expanded its interactions regionally, including providers and organizations outside of their individual work places. This greatly enhanced the probability that patients in need could receive appropriate care. With robust data from the Western Maryland Health System, the Network continues to refer urgent dental pain sufferers from the Emergency Department to appropriate, affordable oral health care.

Implications for Other Communities

- Include organizations that represent your targeted service area and population. This includes non-profits, hospitals, voluntary membership groups, Federally Qualified Health Centers, health departments.

- Seriously consider including your local Area Health Education Center (there are over 240 nationwide). AHECs have resources that can identify provider and population needs. An AHEC is a neutral partner and supports all other partners without bias in its attempt to improve the health and healthcare workforce of the community.

- The best qualitative measure that we have observed has been the extent to which our partners are in contact with each other outside of meetings, the linkages and opportunities they have created for each other and the pride with which they share their efforts to an excited group. This shows that we have created a collaborative, non-competitive environment. There may be areas where organizations believe they are battling over the same piece of the pie, however, MHA partners tend to focus on those projects that are mutually beneficial, utilize and build upon existing infrastructure while seeking new solutions to access to care.

Michigan

Alcona Health Center

Organizational Information	
Grant Number	D06RH21655
Grantee Organization	Alcona Health Center
Organization Type	FQHC
Address	177 N. Barlow Rd. Lincoln, MI 48742
Grantee organization website (if available)	www.alconahealthcenters.org
Name of Network	MI-Connect, Integrating Health Services in Michigan
Network Director	Susan Kaderle
	Network Director
	Phone: 989-569-6001 Ext. 1730
	Fax: 989-358-3756
	Email: skaderle@alconahc.org
Project Period (beginning year to end year)	2011 - 2014
Funding level for each budget period	May 2011 to April 2012: $180,000
	May 2012 to April 2013: $180,000
	May 2013 to April 2014: $180,000

Network Partners		
Partner Organization	Location	Organizational Type
Alcona Health Center	Lincoln/Iosco County/Michigan	FQHC
Sterling Area Health Center	Sterling/Arenac County/Michigan	FQHC
Northeast Health Plan	Midland/'Ogemaw County/Michigan	County Health Plan
St. Joseph Health System	Tawas City/Iosco County/Michigan	Community Hospital

Community Characteristics

A. Area

MI-Connect serves a five county service area including Arenac, Iosco, Alcona, Ogemaw and Oscoda.

B. Community description

Our service area faces serious challenges for health care access due to high rates of under and uninsured individuals, widespread economic and social deprivation, joblessness, underemployment, geographic isolation, harsh climate, lack of transportation resources, and a large elderly population with extensive health care needs. All five counties are medically underserved communities and Health Professional Shortage Areas.

C. Need

The Network Development Grant was utilized to develop a stronger structure for programming both in the area of direct services and in shared administrative services. Shared approaches to the delivery of integrated behavioral health services was the first direct service focus area for our Network.

Program Services

A. Description

MI-Connect conducted the following activities:

- Identified patient services for coordination and/or collaboration among members
- Identified key support and/or administrative functions for coordination or integration among members
- Identified areas of current collaboration that may be moved into the MI-Connect structure
- Continued to assess the needs of the health care community through focus groups and forums
- Conducted annual strategic planning sessions to revisit network goals and objectives
- Participated in local, state and national initiatives that focus on best practice and standard of care strategies for health care delivery specific to behavioral health
- Hired a Behavioral Health Clinical Program Director
- Determined areas of highest need for Behavioral Health services
- Explored areas for assistance in delivering care to the behavioral health populations including tele-psychiatry options
- Explored group purchasing of technology infrastructure and other resources necessary for transformation
- Educated practitioners and staff on the Integrated Behavioral Health and tele-psychiatry models
- Provided coaching and support for IBH and tele-psychiatry implementation
- Explored all areas of potential incentive reimbursement for BH
- Educated provider and support staff in documentation requirements
- Coordinated with state and national resources to assist primary care practices in adapting the integrated behavioral health and tele-psychiatry models and payments incentives
- Formed a behavioral health care coordinating team
- Researched and adapted best practice model for integrated behavioral health
- Conducted educational needs assessment for primary care and community resources
- Developed a learning collaborative for clinical teams and community resources
- Updated primary care providers on current evidence-based guidelines and best practices for selected disease states
- Worked with community resources to assure medications are available to low income patients
- Designed and implemented media campaign to increase community awareness of resources
- Studied additional chronic disease/health states for future care coordination opportunities
- Explored other successful Networks in identified area of potential collaboration
- Developed relationship with local community mental health organizations
- Researched cost saving measures for patients, such as drug costs and coverage.

B. Role of Network Partners

Each Network partner was at a different stage of integration when we received our funding award. The two FQHC's members utilized our Nurse Practitioner for integration, they always communicated between the agencies for development and structural changes, UDS measures, and guidelines and assessments. Mid way through our funding period, we lost a partner due to internal restructuring and also lack of provider support of the IBH model. We gained a new partner that was very supportive; this also allowed us to increase our patient access in our service area. We also continue to research the possibility of tele-psych between the partners.

Outcomes

A. Outcomes and Evaluation Findings

The outcomes and evaluation findings include increased access to behavioral health services for the community, as well as in the schools, are both large accomplishments for the Network. We have also formed and kept relationships with other collaborating agencies in our service area.

B. Network Collaboration

The partners adopted the same policies when it comes to development and structure related to treatment planning, guidelines and assessments.

Challenges & Innovative Solutions

One of our larger challenges was having a partner change during the middle of our funding; this was addressed by searching for a new collaborating partner. With that came starting from square one with behavioral health integration within the new addition. Another challenge was provider hesitation which in the overall picture may be why the partner decided to no longer participate in the Network. We did address their reluctance by doing multiple educational sessions directly with the providers and continued to offer resources for behavioral health during their time with the Network. We still reach out to them with resources and educational opportunities. A barrier in increasing access was and continues to be lack of transportation for patients, in response to this ongoing issue, the Network sought out resources to address the issue, helping when possible.

Sustainability

A. Network Structure

We were able to add two new partners to MI-Connect. The partners that will continue are Alcona Health Center, Sterling Area Health Center and Northeast Health Plan, the additions include the Health Department of Northwest Michigan and McLaren Northern Michigan Hospital. The Network Director remains the same as well as the Behavioral Health Program Director. New positions that will fall under grant funding include an LMSW, as the Behavioral Health Integration Coordinator and an Oral Health Program Coordinator.

B. On-going Projects and Activities/Services To Be Provided

Due to the new funding we will be expanding behavioral health services using the same integration model that was originally implemented in the first round of Network funding. We will be continuing our collaboration with local Community Mental Health agencies and local schools. There will be a continued focus on access to care by increasing provider availability and will also continue education regarding behavioral health integration.

C. Sustained Impact

The long term effects include increased access to behavioral health services, an increased knowledge base of integrated behavioral health among partner staff as well as heightened community awareness of behavioral health services, increased knowledge of BHI among providers. We have established a successful model that will be replicated in the future and collaboration with community mental health and other supporting agencies.

Implications for Other Communities

Our Network experience and outcomes are a direct reflection of the support and collaboration that has been present for the last several years. A strong commitment by our partners is an imperative piece to having a successful Network. Having open, organized conversations about where you are currently and where you would like to be in the future are crucial. Having diverse partners is beneficial and most importantly having a similar mission will provide the foundation for your Network.

Michigan

McKenzie Health System

Organizational Information	
Grant Number	D06RH21675
Grantee Organization	McKenzie Health System
Organization Type	Hospital
Address	120 North Delaware Street, Sandusky, MI 48471
Grantee organization website	http://www.mckenziehealth.org/
Name of Network	NeuroOncall
Network Director	Name: Vickie Gordon
	Title: Account Executive
	Phone number: 248-849-2561
	Fax number: 248-849-8313
	Email address: Vickie.gordon@stjohn.org
Project Period	2011 - 2014
Funding level for each budget period	May 2011 to April 2012: $179,725
	May 2012 to April 2013: $179,725
	May 2013 to April 2014: $179,725

Network Partners		
Partner Organization	Location	Organizational Type
Borgess Medical Center	Kalamazoo, Michigan	Hospital
Borgess Lee Memorial	Dowagiac, Michigan	Hospital
Botsford Hospital	Farmington Hills, Michigan	Hospital
Carson City Hospital	Carson City, Michigan	Hospital
Genesys Regional Medical Center	Grand Blanc, Michigan	Hospital
McKenzie Health System	Sandusky, Michigan	Hospital
Providence Hospital	Southfield, Michigan	Hospital
Providence Park Hospital	Novi, Michigan	Hospital
River District Hospital	East China Township, Michigan	Hospital
St John Hospital	Detroit, Michigan	Hospital
St John Macomb	Macomb, Michigan	Hospital
St John Oakland	Madison Heights, Michigan	Hospital
St Joseph- Tawas	Tawas, Michigan	Hospital
St Mary's of Saginaw	Saginaw, Michigan	Hospital
St Mary's of Standish	Standish, Michigan	Hospital
Sturgis Hospital	Sturgis, Michigan	Hospital
Three Rivers Hospital	Kalamazoo, Michigan	Hospital

Community Characteristics

A. Area

The NeuroOnCall network has provided services to southeastern Michigan communities, southwestern Michigan communities, central Michigan communities, the Thumb region communities, and northwest communities.

B. Community description

The region is largely agricultural with 70 percent of the land in farms. In addition to agriculture, the economy depends on wholesale and retail trade and some manufacturing, particularly wood processing. Recreation activities include hunting, fishing, and boating, among others. There are many small towns and cities located in these communities with many small resort communities along the lakeshore.

C. Need

The state of Michigan has a stroke disability and morbidity rate higher than the national average in many of these rural counties. Many of these counties have uninsured rates of 12 percent to15 percent and those with insurance have a tendency to be underinsured (average 14 percent to17 percent). These communities also lack access to neurology services as the sparsely populated rural regions are difficult regions to establish viable specialty practices.

Program Services

A. Description

The NeuroOnCall network provides 24/7 stroke neurology and neurosurgery coverage to all facilities in the network. Utilizing telemedicine carts, the network connects specialists at "hub" hospitals to stroke patients at member hospitals in rural communities, allowing for the neurologist's or neurosurgeon's evaluation of the patient to begin within fifteen minutes of notification.

At each facility the EMS providers, medical and nursing staff underwent team training in the delivery of advanced neurological and neurosurgical care to stroke patients. Upon identification of a stroke patient, the medical team activated the NeuroOnCall network- this notified the neurologist and neurosurgeon that a stroke patient was in need of a consultation. The neurologist and neurosurgeon used robotic technology to evaluate the patient and discuss treatment options with the medical staff, patient and family. Treatment was then instituted at the facility as recommended by the specialist.

The NeuroOnCall network provided feedback to the EMS, medical and nursing staff on all patients treated through the network. Meetings and educational events were held monthly to retain knowledge and hone clinical skills.

With our participation in a telehealth demonstration project, we were able to bring attention to the issues and potential of telehealth in the state. This information was shared with legislators. During the grant period, the State of Michigan enacted legislation that placed telemedicine services on par with face-to-face consultations and required all insurers to reimburse for these services.

B. Role of Network Partners

Each network hospital assisted with the development of clinical algorithms for acute stroke, participated in mock stroke training events, participated in community education events locally, and EMS development and training. Quality assurance review and feedback was provided to each local hospital following each stroke patient event.

Outcomes

A. Outcomes and Evaluation Findings

The NeuroOncall Network has now performed 700 stroke consultations. The past year has seen a doubling of the Network's calls. Many of these patients were able to be treated at the community hospital location with specialist recommendations, 25 percent received tPA (the only known treatment for acute stroke, but needs a neurologist recommendation for administration) or neurosurgical intervention at a tertiary care hospital. McKenzie Health System received a Quality Patient Award for its care of the stroke patient by the Michigan Center for Rural Health in 2013.

B. Network Collaboration

Significant collaboration occurred with the telemedicine devices between physicians in small community hospitals and specialists located in metropolitan tertiary hospitals; this provided both physician education and a collegiality that had not previously been seen in referral relationships. Network feedback provided patient outcomes to nursing and medical staff on the results of the care provided to the patient at the community hospital and the resultant effect on the patient's recovery. Medical, Nursing, EMS clinical algorithms and community education was enhanced by the tools the network was able to provide to the member hospitals, leveraging resources not previously available to the independent facilities.

Challenges & Innovative Solutions

The most significant challenge to the Network was the cost of the telemedicine devices and legal issues with reimbursement for telemedicine consults. Cloud based virtual care solutions were sought out to reduce the cost of telemedicine devices in order to expand services. Efforts were successful in the State of Michigan to enact legislation that placed telemedicine services on par with face to face consultations and required all insurers to reimburse for services.

Sustainability

A. Network Structure

All members are continuing on with the network.

B. On-going Projects and Activities/Services To Be Provided

The NeuroOncall Network will continue to grow- considerations are underway to rename the entity Virtual Care Network of Michigan. Two new hospitals are expected to be added to the network in the next six months for stroke services. The model is financially sustainable in its present form. Michigan is an ACA Medicaid expansion state and the uninsured rate is expected to continue to decline. All services for the network are now reimbursable by private or public health insurance. Services are expanding to include 24/7 behavioral health, cardiology, trauma. There are plans under way to launch four virtual specialty clinics in these rural communities beginning with Neurology services (General, Movement Disorders, and Epilepsy), Psychiatry services, and Pulmonary Medicine.

C. Sustained Impact

It is expected that these efforts will, over the long-term, reduce the morbidity and mortality rate of stroke in the state of Michigan and reduce unnecessary transfer to tertiary facilities of patients who will benefit from the expanded specialty clinics under the Virtual Care Network.

Implications for Other Communities

Telehealth provides the ability to provide specialty services to even the most remote regions. With improvements in technology and infrastructure the cost of these programs continues to decline. Legislative action has improved the reimbursement for these services and allows for the programs to become financially sustainable. However, considerable work remains in terms of legislation in the areas of physician licensure, and credentialing. Nationally a Telehealth bill has been introduced to congress to address many of these issues- “The Telehealth Modernization Act of 2013” which would provide guidance to states when developing telehealth policies.

Michigan

Michigan Rural EMS Network

Organizational Information	
Grant Number	D06RH21673
Grantee Organization	Michigan Rural EMS Network
Organization Type (i.e. AHEC, university, hospital, etc.)	Nonprofit EMS Network
Address	P.O. Box 265 Caro, MI 48723
Grantee organization website (if available)	www.mirems.org
Name of Network	Michigan Rural EMS Network
Your Network Director (primary contact person for grant)	Leslie Hall
	Executive Director
	Phone: 989.284.5345
	Fax: 888.709.1718
	Email: leslie@mirems.org
Project Period	2011 - 2014
Funding level for each budget period	May 2011 to April 2012: $ 180,000
	May 2012 to April 2013: $ 180,000
	May 2013 to April 2014: $ 180,000

Network Partners		
Partner Organization	Location	Organizational Type
Sebewaing Ambulance Service	Sebewaing, Michigan	Township EMS Service
Croswell EMS	Croswell, Michigan	Township EMS Service
Central Huron Ambulance	Bad Axe, Michigan	Township EMS Service
Elkton EMS	Elkton, Michigan	Township EMS Service
Sanilac Ambulance	Sandusky, Michigan	Hospital owned EMS Service
Eastern Huron Ambulance	Harbor Beach, Michigan	Township EMS Service
Scheurer Hospital EMS	Pigeon, Michigan	Hospital owned EMS Service

Community Characteristics

A. Area

For this project we targeted EMS companies and professionals that provide EMS service in rural Michigan. Our primary target was counties designated rural by the U.S. Census. Of 83 Michigan Counties, 57 (68%) are designated as rural. We also reached out to EMS companies and professionals that are located in urban areas but provide service in rural communities. This is critical as often the companies and professionals serving in this capacity are not integrated into the rural community and do not have the skills or knowledge needed to treat patients at rural scenes such as farm accidents or remote areas. Urban and rural companies also interact frequently during transfers and intercepts making their working relationship critical to the effective transfer of patients from one company to another. Rural counties in Michigan have higher percentages of poverty and unemployment than metropolitan counties in Michigan. Unemployment rates are consistently higher in rural areas than the rest of Michigan. In September 2010 54% of rural counties had unemployment rates higher than Michigan, with the top rate for a rural county being 21.3%. Seventeen of the rural county rates were higher than the highest urban county rate of 14.4%.

B. Community description

Michigan's rural population is aging. In 2005, the median age in Michigan was the 40-44 age group for rural counties. From 1990 to 2005, the percent of the population for ages 45 to 59 increased by at least 50%, while the percent of the population aged 80 years or older increased by as much as 85%. During the same time period, the percent for the population aged 10 and under decreased by 10-15%, and it decreased for those aged 25 to 40 by as much as 20%. Rural county residents tend to have lower education levels than other Michigan residents. In 2000, 19.3% of rural county residents in Michigan had not completed high school (or equivalent).

C. Need

We began with review of a local needs assessment which we originally conducted in 2004 and repeated in 2009. An eight page survey was mailed in 2009 to 278 licensed EMS professionals in Huron and Sanilac Counties with a 33% completion rate. The survey asked a variety of questions to help the two county network identify and address priority needs. Based on review of all the needs assessment data, we determined that there is a strong need for Rural EMS companies and professionals to have an organization dedicated to providing a voice for rural EMS concerns.

The rural EMS agency administrators who responded to the survey focused on organizational needs which included staff recruitment and retention, financial concerns, and a lack of advocacy for rural EMS in Michigan. The rural EMS professionals who responded cited individual needs which included benefits, compensation and career opportunities; a desire to work under better management and medical oversight; communication between leaders and EMS professionals; and a desire for increased opportunities for initial and continuing education.

Program Services

A. Description

A key goal of our project was to improve the healthcare environment and level of support for Rural EMS professionals and the agencies for which they work. The establishment of a statewide rural EMS network was the vehicle to provide opportunities, education, services and advocacy. We registered the network as a federally recognized 501(c)3 , effective January 2012. With the input of major stakeholders from across the state, we implemented the Mobilizing for Action through Planning and Partnerships (MAPP) strategic business and planning process. Our first statewide network Board of Directors was voted in by membership in October 2012 and, with the assistance of various committee members, work began in earnest to develop self-generating revenue streams. These included educational events and programs, membership structure and targets, management classes, a corporate sponsorship program, group purchasing programs, and consultant services.

We sought to increase communication between Michigan's rural EMS professionals and their local, regional, and state organizations and authorities. We accomplished this by developing and implementing a communication plan for rural EMS topics. Information that was critical to rural EMS issues was regularly disseminated to agencies and professionals. Network staff also participated in regional and state meetings, allowing for an opportunity to provide rural input and perspective related to EMS policy, standards, initiatives, and operational issues. Meeting highlights were distributed as part of the communication plan.

Another major goal of our network development project was to provide opportunities, events, resources and technical assistance to enhance the effectiveness of rural EMS agencies and EMS professionals. One way we accomplished this was by increasing the availability of expert resources to rural EMS companies. We partnered with experts to provide regional and electronic educational opportunities on topics that were identified by rural EMS administrators during the MAPP process. We also provided consulting and other opportunities (such as group purchasing, discount programs) for EMS companies to increase their cost effectiveness. We also identified the importance of providing a venue for rural EMS representatives to discuss and develop initiatives to improve patient outcomes in the rural EMS system. We provided a variety of networking opportunities, as well as specific plans to engage a variety of EMS administrators, professionals and key stakeholders in discussions regarding care initiatives. We also provided educational opportunities in which rural EMS could showcase and become further engaged in emerging technologies, best practices and evidence based care. Finally in an effort to increase career opportunities for EMS professionals, we have been active in the development and promotion of a career path for EMS, and also advocated for gaps in federal programs and funding to be addressed.

Through the process of developing our statewide network, we achieved several major accomplishments which have had an impact on the provision of EMS, both rural and urban, across Michigan. One of our biggest accomplishments has been our network's role in expanding educational offerings which have grown out of relationships developed statewide, as well as nationally. We have partnered with Michigan Center for Rural Health to provide Rural EMS Leadership Academies, as well as Recruitment and Retention trainings, several times across the state. We brought a new EMS program to Michigan, attended by rural and urban EMS professionals, called First Few Moments Scene Safety Program. We also were instrumental in expanding the provision of the Virtual Dementia Tour to EMS. Finally we are in the process of implementing a statewide rollout of High-Performance CPR, Dispatch Assisted High-Performance CPR, and Bystander High-Performance CPR. This is a program that was developed by Seattle/King County, Washington which has increased their sudden cardiac arrest survival rates from 20% to over 60% in the past few years. We anticipate that this program will significantly impact outcomes from cardiac arrest in Michigan.

B. Role of Network Partners

Each Network partner participated in the planning and implementation of the grant-funded program by:

- Provided leadership on network structure
- Assisted with the transition of the two-county financial structure, to a structure which supported the state network
- Serving on committees
- Either attended, or appointed a representative to attend, Network meetings and activities
- Made decisions pertaining to the business of the Network
- Read minutes, reports and newsletters to keep abreast of Network decisions/activities
- Disseminated relevant information to organizational members
- Kept the Network informed of their individual agency's activities
- Encouraged and promoted membership in the Michigan Rural EMS Network by other EMS companies and EMS professionals
- Made a financial commitment for annual dues
- Provided in-kind contributions which included staff time, material resources, or meeting space
- Networked with other key organizations/individuals

Outcomes

A. Outcomes and Evaluation Findings

Evaluation is not complete due to a no-cost extension through April 30, 2015.

B. Network Collaboration

- We established the statewide board of directors with a representative from each Trauma Region of the state, and all are actively engaged in the work of the network.
- We expanded education offerings, which grew out of successful relationship building with individuals and agencies, to include High-Performance CPR, Leadership Academies, First Few Moments Scene Safety Program and Virtual Dementia Tour.
- We added several new members each year and, as each of our outreach activities are completed, our interest in membership grows. That interest is accompanied by increased recognition across the state, and demand for technical assistance and participation in forums and events. This growth includes partnerships with other organizations and sponsors.
- As a network we provided leadership in five grant applications: Network Planning for an HP-CPR network, BCBS Grant writing Support, CMS Innovations, AFG, Agency for Healthcare Research and Quality Small Conference Support Grant.
- We have utilized new contractors to create a very successful branded image, and new marketing materials for the network and for EMS summit.

Principles for successful partnership:

- Get involved, be visible, attend relevant meetings and events
- Develop relationships, conduct joint planning, visioning and problem-solving BEFORE grant opportunities arise
- Learn as much as you can about potential partners
- Conduct needs assessments to assist in identifying and planning with partners

- Build trust
- Communicate clear vision and goals of the partnership
- Utilize memorandums of understanding
- Nurture relationships
- Be clear about roles and responsibilities of each member
- Use team-building activities
- Maintain equality in power and influence
- Regularly assess what each individual and/or agency contributes to the partnership
- Maintain transparency
- Be flexible
- Start small, and build on successes

Challenges & Innovative Solutions

Initially the community paramedicine project was proceeding with great momentum. This was halted due to resistance from Michigan Department of Community Health. We continue to work with interested EMS companies and professionals around the state, and nationally, to identify ways to move the community paramedicine program forward.

It took longer than anticipated to establish the statewide network board. There was unplanned resistance from the two county network to let go of control and bring in additional members. We resolved this issue by retaining three of the two county members on the new statewide board.

Working with the IRS to get non-profit status approved was a struggle due to the name change delay putting the organization past the 18 month application deadline. We resolved the issue and the non-profit status has been approved.

With the current pay structure (no health benefits) it has been difficult to recruit well qualified individuals to work for the Network. We resolved this issue by contracting some of the work to other organizations like Michigan Center for Rural Health or project related work to independent contractors.

As staff all conduct work remotely, this has been a challenge to identify ways to communicate efficiently and effectively. We have adopted procedures and means of communication, such as an online project management system, which have greatly improved communication.

Several strategies for effectively working with remote members and partners have proven to be cost-prohibitive. We did not originally budget for subscriptions to systems such as online project management, video conferencing, electronic newsletter services, and electronic cloud storage. We have overcome a portion of this challenge by not being afraid to ask for donated or nonprofit rate services.

Sustainability

A. Network Structure

The Michigan Rural EMS Network will continue to exist beyond the grant period, and several sustainability products have been identified to assure viability of the network. The Executive Director will continue to manage the operations of the network, assisted by a part-time Business Manager. We will utilize contractors when necessary to provide additional services. All original partners of the network have committed to being a part of the network activities going forward. We continue to identify and add partners and members to the network.

B. On-going Projects and Activities/Services To Be Provided

The network will continue to strive to meet the identified needs of the rural EMS services and EMS professionals in rural Michigan. We have identified the following projects which will be further developed to provide sustainability for the network:

- EMS Summit – an annual continuing education conference for EMS professionals with a focus on provision of EMS in rural areas
- Michigan Resuscitation Consortium – a program of the Michigan Rural EMS Network which focuses on improving cardiac arrest survival in Michigan. Components include High-Performance CPR training for EMS professionals, Dispatch-assisted CPR, and Bystander CPR.
- Educational opportunities for rural EMS professionals which are typically difficult to access such as leadership academies, Virtual Dementia Tour, and First Few Moments Scene Safety program.
- Advocacy for rural EMS at the local, state and federal level
- Consulting and grant writing assistance for rural EMS agencies

C. Sustained Impact

Direct Impact: The development of the Michigan Rural EMS Network will have a direct impact on rural EMS agencies, rural EMS professionals, and the residents of rural areas requiring prehospital care. The activities of the network are expected to strengthen the financial viability of rural EMS companies, as well as the capability of providing quality care. Initiatives which address the needs of EMS professionals have helped to ensure that there is adequate training and support for rural EMS professionals, thereby ensuring they are up to date on new and emerging technologies and standards. Additionally, efforts to advocate for an EMS career path which provides adequate compensation and benefits will attract highly qualified professionals to the service of EMS. With recruitment and retention cited as the top need of rural EMS companies, this is critical to the long term survival of rural EMS systems.

Examples of how project activities are expected to positively impact rural EMS companies and professionals include:

- Documentation and insurance submission of rural EMS claims is unique. Successful training of rural EMS administrators and billing staff will improve the recovery of insurance and private pay claims, thereby increasing revenue to replace outdated equipment and to train EMS professionals.
- Participation in Group Purchasing and Discount Programs will allow rural EMS companies the same efficiencies of scale that their urban counterparts have in relationship to purchasing supplies, equipment, and materials. This will help to decrease the disparity between rural EMS equipment and resources as compared to urban companies.
- Increasing financial stability of rural EMS companies will make room in tight budgets to improve salaries and benefits for EMS personnel, improving morale and assisting in retention and recruitment efforts.
- Formal and informal networking efforts will enable rural EMS providers to learn from their peers about opportunities and successful programs in other areas of the state.
- Financial viability will allow rural EMS agencies to stay in business in local communities, thereby reducing response times and impacting morbidity and mortality rates.

Indirect Impact: The network's activities have potential to benefit all residents of rural areas of Michigan as well as visitors to rural areas. It has been shown that rural communities that do not have a locally owned and community dedicated EMS system suffer greatly from poor response times. Even with local EMS companies in rural areas, the geographic distance and weather related road conditions can cause delays. Having in place a strong rural EMS system including local services with highly qualified professionals is critical to the life and death of patients as well as reducing unfavorable patient outcomes. We have also found that local, regional, and state leaders often struggle with the task of obtaining input from rural EMS. A root problem to this issue is the volunteer and part time nature of rural EMS. It is difficult for rural EMS professionals and administrators who have other full time jobs or who have difficulty leaving their on-call area to participate in state meetings and planning efforts. By developing technology systems and having staff that focus on rural EMS issues, we have been able to address this need of policy and decision makers. The anticipated impact will be policies and regulations that support the infrastructure of rural EMS and help to preserve their critical service to rural areas.

Implications for Other Communities

The growth of our organization from a two-county initiative to a statewide network seemed a daunting task at the outset. Other communities may benefit from our experience and lessons learned:

- Early on, establish relationships with key stakeholders and potential partners/members

- Conduct needs assessments to understand your target population and identify program activities
- Develop a detailed implementation plan and timeline which clearly identifies which members are responsible for specific activities
- Whenever possible, new networks should capitalize on existing and new partnerships in order to leverage financial and staff resources
- Utilization of contractors and topical experts can be a cost-effective means of meeting objectives
- Engaging and educating stakeholders throughout the process is key to implementation of activities
- Even the best laid plans can often go awry. It is critical to maintain flexibility and to anticipate challenges before they occur
- Implement a good system for collecting and tracking data; use that data to understand your target population and to substantiate funding requests
- Celebrate even the smallest successes and build on them

Michigan

Northern Michigan Hospitals, Inc.

Organizational Information	
Grant Number	D06RH21677
Grantee Organization	Northern Michigan Hospitals, Inc.
Organization Type	Hospital
Address	416 Connable Avenue, Petoskey, MI 49770
Grantee organization website	http://www.mclaren.org/northernmichigan/northernmichigan
Name of Network	Health and Wellness Collaborative of Northern Michigan
Network Director	Name: Marian E. Weber
	Title: Network Director
	Phone number: 989-306-0829
	Fax number:
	Email address: mweber@healthconsultingstrategies.com
Project Period	2011 - 2014
Funding level for each budget period	May 2011 to April 2012: $180,000.00
	May 2012 to April 2013: $180,000.00
	May 2013 to April 2014: $180,000.00

Network Partners		
Partner Organization	Location	Organizational Type
Alcona Health Center	Harbor Springs/Emmet/Michigan	Federally Qualified Health Center (FQHC)
Mackinac Straits Health System	St. Ignace/Mackinac/Michigan	Critical Access Hospital

Community Characteristics

A. Area

The Health and Wellness Collaborative of Northern Michigan (HWCNM) served Emmet, Cheboygan, and Mackinac counties of Northern Lower Michigan.

B. Community description

Problems addressed in the proposed project: 1) Primary health care in the region is not well positioned to participate in health care reform initiatives; 2) Primary health care practices in the region experience constraints that prevent timely adoption of evolving health care delivery models; and 3) Residents of the region experience difficulty accessing health care due to rurality, the isolation of island living, severe winter weather, and a shortage of primary care providers. These problems present a threat to long-term stability of health care in the region due to delayed implementation of financial incentives and emerging quality of care initiatives. There is an increased risk of unmanaged chronic diseases.

C. Need

The Network focused on planning for health care transitions, and improving systems of care for chronic disease states. The overall goals of the project as outlined in the work plan were by the end of the project 25% of the participating primary care providers will qualify for Patient Centered Medical Home certification, with another 25% working toward such qualification, and there will be a 30% increase of persons with diabetes who are monitored and receive appropriate care according to evidence based guidelines.

Program Services

A. Description

1) Planned, strategized and promoted clinic redesign through communication with the network advisory board, health system leaders, physician organizations and care team players.
2) Educated healthcare members on quality initiatives, value based healthcare, chronic care model and Patient Centered Medical Home (PCMH) requirements.
3) Designed a systematic process to evaluate report and document each clinic's performance and progress. Developed individual work plans/time lines and managed progress on a weekly/bi-weekly basis.
4) Facilitated clinic transformation through face to face care team coaching, PCMH training and improving policy/procedure/process.
5) Technical/expert assistance was provided on-site and electronically with registry and electronic medical record development, training and implementation.

B. Role of Network Partners

Northern Michigan Hospital was the fiduciary and partner in the Planning Grant that was submitted in 2010 to fund the needs assessment process and assist the collaborative partners in researching areas of focus for the Network. They were also the fiduciary for the Rural Health Network Development grant. Two of their primary care clinic sites, one in Cheboygan (MI) and the other in Indian River participated as sites in the grant project. Both of these clinics were actively working toward Blue Cross/Blue Shield of Michigan (BC/BS) Patient Centered Medical Home (PCMH) designation. Their Chief Executive Officer was a member of the HWCNM Board.

Mackinac Health Systems-Mackinac Health Systems is a Critical Access Hospital that has several Provider Based RHC clinics located throughout Northern Lower and the Southern Upper Peninsulas of Michigan. Two of their clinic sites participated in the BC/BS Designation process. Their Chief Executive Officer served as a member on the HWCNM Board.

Alcona Health Center-Alcona Health Center is a large Federally Qualified Health Center (FQHC) with several locations in the Northeast and Northwest regions of Northern Lower Michigan. Their clinic located in Emmet County in Harbor Springs, participated in the PCMH designation process through the National Committee for Quality Assurance Level 2 PCMH designation status. Their Executive Director served as a member of the HWCNM Board.

Outcomes

A. Outcomes and Evaluation Findings

Outcome #1. A fully functioning primary care network with defined activities that are valued by members.

During the grant period, two of the original Network members (Northern Michigan Regional Hospital and Cheboygan Memorial Hospital) were purchased by McLaren Health System. Because these members were under the same parent organization, we recruited a new third member, Alcona Health Center, in May of 2012. The Board includes representation from all three members. We established a regular meeting schedule that included every other week conference calls and quarterly face-to-face meetings. Members were brought up to date on new developments and were actively involved in the network decision making process. We completed an annual strategic planning session each year to review the status of the Network and obtain input from the Board members regarding goals and strategies for the upcoming year in order to achieve the established overall goals of the Network. We identified the BC/BS PCMH designation as our network model. We recruited and hired an experienced Manager of PCMH Facilitation in October of 2013. The PCMH Manager completed assessments and developed work plans and associated timelines for each of the Network member's pilot clinics to track and identify any potential issues with achieving the goal of PCMH designation by April of 2014.

Outcome #2. Patient focused health care that provides quality, efficiency and financial stability.

The HWCNM participating clinics have achieved BC/BS PCMH designation in two out of three of the membership organization participating clinics. The third member is nominated for NCQA designation in October of 2014. As a result of the pursuit of PCMH designation, all participant clinic sites have established patient centered medical treatment plans and other key components that include patient tracking and registry functions, case management, adoption and implementation of evidence-based guidelines, patient self-management support, and referral tracking. The BC/BS designation provides financial incentives that will support the

organizations as they move forward post grant. Obtaining PCMH designation will provide the foundation for the ability to meet payor requirements related to health outcomes in the future and position all member organizations to meet these requirements.

Outcome #3. A coordinated care process to improve population health.
All three participating organization clinics that were included in the HWCNM work plan have either achieved PCMH designation or are nominated for designation. An important part of the PCMH requirement is the inclusion of chronic care conditions and the ability to track and monitor chronic disease conditions (diabetes, hypertension, COPD, etc.) and develop patient centered treatment plans to address the desired outcomes. Care Coordinators were hired and utilized to assist with the data tracking and aggregation to efficiently monitor outcomes in all three Network member organizations. Our original work plan established a goal of a 30% increase of persons with diabetes who are monitored and receive appropriate care according to evidence based guidelines. We were not able to establish formal processes to track and aggregate the data specific to diabetes on a Network wide basis as of this writing. We were able to establish formal processes within all clinic sites specific to diabetes care based upon established clinical care guidelines.

B. Network Collaboration

The HWCNM was able to sustain as an organization and recruit an experienced manager of PCMH Facilitation and an experienced Project Director despite the internal reorganization of two of its members and the loss of two of the original members. The member leadership recognized the value in the development of a regional network whose focus was improvement of the primary care health delivery system in their service area. We determined that a key component of our success was leadership within the respective organizations that saw the value of the Network. Another important key to success was the ability to communicate concerns and deal with issues in an objective manner. We held monthly meetings and were committed to scheduling and completing an annual strategic planning sessions to re-establish commitment and determine goals and strategies for the upcoming year.

Challenges & Innovative Solutions

HWCNM struggled in the first year of the grant to get in action with a clear vision. The leadership among partners held a critical strategic review of the challenges to effective network development and reaffirmed their goals and focused on strengthening the effectiveness of the network director role. In addition, the network lost two of the original members and went through re-organization of two of the existing members.

These challenges were addressed through honest and open communication among the network leadership and the ability to put aside individual concerns in order to achieve for the good of all. Despite a great deal of uncertainty we were able to keep focused and achieve all established goals within our work plan.

Sustainability

A. Network Structure

The HWCNM will no longer function as a formal entity. The network as a whole, decided to not pursue the most recent Rural Health Network Development grant opportunity in order to join an already established mature network located in the Northeast portion of the state. Alcona Health Center and McLaren Northern Michigan Hospital will participate as members in the MI-Connect Network. They will jointly pursue the development of integrated behavioral health and school-based oral health services throughout a 13 county region in Northern Michigan.

B. On-going Projects and Activities/Services To Be Provided

All Network members will continue to be PCMH designated sites. In addition, those organizations who have not achieved designation within all clinic sites will establish designation in those sites utilizing the established policies and processes developed as a result of their participation in the network.

C. Sustained Impact

The sustained impact within the HWCNM region will include improved health outcomes for the patient population as a whole as a result of obtaining PCMH designation within member clinics. They will also benefit from the Network members becoming members of the MI-Connect Network whose focus areas are integrated behavioral health and school-based oral health care. The MI-

Connect Network received notification of funding through the 2014 RHND opportunity. The Care Coordinator positions brought on through participation in the network will be sustained positions in all three organizations.

Implications for Other Communities

The HWCNM was able to maintain its status and move ahead to achieve all established outcomes despite a very turbulent healthcare environment. A key to the success was the ability for member leadership to focus on the value of the Network as a whole and set aside individual differences. In addition, the network recruited experienced staff to assist in the efforts to move the Network forward.

Measures to consider when creating Networks include:

- Progress toward maturity, such as establishment of formal by-laws/legal status and a formal separate Network leadership team
- Percent of participating members/percent of participation in network activities
- Analysis of self-sustainability through development of a formal business plan
- Member satisfaction survey and other tools to evaluate member satisfaction and Network value
- Presence of an annual formal Board approved strategic plan

Nevada

Humboldt General Hospital

Organizational Information	
Grant Number	D06RH21672
Grantee Organization	Humboldt General Hospital
Organization Type	Hospital
Address	118 East Haskell Street, Winnemucca, NV 89445-3247
Grantee organization website	www.hghospital.ws
Name of Network	Nevada Rural Health Network
Network Director	Name: Kelly O'Shaughnessy
	Title: Network Director
	Phone number: 702-979-6902
	Fax number: 702-979-6904
	Email address: Koshaughnessy@medicine.nevada.edu
Project Period	2011 - 2014
Funding level for each budget period	May 2011 to April 2012: $180,000
	May 2012 to April 2013: $180,000
	May 2013 to April 2014: $180,000

Network Partners		
Partner Organization	Location	Organizational Type
Humboldt General Hospital	Winnemucca, Humboldt County, Nevada	Critical Access Hospital
University of Nevada School of Medicine, Family Medicine Department	Las Vegas, Clark County, Nevada	School of Medicine
High Sierra Area Health Education Center	Elko, Elko County, Nevada	AHEC
State Office of Rural Health	Elko, Elko County, Nevada	University
Independent Family Physicians	Winnemucca, Humboldt County, Nevada	Individuals

Community Characteristics

A. Area

The Nevada Rural Health Network served Winnemucca, NV, and Humboldt, Lander, and Pershing Counties.

B. Community description

Encompassing rural/frontier Nevada communities, the Network service area (Humboldt County, Lander and Pershing) faces difficulties in trying to provide rural health care services that are compounded by the combination of inadequate infrastructure resources and geographic isolation. The Network service area has roads and referral patterns leading to Winnemucca which is situated 163 miles east of Reno, the nearest "urban" area, and 500+ miles north of Las Vegas, educational base of the University of Nevada Family Medicine Residency. Humboldt General Hospital in Winnemucca serves residents from Humboldt, Lander and Pershing Counties which are the target service areas. Winnemucca and the surrounding rural areas are isolated in their proximity to specialty and tertiary health care. Primary challenges/barriers in facing the delivery and supply of primary care workforce includes attracting and retaining physicians/healthcare professionals to serve the areas with low ratios as in Winnemucca with population to provider ratio of 2,564:1 (for MD, DO). Licensed primary care doctors in the three counties being served are: Humboldt County (9), Lander (2), and Pershing (0). Two of the three target counties had no prenatal or obstetrical delivery services. In 2011, 25.7 percent of residents in Humboldt County were uninsured, 22.2 percent in Lander, 28.4 percent in Pershing counties. Percentage of the population enrolled in Medicare: Humboldt County (12.5 percent) Lander (12.3 percent) and Pershing (12.4 percent) Elko (11.2 percent); percentage of the population enrolled in Medicaid: Humboldt County (11.2 percent) Lander

(10.5 percent) Pershing (9.2 percent) and Elko (9.4 percent). Over ten percent of the population in all three counties lives in poverty: Humboldt County (11.2 percent) Lander County (10.4 percent) and Pershing (19.3 percent).

C. Need

Nevada is faced with a multitude of health disparities and barriers to healthcare unique to its rural/frontier character. Nevada is a large state with many rural/frontier counties designated as Health Professions Shortage Areas and/or Medically Underserved Areas. Rural and frontier Nevada comprises 95,431 square miles and is distinguished by small towns separated by vast distances. Distances between rural towns average 100 miles, with instances of 180-200 miles between more isolated areas, and 500 miles between major metropolitan areas. Eighty-nine percent of the population lives in three urban counties separated by deserts and high mountain ranges encompassing fourteen other counties designated as rural (two) and frontier (12). The frontier nature of Nevada's geography affects the type of health system and practitioners that can be supported.

Nevada has a critical shortage of primary care physicians. Rural/frontier areas in Nevada have higher mortality rates which may be partially explained by lack of access to prevention, detection, and treatment of chronic disease and to the shortage of physicians. All three of the service area counties were designated as Health Profession Shortage Areas (HPSA's); 75 percent of these counties were designated as Dental HPSA; and 100 percent of the target area was designated as Mental Health HPSAs. The aging of rural Nevada's physician practitioners is not factored into the statistics, but does further affect the need to develop and sustain a training program that addresses short and long term recruitment and retention for the eventual turnover of the workforce.

The Nevada Rural Health Network was formed to address issues facing the delivery and supply of primary care including: (1) how to overcome the spatial isolation and enormous geographic distances that characterize most of rural/frontier Nevada; and, (2) how to attract and retain enough physicians and healthcare professionals to serve these communities with low population to provider ratios. The Network members include Humboldt General Hospital, local family medicine physicians, the University of Nevada School of Medicine Family and Community Medicine Department and High Sierra Area Health Education Center.

Program Services

A. Description

Through the Rural Health Network Development grant program the Nevada Rural Health Network: 1) solidified the collaborative agreement amongst its member organizations; 2) expanded network relationships to include community solo practicing physicians; 3) achieved efficiency through additional collaborative agreements and activities; 4) utilized health professionals and family medicine resident physicians to increase delivery of quality care to rural residents; 5) enhanced health activities through community based wellness and chronic disease management programs; and, 6) increased access and quality of rural health care for underserved rural communities.

Activities conducted through the Nevada Rural Health Network Development grant program include workforce development trainings utilizing the Advanced Life Support in Obstetrics Course (ALSO®), professional development of rural faculty and training of ancillary healthcare professionals that will work with the residency program, and improving recruiting and retention in Humboldt County and surrounding areas

The Nevada Rural Health Network achieved its short term goal of coalescing the function of the Nevada Rural Health Network through the implementation of the Advanced Life Support in Obstetrics Course. This national, evidenced based, two-day simulation intensive course on obstetrical emergencies is taught around the nation and internationally. Acknowledging the barrier of distance in accessing professional development, the Nevada Rural Health Network brought the Advanced Life Support in Obstetrics Program to Winnemucca to further the quality/delivery of obstetrical care in rural Nevada. This specific program includes simulation training on obstetrical emergencies for physicians, resident physicians in family medicine and obstetrics in addition to nurses, midwives, and paraprofessionals such as emergency medical services (EMS) personnel who train together using simulation models readily available at the EMS center at Humboldt General Hospital. The courses can be revenue generating once the initial cadre of instructors is trained in teaching the course. More than 30 healthcare professionals have been trained in obstetrical emergencies: paramedics, nurses, and physicians participated in professional; development activities and train-the-trainer trainings were also provided.

Achievement of the Nevada Rural Health Network's long term goal of establishing a family medicine training program in rural Nevada was achieved and implementation is well underway. Resident physicians are participating in month-long rotations at Humboldt General Hospital, the future site of the rural residency program. The groundwork has been laid for bringing the rural

residency program to Humboldt General Hospital. The Rural Residency Training Program has been accredited; recruiting for Rural Resident Physicians in training is underway. The first year of the Rural Residency program is set to begin July 2014 with full-time resident physicians being placed in Winnemucca in July 2015 which will increase access to quality primary care services. The placement of the Rural Family Medicine Training Program in Winnemucca provides the infrastructure to address health professions deficiencies and long term recruitment. Adjustments to the serious deficiencies in the rural health care workforce can be addressed by the presence of the training programs and their diffusion of graduates into the service area. The presence of a residency program provides access to continuing medical education training for community practitioners.

B. Role of Network Partners

Humboldt General Hospital (HGH) serves as the lead organization for the Nevada Rural Health Network. It is the site where the rural residency training program will be implemented and the hospital has committed to incorporating the training program into health care operations. The CEO, administrative personnel including CFO and department heads, and resources of the HGH structure provide the fiscal structure for the Network and implementation of the residency program. They assisted with business plan development, collection of supporting documents and data for the Network and accreditation process and coordination of residency program implementation. HGH has provided personnel to serve as Site Director, Assistant Site Director, faculty and coordination of residency program activities.

The Department of Family and Community Medicine-Las Vegas-University of Nevada School of Medicine was selected as a partner due to their outreach efforts in rural Nevada, commitment to addressing rural health issues, and dedication to expanding their residency training program to include a rural residency track. The Department has diligently pursued and obtained accreditation for a new rural residency at Humboldt General Hospital. The Department created the plan and accreditation document for the training program, provided training and faculty development to personnel at Humboldt General Hospital in preparation for implementation of the residency program. The Department Chair, Residency Coordinator and senior faculty of the Family and Community Medicine department guided the development and criteria necessary for establishing a rural satellite family medicine residency training program. The Department engaged a fiscal review and performed a site assessment of the Winnemucca community and health care facility in order to further develop the infrastructure and assess stage of readiness of the site. It is also the only provider in Nevada for teaching Advanced Life Support in Obstetrics (ALSO) and Basic Life Support in Obstetrics (BLSO). The Department is the pilot national provider chosen by the AAFP to teach CareTeamOB Courses. Their depth of expertise in graduate medical education and obstetric training is a valuable asset of the Network and resource for the project.

The High Sierra Area Health Education Center (HSAHEC) was selected to be a partner as an appropriate educational and community liaison organization that could act as a bridge between academic partners and the community. The HSAHEC has defined their focus in health workforce development activities. They provided community assessments and research of healthcare professional development needs in the rural communities. They support student rotations and rural training for various university and college health professions programs and provide this expertise for the Network in addressing the significant health workforce recruitment and retention issues in rural and frontier Nevada.

The Nevada State Office of Rural Health (SORH) was organized as part of the University of Nevada School of Medicine in 1965. The staff has provided a long history of commitment to the office and to rural Nevada. The Director, who has been actively involved in the Network Partnership, has provided service to SORH for 27 years. SOHR is a supportive partner in activities that range from recruitment/retention, to technical assistance in resource procurement, economic development, health workforce development and health policy.

The independent solo practicing family medicine community physicians volunteered to serve as onsite faculty and preceptors for the Rural Residency Training Program and actively support implementing the training program in Winnemucca. These physicians have demonstrated strong commitment to the implementation of the Rural Residency Training Program in the community and participating as on-site faculty. These physicians have participated in healthcare professional and faculty development in preparation for the accreditation and implement of the residency program. Several are trained certified instructors in ALSO and teach ALSO, Basic Life Support in Obstetrics, and CareTeam OB Courses in the rural communities.

Outcomes

A. Outcomes and Evaluation Findings

Outcomes from the Network's efforts include:

- Solidified collaborations among Network organizations

- Increased access to educational development opportunities for healthcare professionals in Humboldt County
- Increased access to care for rural/underserved populations
- An accredited residency in the field of family medicine is planned, developed, and implemented
- Increased number of resident physicians electing to practice Family Medicine in rural areas

In addition, workforce development trainings relevant to healthcare needs of rural citizens were conducted and delivered in a format enabling them to remain in the rural community, increasing the quality of primary health care services. More than 30 healthcare professionals have been trained in obstetrical emergencies, including paramedics, nurses, and physicians. Train-the-trainer trainings have been provided as well. Resident physicians are participating in month long rotations at Humboldt General Hospital, the rural site of future rural residency program increasing access to quality primary care services. Groundwork has been laid for bringing the Rural Residency Program to Humboldt General Hospital and the Rural Residency Program has been accredited. Currently, recruiting is underway for the first year of the Rural Residency program to begin July 2014 with full-time resident physicians being placed in Winnemucca in July 2015.

The Nevada Rural Health Network solidified collaborations among Network organizations through the following select activities:

- Expanded and maintained a sustainable Network coupling core concepts in community based training, wellness, and prevention with the delivery of health care services to increase physician/patient ratios with the addition of resident physicians.
- Network partners instituted an expanded self-governance structure to reflect community and academic partnerships addressing rural graduate medical education.
- By-laws were prepared, executed and implemented.
- Network partners developed and implemented crucial documents governing resident education outlining responsibilities for fiscal matters, policies and procedures, teaching, and supervision. Master Affiliation Agreements (MAA) between the residency program's institution and all major participating sites involved in the residency education were completed, approved and signed by Network partners. Accreditation documents were submitted to the Accreditation Council for Graduate Medical Education in connection with the Rural Residency Program.
- Two Community Family Medicine physicians accepted the positions of Program Site Director and Assistant Site Director for the Rural Residency Training program and have participated in faculty development in preparation for commencement of the residency program at the rural site.
- Network members have participated in a number of site visits, meetings, presentations and trainings which provided opportunities for face-to-face interactions among Network members, including Humboldt General Hospital chief executive officer, chief financial officer, Rural Residency Program Site Director, Assistant Site Director, onsite Residency Coordinator, University of Nevada School of Medicine faculty, Network Director, Dean, University of Nevada School of Medicine, Family Medicine Residency program Director, Family Medicine Department Chair. A Residency Day was held to educate staff on the residency program.
- Network Members worked together to prepare for and complete the ACGME Accreditation Site Visit, a major undertaking requiring cohesive institutional effort to complete.

The Nevada Rural Health Network developed a sustainability strategy for revenue generation through the completion of the following select activities:

- A strategic plan was developed that includes business, operational, communication, marketing, media and economic impact components; implementation of the ALSO program, a program based on a self-sustaining model; marketing and media activities; community engagement activities including community assessments and outreach; and maximizing marketing/media opportunities. Sustainability planning for the development and implementation of the Rural Residency Training program was outlined after consultation with the American Academy of Family Practice Residency Program Solutions which provided network members with a good snapshot of specific revenue and suggestions on program structure to maximize funding sources for the residency program.
- The ALSO course was implemented and developed as a source of revenue generation.
- Humboldt General Hospital has committed to incorporating the rural residency program into their health care operation. They have also hosted, and will continue to host, workforce development trainings allowing easier access for rural healthcare professionals.
- Each Network Partner brings unique expertise, experience, and resources necessary to address the collective goals and objectives related to continuation of Network activities. Individually none of the network partners have the ability to address the health workforce needs and access to care issues, but collectively have the expertise and resources to be successful.

Increased access to educational development opportunities for healthcare professionals in the targeted area is documented with the completion of the following select activities:

- Community needs assessments, focus groups, evaluation and data collection was initiated, assessed and integrated into Network work plan.
- Educational development opportunities were offered to healthcare professionals within their area which facilitated access by addressing both financial and distance barriers.
- The evidence based national Advanced Life Support in Obstetrics (ALSO) course was implemented in the three-county service area. Thirty healthcare professionals were trained in obstetrical emergencies (ALSO) through the Network partnership, including EMTs, paramedics, nurses and family medicine resident physicians. Three healthcare professionals achieved the level of certified ALSO instructor to increase the cadre of rural Nevada certified instructors capable of teaching in the course. Six of the seven instructors are affiliated with the Network which demonstrated the successful certification of trainers and the sustainability of the Network's ability to continue presenting ALSO courses. Value added benefits included utilizing health care providers in the rural community that were trained as certified ALSO Instructors, increasing the experience of trainers and the sustainability of future ALSO courses. The Network will implement ALSO course trainings as a source of revenue generation using the proven success of the University of Nevada School of Medicine Department of Family and Community Medicine in developing the courses into an income-generating, self-sustaining program as its model.
- Various training opportunities were facilitated by the Nevada Rural Health Network in anticipation of the implementation of the rural residency at Humboldt General Hospital, providing access to educational opportunities for rural physicians and healthcare professionals relevant to the residency training programs as well as the healthcare needs of rural citizens. The Network sponsored participation in the American Academy of Family Physicians Program Director's Workshop and Residency Program Solutions Symposium attended by the Rural Residency Program Director, Rural Residency Site Director, Rural Residency Coordinator, Rural Health Network Director. Rural faculty also attended Society of Teachers in Family Medicine conferences, TeamStepps training, and CareTeam OB training. The National Rural Health Association Annual Conference and the National Rural Health Association Policy Institute were attended by the Network Director and Network Partner Humboldt General Hospital Chief Financial Officer. The Rural Residency Coordinator attended the Medical Group Management Association and National Association of Rural Health Clinics Conferences.

Increased access to care for rural/underserved populations and increased ratio of physician primary care providers was achieved through the completion of the following activities:

- A family medicine physician from outside the community was recruited within the first year to join the community physicians, increasing patient care delivery in anticipation of the arrival of resident physicians for one-month rotations until training program was accredited.
- Resident physicians were placed in two- to four-week rotations at Humboldt General Hospital to deliver care and work with future faculty of the Rural Residency training program, increasing access to quality primary care services. Added value includes feedback obtained by Network members meeting with resident physicians to learn from the resident's experience in the rural community.
- Healthcare professionals were provided with access to educational opportunities with the delivery of the Advanced Life Support Obstetrics course onsite at Humboldt General Hospital. Healthcare professionals received education relevant to healthcare needs of rural citizens delivered in a format that enabled them to remain in the rural community and to increase the quality of primary and mental health services.

An accredited residency program in the field of family medicine was planned, developed and implemented as demonstrated by the following accomplishments:

- Finance consultation with Residency Program Solutions of the American Academy of Family Physicians was held specific to operational planning and development of residency program. Fiscal planning addressing billings, collections and revenue sources directed at the residency program and at Network sustainability has been underway.
- Community rotations for physicians in training under the Rural Residency Training program have been planned, developed and incorporated in curriculum approved by the ACGME accreditation process.
- Resident physicians were placed in two- to four-week rotations at Humboldt General Hospital to deliver care and work with future faculty of the Rural Residency training program providing valuable feedback incorporated in development of approved curriculum.
- The Residency Program Master Affiliation Agreement was executed outlining the specific details of the program delineating training program requirements and responsibilities required under Accreditation Council for Graduate Medical Education (ACGME). A Master Affiliation Agreement is the legal document that serves as the basis for the

residency program at a particular site. In process are Program Letters of Agreement which are required from all participating rotation sites.

- Accreditation Council for Graduate Medical Education (ACGME) documents were prepared, submitted and approved. ACGME accreditation was approved without citations, a commendable achievement.
- Recruiting for the Rural Resident Training program commenced. Three resident physician candidates were recruited and traveled to the rural site at Humboldt General Hospital for interviews with the rural site faculty and hospital personnel. At least one resident physician has been selected for the first Rural Resident Training program class commencing July 1, 2014 in Las Vegas, Nevada. The projected start date for the first full two-year residents to be onsite at the rural location is July 2015.

For the outcome of an increased number of resident physicians electing to practice Family Medicine in rural areas:

- Network activities resulted in added rural residency opportunities anticipated to lead to a greater number of physicians electing to practice family medicine/primary care in rural areas.

B. Network Collaboration

The Network partners instituted a self-governance structure that fit both the individual needs of the Network members as well as their shared vision of bringing education, training, recruitment and retention opportunities to the health workforce in rural communities to address issues facing the delivery and supply of primary care. Care was taken to select the Network governance board, develop bylaws and reach agreements delineating roles, responsibilities and goals that keep intact the shared vision of initiating a community-based Family Medicine residency training program as the nexus for the ongoing collaborative relationships to integrate systems of care administratively, clinically and financially to strengthen the rural health system.

Network partners utilized the strengths and expertise of each organization to develop and implement a strategic plan that resulted in establishing a Rural Residency Training Program.

Network partners employed resources and expertise available to implement outreach and collaboration within target rural communities that acknowledged and supported rural health professions education in the rural community. Providing professional development within the community utilizing health professionals local to the community developed strong relationships with healthcare professionals that will support implementation and success of the rural residency training program.

Network partners identified community healthcare needs early on and tailored healthcare professional development to address those needs specifically to increase quality of care in target service area through implementation of a primary care residency training program with a focus on enhancement of prenatal service delivery and educational development.

The Network developed a two-pronged sustainability strategy for revenue generation that leveraged network members' existing resources, expertise, linkages with other resources as well as delineating both short-term and long-term focuses. Short term, the Nevada Rural Health Network focused on implementing workforce development programs – specifically through the implementation of the Advanced Life Support Obstetrics course which 1) provided training to healthcare professionals in the rural community improving quality of care; 2) engaged the community's health care workforce through train-the-trainer activities utilizing local onsite staff to engage others and 3) developed a cadre of trainers to generate future revenue and sustainability. For the longer term, the Network's focus is on implementing the rural residency training program as the nexus for providing infrastructure for continued workforce development addressing health profession deficiencies and long term recruitment and retention needs. The presence of a residency program provides the foundation for further expansion of continuing medical education training for community practitioners as well as diffusion of graduates into the service area.

Challenges & Innovative Solutions

Building relationships and establishing effective communications among Network partners located as far away as 500+ miles was one of the biggest challenges. Face-to -face meetings with key personnel from each of the partner organizations was crucial to building trust, working relationships and buy-in on multiple levels. In addition to having Network members travel to the rural site, attendance at national trainings, conferences and meetings were utilized to create valuable time to "network" with each other by sending representatives from Network members to the same meetings. Educating and training personnel in each member organization on multiple levels was also key in building strong relationships and utilizing "train-the-trainer" methods has proved to be very successful.

Turnover of personnel in key positions posed another challenge and affected the initial progress in the implementation of the workforce training activities and hindered development of the curriculum for the Rural Residency Program which resulted in a delay in submitting the program for accreditation. Once positions were filled, the new individuals were quickly introduced to the Network, the shared vision of its members and their proposed role.

Sustainability

A. Network Structure

The Nevada Rural Health Network will continue to serve as the organization bridging the University of Nevada School of Medicine, Humboldt General Hospital, High Sierra AHEC and local primary care physicians practicing in the rural community. Network partners instituted an expanded self-governance structure to reflect community and academic partnerships addressing rural graduate medical education. By-laws setting forth the governance structure have been prepared, executed and implemented. Long-term staffing and leadership will be provided both locally and from network partners. The University of Nevada School of Medicine Family Medicine Department – Las Vegas will continue to provide residency and workforce-training program direction and oversight; Humboldt General Hospital offers financial and community leadership capabilities to support the Network; committed community physicians will serve as faculty and leadership for rural residency training program education and the AHEC program will utilize its expertise in assessing community needs. The sustained financial commitment of Humboldt General Hospital and the University of Nevada School of Medicine to the implementation of the Rural Residency Training program is formalized in the Master Affiliation and Program Letter of Agreements executed by the parties, essential legal documents for the implementation of a residency program and are required to be in place for the duration of the residency program. The implemented workforce development training courses will eventually generate revenue for the Network once enough trainers have been trained and certified. Training is ongoing.

B. On-going Projects and Activities/Services To Be Provided

The Nevada Rural Health Network was formed years ago to pursue the possibility of bringing a family medicine residency program to rural Nevada. After being granted the opportunity to plan and develop a Network to support such a proposition, now, with the accreditation of the residency program just approved in January 2014, it has come time to implement the family medicine residency training program at Humboldt General Hospital to serve the surrounding rural communities. The Network is committed to continuing working towards the mutual vision of its members and pledges its support of continued workforce training, implementation of the residency program and integrating systems of care administratively, clinically and financially to strengthen the rural health system. Collaborative activities through the Rural Health Network will include expanded workforce development trainings; implementation of the rural residency training program in the rural community, thereby increasing the healthcare workforce; and, public activities ensuring the rural community awareness of increased access to quality essential healthcare. The first resident physician in training starts July 1, 2014 and is anticipated to be at Humboldt General Hospital for two years commencing July 2015. The Nevada Rural Health Network will continue providing professional development for rural faculty and training of ancillary healthcare professionals who will work with the residency program. The Network is poised to expand the scope of activities to include additional training opportunities for the healthcare workforce who will be interfacing with the residency program community experiences.

C. Sustained Impact

The Network Development grant allowed the Nevada Rural Health Network to formalize a partnership started years ago amongst its members with a shared vision of implementing a family medicine residency program at Humboldt General Hospital and addressing issues facing the delivery and supply of primary care in rural communities in Nevada. Great strides have been made towards solidifying the Nevada Rural Health Network, conducting Network activities and achieving a mutual vision of bringing education, training, recruitment and retention opportunities to the health workforce in rural Nevada communities.

The Network partners have successfully developed an accredited family medicine residency training program that will submerse resident physicians in the rural community in years two and three of the residents' training, increasing access to care for the population served by Humboldt General Hospital. The first residency class starts July 1, 2014 at the University of Nevada School of Medicine Family Medicine Department in Las Vegas and after a year of training there, resident physicians will be based for two years at Humboldt General Hospital. The rural residency program offers the opportunity to increase the number of physicians in a rural community-both those in training and those recruited and or retained because of the opportunity that involvement in a residency program offers. Resident physicians in training increase the number of physicians available to provide care and expand essential clinical patient services in the rural community. Access to primary care is also improved with the increase in workforce with the addition of physicians in training as well as potential faculty drawn to and/or retained because of involvement in the

program. Implementation of the Rural Residency Program at Humboldt General Hospital will result in both short-term and long-term increases in primary care physicians available to serve the rural community. Studies have shown that providing residents in training with positive experiences in working in underserved communities increases the likelihood that they will choose to practice in rural communities upon completion of the program.

The Nevada Rural Health Network has provided access to healthcare workforce training opportunities. The professional development training of primary care workforce and rural residency faculty is directly related to health care needs in our rural community. Bringing such educational opportunities to rural communities addresses workforce development geographical obstacles, improves the quality of care and enhances capacity for recruitment and retention in the rural community. The evidence based national Advanced Life Support in Obstetrics (ALSO) course was implemented in the three-county service area, training healthcare professionals such as EMTs, paramedics, nurses and family medicine resident physicians in obstetrical emergencies (ALSO). Using a train-the-trainer model, three trainees achieved the level of certified ALSO instructor to increase the cadre of rural Nevada certified instructors capable of teaching the course. This value added benefit increases the sustainability of future ALSO courses as does the ability to utilize ALSO course trainings as a source of revenue generation using the proven success of the University of Nevada School of Medicine Department of Family and Community Medicine in developing the courses into an income generating self-sustaining program as a model. Proposed training programs will further enhance recruitment and retention, increasing the primary care workforce in Humboldt County and surrounding areas and improve the quality of essential health care services.

Implications for Other Communities

The Nevada Rural Health Network exemplifies how collaboration among stakeholders can lead to the successful implementation of comprehensive programs utilizing educational training opportunities to address issues facing the delivery and supply of primary care in rural communities. Successful development takes time, patience, resources, and a shared vision. Community support and the support of key officials within each network partner organization are crucial. Utilization of the existing strengths, expertise and resources of each organization resulted in the development of a strong Network, a sustainable strategic plan, and achievement of short and long term goals. Kelly O'Shaughnessy, JD, Nevada Rural Health Network Director, and Elissa Palmer, MD, professor and chair, Department of Family and Community Medicine, School of Medicine, Las Vegas campus, presented a competitively selected workshop *"Collaboration and Innovation in Creating a Network to Provide Professional Development and Graduate Medical Education Activities"* at the Association of American Medical Colleges Western Group on Educational Affairs Conference in March 2014 based on some of these network development experiences.

Integration of community-based, rural specific, graduate medical education and training situated in a rural setting connects community practitioners and local health conditions, prepares appropriately trained physicians for diffusion to areas affected by geographic disparities in health workforce recruitment and retention. This program has demonstrated that evidenced-based, workforce development trainings conducted relevant to healthcare needs of rural citizens, delivered in a format enabling healthcare workers to remain in the rural community, and utilizing train –the-trainer models increases sustainability of the program as well as the quality of primary health care services.

New Mexico

Clayton Health Systems

Organizational Information	
Grant Number	D06RH21667
Grantee Organization	Clayton Health Systems (flow-through fiscal agent)
Organization Type	Hospital
Address	Clayton Health Systems (Union County General Hospital): P.O. Box 38; 300 Wilson Street; Clayton, NM 88415 For all correspondence: Union County Network P.O. Box 444; 4 ½ Main Street. Clayton, NM 88415
Grantee organization website	www.unioncountygeneral.com
Name of Network	Union County Network
Network Director	Name: Kristen Christy
	Title: Executive Director, Union County Network
	Phone number: 575-779-7746
	Fax number: N/A
	Email address: kchristy@ucnetwork.us
Project Period	2011 – 2014 (requesting a no-cost extension)
Funding level for each budget period (original NOAs plus Denver conference allotment for Y1)	May 2011 to April 2012: $169,307
	May 2012 to April 2013: $174,066
	May 2013 to April 2014: $173,216

Network Partners		
Partner Organization	Location	Organizational Type
Clayton Health Systems	Clayton; Union County; New Mexico (NM)	CAH and primary-care clinic
Tri County Community Services	Taos/Raton/Clayton; Taos, Colfax, and Union counties; NM	Behavioral-health provider
Service Organization for Youth	Raton / Des Moines (satellite); Colfax and Union (satellite) counties; NM	Youth behavioral-health provider
McGowen Family Chiropractic	Raton / Des Moines (satellite); Colfax and Union (satellite) counties; NM	Chiropractic services
Region II Public Health, Clayton Office	Clayton; Union County; NM	Public health
Golden Spread Rural Frontier Coalition	Clayton; Union County; NM (with sites in other parts of northeast NM)	Assisted living services; transportation services; low-income housing; other
Union County Commission	Clayton and beyond; Union County; NM	Local government
Town of Clayton	Clayton; Union County; NM	Local government
Northeast Soil & Water Conservation District	Clayton and beyond; Union County; NM	Soil and water conservation district
DMMS	Des Moines; Union County; NM	K-12 school district
DMSBHWC (Network-managed)	Des Moines; Union County; NM	School-based health center
Health Action New Mexico	Albuquerque; Bernalillo County; NM	Health advocacy organization
Union County Community Development Corporation	Clayton; Union County; NM	Economic development corporation

Community Characteristics

A. Area

Union County, New Mexico

B. Community description

Union County is characterized by low population density (approximately 1 person per square mile) and extreme distances (1 hour, 40 minutes to the nearest Wal-Mart). As result, resources are scarce; the community experiences severe provider shortages and high turnover and struggles frequently to meet its needs. Service gaps include oral health care, prenatal and maternity care, specialized services, and consistent primary-care coverage. Perceived scarcity also breeds reactionary territorialism, augmented by the self-reliant, make-do attitude inherent in the pioneer, cowboy culture. This has posed an obstacle, at times, to collaboration. Health disparities include high rates of accident-related injury and death, lung and colon cancer, dental caries and oral disease, and coronary heart disease. Smoking and tobacco use are above average. Union County is located in an extreme food desert with only one grocery store. As such, fruit and vegetable consumption is low. On the positive side, because Union County is a heavy ranching community, most residents have access to healthy sources for meat and eggs. Yet the community possesses several strengths, such as sense of self-reliance, conservatism, resilience, and close internal relationships.

C. Need

1. Provider shortages (primary care and dental)
2. Inadequate coordination of a continuum of care
3. Need for community wellness programming in the face of health disparities and healthcare resource shortages
4. Insufficient collaboration and need for a strong, stable network infrastructure

Program Services

A. Description

1. Primary care and dental recruitment and retention programming

Physician Recruitment and Community Marketing Initiative (PRCMI): Three years in progress, the PRCMI is a consortium of healthcare agencies, civic, and community groups who collaborate to attract and retain physicians, dentists, and other needed healthcare professionals to the community through (a) hospitality-based programming (pot lucks, receptions, appreciation days and gifts, one-on-one integration into the community for providers and their family members); (b) development of a community marketing platform to attract professionals that would appreciate Union County's unique assets; (c) exploration and pursuit of direct physician-hire programming, such as J-1 VISA, Health Service Corps, and MD student financial aid and loan assistance.

We have provided direct assistance for interested dentists: (a) business planning; (b) capital financing assistance (bridging a USDA loan program through a local utility company; (c) coordination of a facility and new equipment purchases for a satellite dental clinic. We have engaged in three-year, active advocacy efforts (5 speeches at hearings and legislative committee meetings, testimonials, strategic planning) for the Dental Therapist Bill, sponsored by our State Representative for all 3 years (includes outside funding).

We also explored and made initial attempts to establish healthcare career pathways programs with mentoring opportunities at both high schools. However, changes in school administration did not support these efforts as originally proposed.

2. Coordination of a Continuum of Care

Management of the DMSBHWC (DMSBHWC): The DMSBHWC provides the only source for primary-care, behavioral-health, chiropractic, and WIC services to Des Moines students, families, and community members of western Union County within a 35-mile radius. When DMMS could no longer operate its own school-based health center due to a conflict between HIPAA and FERPA, the Network applied for the management contract through the NM Department of Health (DOH). Although management and direct care are funded through the DOH contract, the DMSBHWC has provided the Network the opportunity to ensure availability, continuity, quality, and care coordination in western Union County. Some grant funding has been used for this objective as in line with our approved scope. It also has given the Network needed leverage for coordinating services in other parts of Union County and beyond (see below).

Coordination of care throughout Union County has included increased telehealth services, telehealth and distance-learning equipment available for continuing education for providers, nurses, and other healthcare professionals, initial steps toward coordination of an education, referral, and enrollment system for NM Medicaid and the State Healthcare Exchange, and community and Network Board engagement in health needs assessment and healthcare/wellness planning and programming.

We also explored and researched the possibility of establishing a Federally Qualified Health Center (FQHC) with locations in both the county seat (Clayton) and at the DMSBHWC. However, attempts were frustrated by lack of participation from the hospital and politics surrounding perceived competition for resources.

3. Community Wellness

During the first year, we focused heavily on developing a Workforce Wellness program in conjunction with LoneStart Wellness, a private Texas-based workforce wellness program. A Network staff member and former personal trainer / weight and nutrition coach delivered classes to employees of one Network partner organization and was responsible for marketing the program to Network partners. However, the program did not meet with much interest and never got off the ground. We had planned to combine the workforce wellness programming with a fitness initiative. We dropped both simultaneously.

Our efforts to support local growing and the increased consumption of fruits and vegetables, however, have begun to take root. We collaborated with one of our partners, a K-12 school district, on a USDA-funded Farm to School Planning Grant. After a year of work, their leadership team now has a plan for engaging the school and community in nutrition education, a school/community greenhouse, and integrated nutrition and agriculture curriculum. Our hope is that these efforts may later provide increased access to fresh, nutrient-rich fruits and vegetables as well as encourage dietary behavioral changes.

We also are currently working with multiple partners to introduce a community greenhouse and green space (park) in another Union County community. The greenhouse, partially sunken and angled to take advantage of geothermal heating and passive solar heating is positioned to serve as a pilot project for overcoming the harsh growing conditions of our region. The greenhouse will be available to the community, and interest is already growing from both individuals and businesses (such as the local grocery store). The Network had coordinated a local Grower's Club during its initial grant year. However, we had to drop the initiative due to staff unavailability. We now have a new staff person on this project and hope to revive the Grower's Club surrounding this greenhouse initiative so that we may continue making progress toward our goal of supporting local growers and encouraging increased fruit and vegetable production and consumption. Various sources of funding apply.

4. Network Infrastructure

We started our RHND grant on the heels of a one-year RHND Planning Grant. The planning grant had taken us through the stages of the formation of a solid Steering Committee with high-level representation from multiple health-related organizations throughout the county, MOA and bylaws formation, and initial strategic planning and prioritization. With the three-year RHND grant, we were able to incorporate, form a stronger and more committed Board, obtain our IRS 501(c)(3) status, draw in new members and partners, conduct three annual strategic and sustainability planning retreats, secure additional sources of funding, and take on our first collaborative projects (described above). We are still in process with several of our grant programs, as well as our sustainability planning and evaluation.

B. Roles of Network Partners

Clayton Health Systems (critical-access hospital, primary-care clinic, home health, respiratory therapy)

- Flow-through fiscal agent
- Partner for PRCMI, Dental Therapist advocacy, and telehealth
- Provides primary-care and follow-up outpatient services for the DMSBHWC
- Explored the Workforce Wellness program; coordinated fitness and weight/nutrition classes with the Network
- Board member serves on the Network Board and Finance Committee

Tri County Community Services (behavioral-health provider)

- Coordinates behavioral-health services with other providers in the county, including the DMSBHWC; telehealth partner
- Active in efforts to form a network for education, referrals, and enrollment in Medicaid and NM Health Exchange
- Staff member serves as Secretary on Network Board and former member of the PRCMI

Service Organization for Youth

- Provides behavioral-health care at the DMSBHWC and coordinates with providers in western Union County and beyond
- Telehealth partner

McGowen Family Chiropractic

- Provides chiropractic are at the DMSBHWC and coordinates with providers in western Union County

Region II Public Health, Clayton Office

- Provides Women, Infants, and Children (WIC) services at the DMSBHWC and coordinates care in western Union County

Golden Spread Rural Frontier Coalition

- Provides transportation and home health assistance services, both available to all Union County residents
- Partner in the community greenhouse and community marketing / physician recruitment initiatives
- President / Executive Director serves as Treasurer of the Network Board and member of the Finance Committee

Union County Commission

- Owns the hospital (Clayton Health Systems) facility
- Participant in discussions surrounding indigent care, hospital management, FQHC, and tax levies to support healthcare
- County Commissioner serves as Chair of the Network Board and a member of the Network Finance Committee

Town of Clayton

- Partner in the greenhouse / green space initiative, PRCMI and Roundtables
- Town Trustee serves on the Network Board

Northeast Soil & Water Conservation District

- Participant in the farm-to-school and greenhouse initiatives
- President of their board serves as Chair of the Network Board (same person as County Commissioner)

Des Moines Municipal Schools (DMMS)

- Coordinates services and health programming with the Network and other partners (behavioral health, primary care, chiropractic, WIC) for the DMMS and surrounding community
- Teamed with Network staff and other outside partners toward a farm-to-school planning program
- Former Superintendent served as a very active former Network Board Chair; current Superintendent serves on board

Des Moines School-Based Health and Wellness Center (DMSBHWC) (Network-managed)

- An extension of the Network, with management and direct care funded by the Department of Health
- Coordinates care throughout western Union County and with other parts of Union County and beyond (primary care, behavioral health, telehealth, chiropractic, WIC, and hopefully dental)

Health Action New Mexico

- Champion for the New Mexico Dental Therapist bill; advocacy partner
- Partner for State Health Exchange education

Union County Community Development Corporation

- Partner for the Physician Recruitment and Community Marketing Initiative
- Partner for dental recruitment and business planning

Outcomes

A. Outcomes and Evaluation Findings

1. Provider recruitment and retention (primary care and dental)

- Primary-care FTEs have been increased from 1.35 to 2.6, in part attributable to our Physician Recruitment and Community Marketing Initiative (PRCMI). This exceeds our objective (100% achievement).
- The number of full-time primary-care providers has increased from 0 to 1 (nurse practitioner, 50% of our objective), although this has not been due to our efforts. However, we are hopeful that a new full-time MD will be joining us within a month.
- Preventive dental care is not available 2 days per week. At one point early in our grant, we did have dental care available 2 days per week through a dental van, but this was unsustainable. We also worked to recruit a dentist for a part-time clinic, which opened last summer but terminated abruptly in November, 2013 due to the provider's busy schedule. Currently, we have secured a facility out of which a dentist can operate and are working to purchase equipment that will allow for preventive, diagnostic *and* basic restorative work (fillings, crowns). We are hopeful to have a dentist use this facility on a part-time basis starting next fall.
- We have not retained 1 new full-time primary-care provider for at least 1 year. However, we have retained 2 new part-time providers for at least one year, in part due to the efforts of our PRCMI. (Objective in progress.)
- We have not increased the number of high-school graduates declaring a major in healthcare; the healthcare workforce program was put on hold (see above).
- We have not increased the number of Union County residents pursuing certification in high-need healthcare areas. We chose to assist students already enrolled in healthcare fields with financing options and also focused significant efforts on the Dental Therapist initiative. If this passes, we will attempt to facilitate one or two Union County residents in pursuing certification as a Dental Hygienist/Therapist. We also have established initial linkages with existing Workforce Development programs and are taking initial steps to make their services more accessible.

2. Continuum of Care Coordination

Most of the measures here were process measures. The Board of Directors served the function of the Continuum of Care committee. This county-wide collaboration consisted of the following:

- Conducting and prioritizing projects based on a community health needs assessment,
- Laying the groundwork for a Medicaid and Health Exchange education and enrollment program,
- Establishing telehealth for behavioral health between two members and two outside providers, and
- Identifying gaps in service and of areas that needed to become sustainable.

Coordination of care in western Union County reached higher levels of integration: Primary-care, behavioral-health, chiropractic, and WIC providers, as well as some telehealth (and hopes for dental) each operate out of the same clinic location with a single coordinator/administrator, shared policies and procedures, and shared patient charts for DMMS students. An opportunity is available each month for providers to discuss cases and coordinate care. We continue work in this area, with hopes of approaching an even more student-centered / patient-centered model within the next year or two.

3. Community Wellness

Our Workforce Wellness with coordinated Fitness Program did not materialize due to lack of interest on the part of our member organizations. However, we have been working in coordination with the DMMS' School Health Advisory Council (SHAC), which convenes twice per semester, to coordinate health and wellness program for DMMS and the surrounding community. Through outside funding, we have sponsored and/or collaborated in ten health-promotion and risk-reduction campaigns for DMMS and the surrounding community. We also formed and facilitated a Des Moines farm-to-school (FTS) planning to address support for growing in the region, consumption of fresh fruits and vegetables, and curriculum integration. This group has met on a monthly basis for one year and has assembled a separate portfolio of written plans surrounding aspects of the school's FTS program and community integration. We also have formed a Community Advisory Committee to address community wellness.

We were unable to pilot the LoneStart Wellness Program (a workforce wellness program) due to lack of interest on the part of member organizations. We did, however, market the program to our member organizations, worked with one hospital to explore it more in-depth, and then taught three fitness/weight/nutrition classes at the hospital when they declined LoneStart.

The fitness campaign had been conceived in conjunction with the workforce wellness program and was dropped simultaneously. We have, however, coordinated wellness-promotion programming extensively with DMMS, the DMSBHWC (which we manage), and the DMMS Farm-to-School Leadership Team. A Clayton-based greenhouse/nutrition group is under discussion.

4. Network Infrastructure

The Network has benefited from the consistent leadership and management of a single Network Executive Director throughout its grant period. The Network also has formed a solid board of directors representing the highest level of decision-making authority available from multiple healthcare and other community organizations. The Network has developed Articles of Incorporation and Bylaws for internal governance. Other policies and procedures exist at the staff levels. The board meets monthly in addition to annual planning retreats. A Finance Committee provides additional financial monitoring and planning.

We have struggled to recruit and retain a qualified Administrative Assistant . This puts significant weight on the Executive Director and prevents us from cross-training someone in the absence, temporary or long-term, of the existing Director.

The Network has developed an effective meeting structure, decision-making structure, and communication system. It also has established a separate set of values for working together. Financial systems are still in-process. The Finance Committee meets to develop and monitor budgets and plan for future needs accordingly.

When we started, 3 of our 5 members were healthcare provider organizations. We now engage multiple civic and community groups, local government, school districts, and occasionally individuals. Collaboration has been a challenge due to territorialism and feelings of surrendering control. However, we have successfully engaged in three collaborative projects, and two more have been initiated. Board meetings also serve as fora for collaboration. Commitment has increased as evidenced by the length of membership and time committed by some officers.

On one hand, we have gained recognition and appreciation through our achievements, numerous newspaper articles, word of mouth, and presence on other committees and boards. Simultaneously, we continue to receive resistance and some ill feelings from organizations and the general public. This may be partially attributable to our successes and competition for "glory." Yet, we have been successful in laying a foundation for collaboration that was absent before.

We have worked to successfully position ourselves for access to capital through our collaboration, a well-developed strategic plan, and a successful track record. This positioning has garnered additional grant funds and also helped us secure grant funding for members and partners through contractual arrangements.

B. Network Collaboration

Ways in which our network effectively collaborated to achieve the goals of our program . . .

- The best example of our collaborative efforts has been the PRCMI, which has enjoyed broad community support. Each partner has recognized the physician shortage crisis as a community problem with a community solution. Collaborative successes have included a potluck for a visiting physician, community receptions at the Herzstein Museum, physician appreciation days, and community welcoming and integration efforts. Currently, participating organizations are developing a comprehensive marketing strategy.
- The DMSBHWC and coordination of care in western Union County (see above) involves the collaboration of multiple providers and other entities, including DMMS and Network staff.
- In western Union County, part of the collaborative farm-to-school planning project involved collaboration between Network staff, DMMS, and other entities. Other entities have been part of our early discussions surrounding the community greenhouse / green space (park) project for Clayton / eastern Union County.
- The Network's Dental Therapist advocacy efforts also have engaged the participation of various Network members and partners toward the common goal of seeing this legislation pass and expanding the potential for needed oral-care services in Union County and other frontier regions. Network members have written letters of support, and one Board member provided testimony at a few hearings.

Principles of Successful Partnership

- Develop advance memoranda of agreement (MOAs) or contracts for projects or programming that will require significant effort. This is especially important when the organization's representative to your network may not speak for the entire organization. This involves organizations at the board level and helps ensure survival through administrative changes.
- Provide members with window decals, plaques, or other constant reminders of their association with your organization.

- Constantly remind members and partners of the value the Network and the collaboration provide in a simple way (graphic and/or figures work great). Work with your evaluator and your board from the start to hone the process. Publish your results on your website or local newspaper and/or share them with community groups and prospective members. This offers a double benefit and gets your members and partners to take the review of the results more seriously.
- As a group, develop talking points for representatives to take back to others in their organization and to community members. Provide them with graphics, figures, brief outcomes statements, and other tools to "brag" about your network.

Challenges & Innovative Solutions

Non-Participation of Clayton Health Systems CEO: Within months of the grant award, hospital and grantee Clayton Health Systems lost its CEO, a community champion for the formation of the Network who had served as the Chair of the Network Steering Committee. The new CEO expressed limited interest in participation. Network Board members met with Hospital board members to explain the situation, encourage their continued participation, and select a replacement – a Hospital board member.
The Network Executive Director has attended Hospital board members and met privately with the new Hospital CEO from time to time.

We also experience changes among two superintendents of schools, both of whom had been Network Board members. These changes posed set-backs to our programming. With the first, Superintendent of DMMS, we had forewarning and were able to develop succession plans; however, the new Superintendent has had different priorities and concerns, which we have had to work through – in part, with outside help. The loss of the Superintendent of Clayton Municipal Schools (and a Network board member) effectively removed the organization as a Network member and terminated collaboration we had initiated toward a school/community greenhouse (with an outside grant already in place). First we pursued collaboration with the high-school principal and now are seeking alternative solutions for the greenhouse.

Sustainability

A. Network Structure

The Network intends to maintain a certain level core operations, which it defines as the capacity to collaborate, assess and prioritize community needs, develop resources (as a network corporation or collectively), and respond. The matter of sustaining an Executive Director and other administrative staffing is currently under discussion.

B. Ongoing Projects and Activities/Services To Be Provided

The Network believes that its foremost purpose and role should be in encouraging and facilitating coordination, rather than direct programming. All future outreach programming should either fall within this approach or be "incubator" projects whose impact becomes institutionalized or whose programming becomes absorbed by other organization(s). The Network is seeking a new management entity for the DMSBHWC. The greenhouse / green space project also will be an incubator project, ultimately sustained by other organization(s). We anticipate two more years of Network-managed programming for each.

C. Sustained Impact

It is our goal that many of the functions of the PRCMI will be absorbed and institutionalized by other organizations. We also hope that our marketing efforts will yield physicians and a dentist who will remain in the community for many years – and that the Dental Therapist bill may be passed, providing a sustained impact on the availability of oral-health services for rural areas of New Mexico.

Implications for Other Communities

How our network development experience and outcomes might benefit other communities:

- Extremely rural/frontier communities seeking to establish oral-health services should consider dental therapist legislation in their state. This mid-level provider position would decrease the overhead cost for providing quality, oral-health care and create a feasible, sustainable business model. Overhead also can be reduced through facility provision or free/low-cost use of dental equipment.
- School-based health centers (SBHCs) are an opportunity for increasing access to and integration of care. The clinic can serve as access for community members outside student hours. SBHCs are gaining attention at both federal and state levels.

- Although a broad-based coalition that includes a diversity of community players may be ideal for addressing community health in a holistic fashion, establishing collective priorities that also are individual priorities can be a major challenge. It is imperative that everyone involved be extremely clear about why they are involved and what they hope to achieve.
- From the beginning, set the tone that the network is not just one more not-for-profit acting (and competing) in the community, but a consortium of organizations acting *together*. Ensure that all programs and projects are collaborative in nature – not just common priorities undertaken by network staff. Such programs and projects may take longer to get off the ground, but they will establish your identity as unique from the other organizations and lower the perception of threat. They also are ultimately more sustainable.
- Evaluate the costs and benefits of the projects and programs you undertake – before, during, and after implementation. Assess whether certain endeavors energize or deplete your organization.
- Develop a simple and effective system for tracking and reporting progress toward group priorities (such as a graphic or "dashboard"). Use it at board meetings, on handouts your members, for new member recruitment, on your website, etc.

North Dakota

Coal Country Community Health Centers

Organizational Information	
Grant Number	D06RH21668
Grantee Organization	Coal Country Community Health Centers
Organization Type	FQHC
Address	1312 Highway 49 North; Beulah, ND 58523
Grantee organization website	www.coalcountryhealth.com www.ndrbhn.org
Name of Network	North Dakota Rural Behavioral Health Network
Network Director	Name: Chastity L. Dolbec, RN, BSN
	Title: Director of Patient Care & Innovation
	Phone number: 701-873-4445
	Fax number: 701-873-4199
	Email address: chastity@coalcountryhealth.com
Project Period	2011 - 2014
Funding level for each budget period	May 2011 to April 2012: $180,000
	May 2012 to April 2013: $180,000
	May 2013 to April 2014: $180,000

Network Partners		
Partner Organization	Location	Organizational Type
Mental Health America of North Dakota (MHAND)	Bismarck, North Dakota Fargo, North Dakota	Mental Health America organization
Coal Country Community Health Centers (CCCHC)	Beulah, North Dakota Center, North Dakota	Federally Qualified Health Center (FQHC)
Sakakawea Medical Center	Hazen, North Dakota	Critical Access Hospital
Mandan Hidatsa Arikara (MHA) Nation	Fort Berthold Indian Reservation Newtown, Mandaree, Four Bears, Parshall, Twin Buttes, and White Shield, North Dakota	Tribal
North Dakota Area Health Education Center (ND AHEC)	Western North Dakota	Area Health Education Center (AHEC)
ND Federation of Families for Children's Mental Health	Bismarck, ND	Parent-run organization
Essentia Health	Eastern North Dakota	Healthcare organization

Community Characteristics

A. Area

Initially, the project targeted a seven county region in Western North Dakota, including Dunn, McHenry, McKenzie, McLean, Mercer, Mountrail, and Oliver Counties. The focus expanded state-wide by Year 3.

B. Community description

In 2013, the estimated population in ND was 723,393, compared with 316,128,839 nationally. The population in ND is estimated to have increased 7.6% from the 2010 population, compared with an increase nationally of 2.4%. (U.S. Census, 2014, http://quickfacts.census.gov/qfd/states/38000.html). North Dakota is one of the smallest and most rural states, ranked 48th in population nationally (United States Census Bureau, 2012a). In 2013, the population density of North Dakota was 11.7 persons per square mile, for a ranking of 47th nationally in population density (World Population Statistics, 2013). Sixty-eight percent (36 of

53 counties) are considered frontier areas, with a population density of six or fewer people per square mile (Center for Rural Health University of North Dakota School of Medicine and Health Sciences, 2012). In 2010, 347,173 (51.6%) North Dakota residents lived in rural areas and 325,418 (48.4%) lived in urban areas (United States Department of Agriculture: Economic Research Service, 2011). The population in North Dakota continues to be concentrated in a few areas. Over half of the population (374,201, 54%) lives in 4 of the 53 counties of Cass, Burleigh, Grand Forks and Ward (North Dakota State Data Center, 2012a). The largest minority group is American Indians, 5.5% of the North Dakota population. Their median age is 31.1, which is higher than the state median age of 24.9 (U.S. Census Bureau, 2008-2012 America Community Survey 5-Year Estimates). Fifty-eight percent live on one of the five reservations in North Dakota. The American Indian population (one race) increased by 13.4% from 2000 to 2012; the American Indian population (race alone or in combination with one or more other races) increased by 17.4% from 2000 to 2012 (United States Census Bureau 2012).

C. Need

Behavioral health disparities, including mental health and addictive disorders (Department of Health and Human Services; Finch and Phillips, 2005), exist for persons living in rural and tribal communities. People with co-occurring mental health and substance use disorders are more likely to use emergency room services than people with one or the other or two other chronic diseases, diabetes and chronic respiratory disease (Coffey, Houchens, Chu, Barrett, Owens, Stocks, Vandivort-Warren, and Buck, 2010). People living in rural areas are less likely to receive psychotherapy, more likely to use prescription drugs, demonstrate greater need for mental health services, have lower rural office-based mental health use, and are more likely to have mental health services paid by public insurance and to pay out of pocket more than people in urban areas (Fortney, Harman, Zu, & Dong, 2009, 2009a, 2010; Harman, J. S., Fortney, J. C., Dong, F., & Xu, S.; Ziller, Anderson, & Coburn, 2010). Behavioral health issues are challenging in North Dakota because of the state's rural nature and concomitant issues, from natural resources to access to care. North Dakota has the distinction of being one of the best financially-situated states nationally. North Dakota reserves have increased from 12% in 1991 to 33% in 2011. Farm prices have been high in the past few years and oil exploration has exploded. With the boom in production of natural resources have come rapidly increased behavioral health challenges and even more limited resources. North Dakota has higher rates of binge drinking.

Program Services

A. Description

To accomplish its mission, "To improve access to behavioral health care and eliminate behavioral health disparities in rural and tribal communities," four goals were established:

Goal 1: Creation of a successful Network of behavioral health entities to improve access to behavioral health care and reduce behavioral health disparities.
Goal 2: Increased knowledge regarding rural and tribal health disparities to reduce health disparities and improve outcomes.
Goal 3: Increase access to behavioral health care through outreach and policy change.
Goal 4: Resources in place to sustain the Network.

To create the Network, members formed a Governance Committee to manage the Network; four committees (Organizational Development, Education, Sustainability and Evaluation, and Outreach) to accomplish the products; and an Advisory Council to provide guidance to the formation of the Network. The Network's organizational structure is in place. The Governance Committee and four working committees have met monthly, the Advisory Council quarterly.

Two educational products have been developed and presented: Mental Health First Aid (MHFA) and Bridging Cultures. In addition to the primary Mental Health First Aid training that was initially presented, the Network developed the capacity to also present a newly developed Youth MHFA focusing on adults working with youth.

Bridging Cultures has been adapted from a face -to -face training to a web-based continuing education opportunity.

One Network member has successfully integrated depression screening into their clinic with funding from the ND State Department of Health.

NDRBHN raised its visibility through the application for a grant offered by the state legislature to conduct a statewide behavioral health needs assessment. Although the application was unsuccessful, NDRBHN is now one of the participants providing feedback regarding behavioral health needs and potential solutions.

Two business plans have been completed regarding MHFA and telehealth as the focus going forward.

B. Role of Network Partners

The Network partners are represented on the Governance Committee. All participate in development of policy and implementation of activities. The representative from Mandan Hidatsa Arikara (MHA) Nation chairs the Outreach Committee. The Project Director is also the Director of Mental Health America of North Dakota (MHAND). She also chairs the Organizational Development Committee. The chair of the Advisory Council is the Director of Federation of Families and the incoming Project Director. Coal Country Community Health Centers serves as the fiduciary agent for the Network. One of their staff chairs the Education Committee; another chairs the Sustainability and Evaluation Committee. Essential Health is responsible for the program evaluation.

Outcomes

A. Outcomes and Evaluation Findings

Goal 1: Creation of Network

During the grant period, the NDRBHN established its infrastructure, including a Governance Committee composed of the seven early members, an Advisory Council, and four workgroups; created bylaws; and developed a strategic plan. The NDRBHN met monthly, 10 meetings a year using technology and 2 meetings a year face- to -face for in-depth planning. The 36 member Advisory Council met quarterly, three meetings annually using technology and once annually face to face. Members of the Advisory Committee include representation from diverse constituencies: law enforcement; social and clinical services; education; medical providers; mental health advocacy organizations; emergency medical service providers; juvenile court; tribal government; state and local agencies and institutions; professional organizations; Network of catholic hospitals; health care Network; state government agencies; public agencies; mental health organizations; private nonprofit mental health service providers; advocacy groups; private for profit behavioral health; veterans organizations; consumers and families; and consultants. The committees met monthly and as needed, using technology, to plan and implement the primary activities of the Network.

Goal 2: Increased Knowledge

The NDRBHN supported two educational offerings. Face to face training in behavioral health and cultural competence in rural and tribal communities was initially conducted using the Bridging Cultures Curriculum. The training has now been transformed into a web-based curriculum that will be available, with continuing education credit available for professionals. The second educational offering is Mental Health First Aid, an evidence-based curriculum to increase participants' ability to identify symptoms of a mental health crisis and to intervene. The MHFA trainer has now been certified in Youth Mental Health First Aid Training which is designed for adults who work with adolescents ages 12-18. The documentary, *Resolana: Voice of the People*, has been disseminated in 30- minute and 7 -minute formats.

Goal 3: Increased Access

The NDRBHN Outreach Committee is developing relationships with another tribal community. The fiscal agent, Coal Country Community Health Center, participated in a pilot project to integrate behavioral health into primary care, introducing depression screening with a robust follow-up plan.

Goal 4: Sustainability of the Network

A business plan has been developed to support the ongoing offering of MHFA extend its reach. The NDRBHN initially completed a strategic plan and then updated it, based on a needs assessment and feedback from the Advisory Council. Telehealth was identified as a principal strategy to increase access to behavioral health services in rural and tribal communities. A business plan is being completed and strategies for increasing opportunities for telehealth identified.

B. Network Collaboration

Network members, including members of the Governance Committee and the Advisory Council, worked together to developed the infrastructure for the NDRBHN, created a strategic plan, and are working together to continue efforts to improve access to behavioral health services in rural and tribal communities.

Creating successful methods for convenient and frequent communications, using diverse technologies, is essential to developing a successful Network across a large geographic area. Bringing public and private entities together, as well as consumer and advocate organizations and tribal communities/leaders, is a strong component of the uniqueness and success of the NDRBHN.

Challenges & Innovative Solutions	
Challenges	How addressed
Geography: The advantage of diverse partners in different geographic locations was also a challenge.	The Governance Committee, working committees, and the Advisory Council routinely communicated electronically. Having a conference calling system always available for regular and as needed meetings, the use of Google Drive, and using web-based meeting tools to share documents during phone conferences was invaluable.
Diverse entities/organizations with different missions	Each partner was committed to improving behavioral health outcomes.
Attitudes/Stigma regarding behavioral health issues	Resolana, face book, webpage, MHFA training
Rapidly changing environment in Western ND	Developing implementation strategies for telemedicine for behavioral health
Lack of behavioral health care providers	Discussion of workforce strategies through MHFA, etc.
Unintended Consequences for Medicaid reimbursement (ACA)	Implementation of educational discussion to address concerns at the 36 member NDRBHN Advisory Council level
The amount of time it would take to access new communities and build relationships was underestimated.	The plan for outreach and expanding the Governance Committee was revised.
Challenge with travel in the Western part of the state, due to the truck traffic on rural 2 lane roads resulting from the oil boom.	This is an ongoing challenge for which we will need to continue to be vigilant.

Sustainability

A. Network Structure

The NDRBHN will continue to meet as a Governance Committee with the four working committees meeting as needed. A variety of funding sources will be identified to assist in the development of plans to implement telemedicine for behavioral health strategies in ND rural and tribal communities. The original seven partners have committed to continue the work of the NDRBHN. The website, Facebook and newsletter social marketing activities will continue as in kind for the short term with grant support from the Bush Foundation for longer term future implementation.

B. On-going Projects and Activities/Services To Be Provided

Coal Country Community Health Center will continue offering MHFA in their catchment area. Further funding opportunities will be explored to expand the MHFA program. The *Bridging Cultures* Curriculum will be available online.

The NDRBHN website, Facebook and newsletter will continue to be active and in-kind with plans for grant funding to increase social marketing activities.

The NDRBHN Organization Development committee will continue to meet on a volunteer basis and develop membership categories to produce needed income. Membership recruitment will primarily begin with the 36 member NDRBHN Advisory Council delivering the message of the importance of the work of the Network. The focus on the much needed development of strategies for implementation of telemedicine for behavioral health in rural and tribal communities will be utilized to attract member (organizational and individual) involvement in NDRBHN activities.

The NDRBHN is developing a proposal to obtain funding for a telebehavioral health pilot project through application of the HRSA ORHP Outreach Grant that will be awarded May 2015. In order to prepare for the grant application NDRBHN will apply for a Bush Foundation grant available in ND on a quarterly basis.

Coal Country Community Health Centers (CCCHC) has just submitted a proposal for a Behavioral Health Integration Mental Health Expansion Service Grant to HRSA to further their work integrating behavioral health issues into primary care. They received funding from the Department of Health for depression screening and mentored Sakakawea Medical Center and the Mandan Hidatsa and Arikara Nation Health Center through a successful application for funding for their health care programs including depression screening at the primary care level.

C. Sustained Impact

Never before has an entity existed in ND that includes diverse groups at the "table," such as Native Americans, consumers, advocacy organizations, and public and private organizations to address behavioral health issues. The behavioral health needs of rural and tribal communities are so powerful. Through the development work of the NDRBHN over the last three years, the lack of communication among diverse entities concerned about the lack of behavioral health services was addressed. The NDRBHN sees how valuable it is to share information and speak with one voice regarding needed policy changes and potential solutions to increase access to behavioral health services. This is a long-term effort in the ND community. ND is a rural state with an oil boom that presents ever increasing behavioral health care needs. Increasingly, NDRBHN is the identified "go to" organization to identify and bring behavioral health issues in rural and tribal communities forward.

Cultural Competency training specific to behavioral health providers, EMS, nurses, corrections staff and others on the behavioral health needs of Native Americans and farm and ranch families has never been available before the NDRBHN created *Bridging Cultures*. The *Bridging Cultures* cultural competency curriculum will continue to be available on line to all North Dakotans. Mental Health First Aid (MHFA) will continue to be offered. Evaluations of both of these trainings are excellent and will continue to be part of the NDRBHN contribution of deliverables that are sustainable beyond the life of the Rural Health Network Development grant.

Implications for Other Communities

The experience of creating something from nothing is challenging. In a rural state like ND, the geographic distances are great and the communication of entities focused on behavioral health has been scarce. The opportunity to create something that has never been done before is exciting and rewarding. The outcome of the development of a sustainable ND Rural Behavioral Health Network to address unmet behavioral health needs and identify opportunities for solutions by diverse entities (Native Americans, Consumers, Advocates, Public and Private entities) has been an marked change in the landscape in ND related to the significance of collaboration.

South Dakota

Pioneer Memorial Hospital & Health Services

Organizational Information	
Grant Number	D06RH21679
Grantee Organization	Pioneer Memorial Hospital & Health Services
Organization Type	Critical Access Hospital
Address	315 N Washington St Viborg, SD 57070-2002
Grantee organization website	http://www.pioneermemorial.org/
Name of Network	Emergency Access Network
Network Director	Name: Dmitri Melius
	Title: Project Manager
	Phone number: 605-328-6971
	Fax number:
	Email address: Dmitri.Melius@SanfordHealth.com
Project Period	2011 - 2014
Funding level for each budget period	May 2011 to April 2012: $180,000
	May 2012 to April 2013: $180,000
	May 2013 to April 2014: $180,000

Network Partners		
Partner Organization	Location	Organizational Type
Ortonville Area Health Services	Ortonville/ Big Stone/MN	Hospital
Community Memorial Hospital	Burke/ Gregory/ SD	Hospital
Winner Regional Healthcare Center	Winner/ Tripp/ SD	Hospital
Sanford Medical Center / Trauma 5	Sioux Falls/ Minnehaha/ SD	Hospital
Sanford Vermillion Medical Center	Vermillion/ Clay/ SD	Hospital
Sanford Tracy Medical Center	Tracy/ Lyon/ MN	Hospital
Sanford Hospital Westbrook	Westbrook/ Cottonwood/ MN	Hospital
Sanford Regional Hospital Worthington	Worthington/ Nobles/ MN	Hospital
Sanford Medical Center Chamberlain	Chamberlain/ Brule/ SD	Hospital
Sanford Hospital Canton - Inwood	Canton/ Lincoln/ SD	Hospital
Sanford Deuel County Medical Center	Clear Lake/ Deuel/ SD	Hospital
Sanford Aberdeen Medical Center	Aberdeen/ Brown/ SD	Hospital
Sanford Webster Medical Center	Webster/ Day/ SD	Hospital
Sanford Thief River Falls Medical Center	Thief River Falls/ Pennington/ MN	Hospital
Sanford Mayville Medical Center	Mayville/ Traill/ ND	Hospital
Northwood Deaconess Health Center	Northwood/ Grand Forks/ ND	Hospital
Sanford Bagley Medical Center	Bagley/ Clearwater/ MN	Hospital
Sanford Jackson Medical Center	Jackson/ Jackson/ MN	Hospital

Community Characteristics

A. Area

The target population served by this project includes individuals who receive health care in the 17-county Network service area.

B. Community description

Tel-emergency services provide improved healthcare access to special populations including underserved 1) Native Americans, 2) the frail and elderly, 3) persons at great risk for injury (agriculture related), 4) persons at greater risk from recreation-related accidents.

C. Need

Rural end-user sites lack an emergency care system that meets the needs of residents.

Program Services

A. Description

During the grant period, The Emergency Access Network members: 1) Built an infrastructure for an effective healthcare resource management model through telemedicine technology; 2) Implemented tele-emergency equipment and hardware at hub and end-user sites; 3) Developed a formative and summative evaluation structure to assist in program growth and sustainability; 4) Built the business case for tele-emergency, evaluating clinical quality, satisfaction, and financial indicators; and, 5) Disseminated to all stakeholders, project learnings and outcomes related to changes in system processes and culture.

B. Role of Network Partners

Eleven Network members had input in to the design of the project. During the project, each Network member appointed, at a minimum, one staff member to be a voting member of the Emergency Access Network Project Governance Board. It was understood by all Network members that the Board is independent from any single consortium member; decisions made by the Board as they related to the grant are binding. Additionally, Network members aided in program development and evaluation efforts by submitting, as needed, patient volume and quality data.

Outcomes

A. Outcomes and Evaluation Findings

Some of the primary outcomes and evaluation findings resulting from this project include:

1. Use each member's unique abilities to the benefit of the program. Inevitably, all members will not have the same characteristics. Each will have a unique experience when the intervention (tele-emergency in this case) is introduced. The response to these experiences should be collected and documented as to build a database of lessons-learned and best practices.
2. Build on the unique characteristics of your network. No one tele-emergency initiative will match the intricacies of a program elsewhere. Identify the network strengths and use those to build the program.
3. Tele-emergency specific outcomes – 83% of all encounters were adult and 17% pediatric; the three largest chief complaints during an encounter were trauma, neurology and chest pain, nearly 20% of all encounters resulted in an avoided transfer; Provider satisfaction is very high and overall never went below 85%.

B. Network Collaboration

Network collaboration was the key to success. All members had a voice which included input from all applicable staff at every organization. Lessons learned and best practices were quickly shared throughout the network. Proper channels of communication sharing were well established and issues were quickly addressed by project leaders.

Challenges & Innovative Solutions

Sustainability was and will be the largest challenge facing the Network. Network leaders are confident the sustainability model (Subscription based) in place today will ensure a sustainable program. Great effort will be put in to fine tuning the model to effectively sustain the program.

Sustainability

A. Network Structure

The work completed through this grant is just the beginning of a robust plan to provide to a large number of rural Americans access to numerous emergency-related specialties. All network members will continue to be engaged in program activities. Network staffing will be centrally located at the medical center which will provide board-certified ER Physicians and Network management. This staffing will be sustained through subscription fees paid by each Network member.

B. On-going Projects and Activities/Services To Be Provided

It is anticipated that virtually all of the Network's current services will be sustained. The Network aims to add more members and to provide services to a larger number of rural Americans. Additionally, specialties such as neurology will be part of the on-going conversations to gauge if and how they fit into the tele-emergency platform that is in place.

C. Sustained Impact

Many benefits are readily apparent from providing access to board certified emergency room physicians: better quality outcomes, quicker diagnosis and treatment, streamlined care from CAH to tertiary center to name a few. Tele-emergency will also impact the communities in other ways that are not so readily apparent. Recruitment and retention of providers may improve as many of these rural providers will gain a support system. This especially is true for new graduates who learn to practice medicine in a collegial environment. Additionally, institutional practices could change. With access to a board certified emergency room physician, staffing models between the tertiary center and CAHs can be made more efficient. Also, with an Emergency Room platform in place other specialties naturally connected to urgent care can be connected to patients in remote areas. These can include specialists such as neurologists, cardiologists, and orthopedic surgeons. Having a strong tele-emergency network in place opens the door to many possibilities in the future -- many that are not even imagined at this point.

Implications for Other Communities

The Emergency Access Network created a beneficial framework for implementing for tele-emergency initiatives at other organizations. While every organization is unique, some common guiding principles can be followed when implementing a tele-emergency initiative. First and foremost is the active engagement of key network stakeholders. Second, the initiative must play to the strengths of the network members. There is no one tele-emergency framework that fits all organizations. Lastly, the program must be available and working 24 hours a day. Remote providers will quickly lose interest if the service is not available to them at all times. In addition to these general principles, it is critical to track not only quality indicators but also technical issues. Inevitably, a new tele-emergency network will experience a large number of technical difficulties. These need to be logged and addressed immediately. Do not underestimate the amount of staff time needed to address such issues.

Tennessee

Hickman Community Health Services, Inc.

Organizational Information	
Grant Number	D06RH21671
Grantee Organization	Hickman Community Health Services, Inc., a member of Saint Thomas Health
Organization Type	Hospital
Address	135 East Swan Street, Centerville, TN 37033-1417
Grantee organization website	N/A
Name of Network	Tennessee Rural Telehealth Network
Network Director	Name: Amy Howard
	Title: Director – Regional Network
	Phone number: 615-222-7226
	Fax number: 615-222-7675
	Email address: amy.howard@sth.org
Project Period	2011 – 2014
Funding level for each budget period	May 2011 to April 2012: $180,000
	May 2012 to April 2013: $180,000
	May 2013 to April 2014: $180,000

Network Partners		
Partner Organization	Location	Organizational Type
Saint Thomas Heart	Nashville, TN (serving Middle TN/Southern, KY)	Cardiology Practice
Saint Thomas Neurology	Nashville, TN (serving Middle TN/Southern, KY)	Neurology Practice
Saint Thomas Health	Nashville, TN (serving Middle TN/Southern KY	Health System
Mission Point Health Partners	Nashville, TN (serving Middle TN)	Accountable Care Organization
Hickman County Health Services	Centerville/Hickman/TN	Critical Access Hospital
Ascension Health	Saint Louis, MO	Medical Holding Company
Capella Heatlhcare	Franklin, TN	Hospital Corporation
Lincoln County Health System	Fayetteville, TN	County Hospital

Community Characteristics

A. Area

The Tennessee Rural Telehealth Network served Hickman, Lincoln, Warren, Henry, and Franklin County in Tennessee and Logan County, Kentucky.

B. Community description

The rural residents of Middle Tennessee and Southern Kentucky, on average, have lower household income, higher rate of poverty, lower high school graduation rates and tend to be older when compared to the state overall. There is a large burden of chronic disease among rural residents that result in significant morbidity, complications and premature death. The rural communities and the rural hospitals that serve them are often hours away from specialty health consultation and diagnostic services.

C. Need

Heart disease and stroke are currently the #1 and #3 leading causes of death in the United States. While Americans of all genders, ages, races, and socioeconomic status are affected, extensive research found rural populations and those in the "stroke belt" are more vulnerable than others. Residents in the stroke belt (including those in Tennessee) have rates of heart disease, stroke and high blood pressure disproportionately higher than the rest of the country.[1] The target population included rural counties in Middle Tennessee and Southern Kentucky. Within these counties, there is a shortage of primary care providers as well as limited access to specialty physicians who can address the needs of cardiac and neurology patients. The existing healthcare service gaps opened the door for a telehealth network to connect patients in Tennessee rural settings with specialty physicians.

Program Services

A. Description

Hickman Community Health services along with Saint Thomas Health personnel spearheaded the telehealth project. Several evaluations and needs assessments of Network Partner sites were conducted throughout the Grant period. A turn-key approach was created for site assessments to include IT needs, physician/staff coverage requirements, reimbursement options, staff training program and project rollout plan. A telehealth clinic at River Park Hospital in Warren County, TN was established and sustained. The Clinic currently provides specialty coverage for Neurology patients with the potential to expand to cardiac and pulmonary services. Cardiac and Pulmonary outpatient clinics were established in Lincoln and Franklin, County TN. Also established was an acute tele-stroke hub and spoke model with 3 on-line tertiary sites (Saint Thomas Hospital West, Saint Thomas Hospital Midtown and Saint Thomas Hospital Rutherford) as hubs to provide coverage to rural spoke sites throughout the region - initially in Warren, Lincoln and Henry Counties. An assessment of Women's Health services via telemedicine has been initiated but results are not yet conclusive.

B. Role of Network Partners

Network Member Roles and Responsibilities

Hickman County Health Services • Plan, implement, and evaluate all project-related goals • Manage grant-related funds per Network approval • Provide leadership via Project Director and Network Director • Provide .1FTE Telehealth Program Coordinator to coordinate activities among Network members according to Work Plan • Create continuous project evaluation/quality improvement • Ensure available office space for telehealth equipment and schedule* • Provide feedback on provider and patient satisfaction • Establish broadband connectivity for effective equipment use • Recommendation of an employable medical assistant to operate equipment*	Lincoln Medical Center • Ensure available office space for telehealth equipment and schedule* • Provide feedback on provider and patient satisfaction • Establish broadband connectivity for effective equipment use • Recommendation of an employable medical assistant to operate equipment*
Capella – River Park Hospital • Ensure available office space for telehealth equipment and schedule* • Provide feedback on provider and patient satisfaction • Establish broadband connectivity for effective	Saint Thomas Heart • Provide physician consult visits via broadband and telehealth equipment • Oversee medical records, charting, and billing functions related to telehealth visits • Schedule patients for telehealth visits

[1] American Stroke Association. *Stroke: Could it Start in the Womb?* Stroke Journal Report. June 20, 2003. http://www.americanheart.org/presenter.jhtml?identifier=3012909

equipment use • Recommendation of an employable medical assistant to operate equipment*	• Provide feedback to referring physicians
Saint Thomas Neurology • Provide physician consult visits via broadband and telehealth equipment • Oversee medical records, charting, and billing functions related to telehealth visits • Schedule patients for telehealth visits • Provide feedback to referring physicians	Saint Thomas Health/Mission Point Health Partners • Contribute consultative advice based on other successful rural technology initiatives • Serve as a technical support entity and assist in coordination of the network
Ascension Health • Contribute consultative advice based on other successful rural technology initiatives • Serve as a technical support entity and assist in coordination of the network • Provide National oversight and Direction for program development/expansion • Facilitate relationships and use of contractual service providers (i.e. Iron Bow).	

*If there is currently a Saint Thomas Heart satellite clinic in the community, this leased space will be used to house equipment and hold a telehealth clinic.
**If there is currently a Saint Thomas Heart satellite clinic in the community, the Medical Assistant on staff at that clinic will resume telehealth clinic operation.

Outcomes

A. Outcomes and Evaluation Findings

There were multiple outcomes of the Network. They include: establishing a multi-disciplinary governing board; hiring a Telehealth Coordinator to coordinate and implement proposed activities and manage the telehealth equipment; installing telehealth equipment in rural county medical facilities so patients can have virtual appointments with physicians at Saint Thomas Heart and Saint Thomas Neurology; building upon the existing Tennessee Rural Chest Pain and Stroke Network to maximize collaboration for the Telehealth Network; evaluating telehealth processes, protocols, equipment utilization, billing procedures, and patient and provider satisfaction to ensure best practice procedures and protocols.

The program resulted in better health outcomes of rural populations with the overarching goal to develop and sustain a telehealth network that improves the amount and degree of cardiac and neurology specialty care. The end result was greater access to and improved diagnosis, treatment, and intervention related to cardiac disease and stroke, ultimately reducing regional heart disease and stroke deaths. Importantly, through this process, partnering rural facilities were strengthened through their affiliation with a formalized network of telehealth providers.

B. Network Collaboration

Throughout the course of the grant period new Network Partners were identified with additional resources and benefits to support program changes. For instance, the parent company to Saint Thomas Health, Ascension Health, engaged in a national telehealth pilot in the past year. Ascension identified the work being done through the Tennessee Rural Health Network as a model to be used throughout the country with their other hospitals and clinics within the Ascension Health Systems. Our Network has been invited to participate in an Affinity Group (comprised of Nashville, Indiana and Michigan Ministries) that will model the Tennessee Rural Telehealth program nationwide which is comprised of potentially 127 hospitals capable of serving as telehealth hubs. The number of spoke sites will be exponential as the networks expand across the health system. Since Ascension Health has adopted the Tennessee Rural Teleheath Network as a model, it has offered its Resource Group to leverage purchasing and buying power while lowering costs. Ascension has contracted IronBow, a cloud-based provider to monitor all endpoints - each of the spokes and hubs. This results in an almost instantaneous recognition of a system fault with immediate system maintenance, resulting in minimal downtime and improved efficiency.

Challenges & Innovative Solutions

Telemedicine is a relatively new concept and is not always easily defined. There is a lot of excitement about "telemedicine," but the commitment to the resources and throughput are difficult to secure. Initially our focus was on outpatient specialty clinics. While the need was there, execution proved difficult for many reasons: a turnover of network employee staffing, hiring staff with skill sets that match the technical and clinical requirements, payment/reimbursement structure, space (leases), training competencies and access to sites for maintenance of equipment. An additional factor that affects a telehealth network is facilities management (HVAC, power source and overall condition of site). The Network decided to focus on the quality of sites rather than the quantity of sites. We leveraged clinical sites that had existing leases and staffing resources to maximize productivity and efficiency of the telemedicine patient consultations.

Sustainability

A. Network Structure

We plan to continue to use our existing clinics/partners following a soft re-launch of our specialty clinic program. Contract review and renegotiation is underway. The addition of acute tele-stroke sites as described previously will bolster the growth and use of telemedicine clinics and improve the continuum and quality of care. Ascension Health has committed to pay the Network Director's salary and has established an independent cost center for Telemedicine to fund ongoing efforts. Both the Medical Director and Telemedicine System Network Administrator salaries will be paid within the new cost center.

B. On-going Projects and Activities/Services To Be Provided

The Tennessee Rural Telehealth Network will continue to focus on existing sites within Tennessee and Kentucky while closely working with Ascension Health to serve as a consulting resource as they build comparable networks across their hospital ministries. The Network will continue to flourish and serve patients within rural clinics and be a pivotal influence on the emerging Ascension Health telehealth networks.

C. Sustained Impact

1. Changes in the way that Network partners work together to serve the community – the tertiary hospitals and the rural clinics have forged significant work partnerships and, through this, established patient/specialist relationships.
2. Improved service models: The delivery of virtual appointments through remote telemedicine enhances patient care and access to acute, specialist, and primary care physicians. Patient and family concerns such as transportation availability and out-of-pocket costs are minimized for patients. The patients' fear of traveling to a remote hospital is mitigated through the virtual visits. For patients with potential evolving strokes presenting to a participating rural hospital, acute response time is accelerated and patient treatment is also improved.
3. Changes in Institutional Practices and Increased Capacity: Having analyzed the potential for expansion and replication of the Tennessee Rural Health Network, Ascension Health is dedicating significant resources to the duplication of the Network across its 127 hospitals.
4. New Skills Developed by Service Providers: The remote clinics involved in telehealth have increased the technical and clinical skills of their personnel as well as expanding the capabilities and services of their clinics to support more patients.
5. Policy Changes: The Network has examined its bylaws at facilities and physician credentials to make certain that physicians are appropriately credentialed for telemedicine.

Implications for Other Communities

Our successful telehealth network success serves as an operational tele-health model for linking systems of care in an effective, high quality and resource conserving way that would be relevant to rural communities across the country. Our approach models tele-health solutions for clinic specialty services and acute tele-health, such as life-saving tele-stroke management. This is of particular importance in the health care environment that is emphasizing quality, population health management and shared savings approaches in health care reform. It is already being applied as a replication model throughout the Ascension Health Hospital ministry system. The potential 127 hospitals are grouped into networks as hubs and would be able to serve multiple community and rural spokes.

Tennessee

WestCare Tennessee Inc. / WestCare Kentucky, Inc.

Organizational Information	
Grant Number	D06RH21683
Grantee Organization	WestCare Tennessee Inc. / WestCare Kentucky, Inc.
Organization Type	Human Services Organization
Address	10057 Elkhorn Creek Road, Ashcamp, KY 41512-8702
Grantee organization website (if available)	http://www.westcare.com
Name of Network	Hancock County Rural Health Network
Network Director	Name: Jeffery Caudill
	Title: Senior Vice President, WestCare
	Phone number: 606-471-5887
	Fax number: NA
	Email address: Jeffrey Caudill@westcare.com
Project Period (beginning year to end year)	2011 - 2014
Funding level for each budget period	May 2011 to April 2012: $180,000
	May 2012 to April 2013: $180,000
	May 2013 to April 2014: $180,000

Network Partners		
Partner Organization	Location	Organizational Type
Hancock County Mayor's Office	Sneedville, Hancock County, TN	County Government
Hancock County Law Enforcement	Sneedville, Hancock County, TN	Law Enforcement
Hancock County Department of Health	Sneedville, Hancock County, TN	Public Health
Hancock County Health Council	Sneedville, Hancock County, TN	Public Health
Wellmont Health Systems	Sneedville, Hancock County, TN	Healthcare
East Tennessee State University	Morristown, Hamblin County, TN	School Based Health Center
Hancock County Health and Hospice	Sneedville, Hancock County, TN	Healthcare
Hancock County Substance Abuse Coalition	Sneedville, Hancock County, TN	Grassroots Community Leaders
Hancock County School System	Sneedville, Hancock County, TN	Public Education
Community Residents	Sneedville, Hancock County, TN	Community Citizens/Parents
Rural Health Services Consortium	Rogersville, Hawkins County, TN	Primary Healthcare
Hancock County EMS	Sneedville, Hancock County, TN	Emergency Medical Services

Community Characteristics

A. Area

The Hancock County Rural Health Network served Sneedville, TN and Hancock County TN.

B. Community description

Hancock County is nestled in Central Appalachia between the tranquil Clinch and Powell Rivers. Sneedville is located in the heart of the county, serves as the county seat for government and is the largest township within Hancock County. Hancock County has a population of 6,733 people and Sneedville represents only 1,367 of the county residents. The 2010 census data reports the county is 98% white, non-Hispanic. However, the heritage in this area is known as Melungeon, an ancestry mix of European, African and Native Americans most of whom settled in the area to work in the coal mines. The median household income is

$19,760 representing the lowest in the state, and 29.4% of the population lives below the poverty rate. Hancock County ranks at the bottom of the chart for health outcomes and health factors as described in the 2003 Robert Wood Johnson and University of Wisconsin County Health Ranking a Roadmap report, ranking 93 out of 95 counties in health outcomes and 94 out of 95 in health factors. The county exceeds the U.S. Healthy People 2010 Targets in the following areas (percentages over the target): births to women under 18 years (2.4%), infant mortality 5.1% white, non-Hispanic infant mortality (4.4%), lung cancer (101.7%), strokes (68%), unintentional injuries 31.4% and motor vehicle injuries (115.9%). Out of 95 counties in Tennessee, Hancock County ranks 18th in AIDS cases and 6th in syphilis cases in TN with sharp increases in all sexually transmitted disease. Other than a 10 bed, small emergency care facility located in Sneedville, the nearest full service hospital, primary healthcare, social and human services are 30 miles away in nearby Middletown.

C. Need

Sneedville, TN is a small, rural community in the heart of Appalachia experiencing alarming rates of substance abuse, sexually transmitted disease, and other mental health conditions including depression and anxiety disorders. The community is supported by a small, local hospital but has no resources for people seeking help with substance abuse or mental health issues. The economic status of the community is well below the poverty rate and recent challenges with the economy have severely impacted employment opportunities in this area. Poverty conditions add to the challenge of mobility for residents to seek treatment in Middletown. There are no public transportation options available in this area.

For all causes of death, Hancock County reports 400 more deaths than the national average. The Centers for Disease Control's Community Health Status Indicators for 2009 indicated that 495 people reported drug use in the last month which Network members believe is a driving factor in other poor health outcomes that exceed the Healthy People 2010 Targets.
The primary illicit drugs used in Hancock County are marijuana and methamphetamine, with an increasing number of prescription drug abuse cases. Alcohol and tobacco are also widely abused. The local law enforcement representatives, emergency medical personnel, school officials, hospital and public health professionals and community members all agreed during initial planning grant discussions that the number one health goal for Hancock County was to support increased health education and health promotional activities targeting substance abuse and mental health issues and the ability to provide early identification, assessment and referrals to appropriate substance abuse and mental health services. The Network members are committed to curbing drug use in Hancock County to significantly change the out of balance health outcomes in their community.

Program Services

A. Description

The Hancock County Rural Health Network (HCRHN) identified five major activities to be accomplished through this grant program that would expand access, coordinate, and improve the quality of essential health care services, and enhance the delivery of health care, in Hancock County, TN. These activities included the following:

- The Development of a Community Involvement Center where the HCRHN could provide educational classes, conduct health promotion activities, provide literature and educational materials on substance abuse and other mental health conditions, conduct DWI/DUI offender classes, and conduct substance abuse and mental health screenings and assessments and offer licensed outpatient clinical services using tele-health capabilities with resources available in nearby Morristown.
- Conduct Mental Health First Aid Training for key community service personnel including, educators, law enforcement, emergency service providers, faith leaders, health providers and other members of the community. Mental Health First Aid is a 12-hour course that presents an overview of mental illness and substance abuse risk factors, warning signs, common treatments, and ways to refer people for help.
- Implement the SBIRT (Screening, Brief Intervention and Referral to Treatment) developed by the Substance Abuse and Mental Health Services as an evidence-based practice for identifying substance abuse disorders in the primary care setting. The program is designed for implementation in the hospital emergency room setting and is a tool to help identify problems and refer patients to appropriate substance abuse or mental health providers for further assessment and treatment services.
- Implement the IMPACT (Improving Mood – Promoting Access to Collaborative Treatment) which is an evidenced-based intervention for patients who are 60 years or older who have major depression or dysthymic disorders. This is a year-long, stepped, collaborative care approach in which a nurse, social worker, primary care provider or psychologist works with the patient's primary care provider to develop an effective course of treatment. The IMPACT model has been shown to be effective intervention for a range of depressed clients, including adults of all ages and adolescents, individuals with diabetes, cancer and other health conditions that overtime promote poor emotional health conditions.

- Implement tele-health services that would connect local clients with remotely located psychiatrists or licensed substance abuse and mental health professionals for medication management and counseling services.

B. Role of Network Partners

The Network members recognized that the community's lack of substance abuse services is a growing concern for the overall health conditions of the community. Each individual organization that was represented brought voice to the issue from their specialty area. As the strategic plan was developed, the various partner organizations took ownership of solutions that would impact their identified challenges and researched best practices and available programs and services to adopt.

The most energy and effort came from members of the emergency medical community, law enforcement and the local hospital. They agreed that the community needed front line services and responses to substance abuse and mental health concerns and that the professionals working in these areas were under-educated about how to most effectively manage people experiencing substance abuse or mental health issues. Members from these groups brought forward the recommendations of Mental Health First Aid, SBIRT, IMPACT and the idea of tele-health opportunities in the Community Involvement Center.

Outcomes

A. Outcomes and Evaluation Findings

An overall outcome of this project was achieving community readiness and collaboration for seeking future funding for full implementation of the services and activities identified. The strategic planning brought together community health, education and law enforcement leaders combined with a group of concerned citizens who reviewed data, assessed community needs, developed a five-year implementation plan for improving local health services response to substance abuse and mental health problems, strengthening educational efforts that would assist in earlier identification of substance abuse problems and accessing services through tele-health technology and implantation of evidenced-based interventions. As the grant project came to an end, community leaders are still willing to work together to find funding to sustain the effort to fully implement these needed services.

B. Network Collaboration

The technical assistance support from federal program staff and federally supported contract staff was a significant contribution to this effort. In a rural area such as Hancock County, resources are limited. The assistance of outside experts to help guide the strategic planning process, provide on-going support and offer guidance on best practices greatly strengthened and supported project staff. Community leadership brought their passion and experience to the table. Their knowledge and awareness of local health related problems led to quick consensus on the compelling community concerns and viable solutions that were cost effective, evidence-based and could realistically be implemented in this setting.

Challenges & Innovative Solutions

The most compelling challenge of this project was building trust that simple solutions were possible and that the economic conditions and limited resources in this county were not barriers to progress. The people in this community are accustomed to making-due with what they have and getting by. The frustration of seeing the health conditions of their friends, neighbors, family members and clients continue to decline and the emergence of dangerous drugs like methamphetamine in their community inspired and empowered the members of the HCRHN to look beyond current community conditions and seek solutions that could make a significant impact.

By using a formal, strategic planning process, the members were able to engage in rich discussions from various points of view and develop clarity and purpose around both the problem and the solution. The relationships developed through this process by people whose work may loosely touch one another's, enriched their professional relationships by hearing each other's perspectives on a common set of problems. The sharing of these problems from each stakeholder's viewpoint brought about new awareness and their willingness to work together on a joint project to overcome community problems. Network members also developed ideas and discussed better ways of sharing information related to their individual agency's missions outside of the scope of this joint project. This enhanced their trust and gave them hope that the Network could actually accomplish some goals. The development of a health network in Hancock County has gained the trust and support of strategic partners who are fully committed to making change in the lives of their community members and improving health conditions.

Sustainability

A. Network Structure

The County Mayor, County Sheriff and WestCare staff continue meeting to discuss next steps. The discussions include funding for implementation of the services identified by the group, maintaining the Community Involvement Center and supporting tele-health services between the hospital and mental health resources in Middletown. The Network has agreed to continue to meet at least quarterly to continue the discussions of health issues within the county and seek further support to address the identified needs.

B. On-going Projects and Activities/Services To Be Provided

At the end of the project, the current staff members ended their service to the Network and sustainability is fully the responsibility of community members and leaders. Staff from WestCare Tennessee/Kentucky have continued discussions with members of the HRCH Network to explore further funding opportunities and ways to leverage support for continued programming. The Mayor is committed to keeping this effort going. He believes the Community Intervention Center is a helpful resource for this community and is seeking resources to sustain the physical meeting and training space for Twelve-step meetings, educational programming and a referral resource for community members.

Leadership at Wellmount Health Systems is committed to finding a way to bring psychiatric tele-health to this community with the equipment purchased through this grant. With the changes in health care coverage under the Patient Protection Affordable Care Act (PPACA), there may be increased resources to pay for the health provider portion of the tele-health program for psychiatric care and counseling services. Over 3,300 community members receive Medicaid benefits, another 1,000 receive Medicare benefits and a little more than 800 have insurance coverage, the expansion of services available through the PPACA may provide new resources to help members of this community.

C. Sustained Impact

The relationships that were strengthened among Network members will have the largest impact from this program over time. These providers now know much more about what their counterparts do and how they can more synergistically work together to better serve patients/clients/community members. The strategic plan that was developed by the members is realistic, fairly low cost to implement, and most importantly, has passionate commitment from the members to see it through.

The education programs, Mental Health First Aid training and support groups that were started with this grant funding have significantly built capacity in this community to continue to address substance abuse, mental health and other health problems. Law enforcement and Emergency Medical Services (EMS) are more aware of effective measures to handle people under the influence of substances or suffering from mental health problems and refer them to appropriate services, including finding the means to help them have transportation to Middletown for services.

The strengthened relationship between law enforcement, the local hospital, EMS personnel, and healthcare systems in Middletown has and will continue to change the way substance abuse and mental health patients receive care in Hancock County. Overtime, the systems will become better developed to make referrals to care a more seamless process. The collaborative effort from these systems will seek the resources and services needed to meet the challenges they face.

Implications for Other Communities

One of the lessons learned from this grant opportunity is to build a budget that better supports some implementation and development activities in years two and three. The Network experienced frustration in having limited resources to do some pilot programs and begin some of the identified services from the strategic planning process. Additionally, budgeting resources for doing community surveys regarding the work of the Network and more in-depth surveys with Network members that documents awareness, readiness, commitment, and systems changes would assist with motivation and further development of the Network and potential outcomes.

Texas

Southeast Texas Health System (SETHS)

Organizational Information	
Grant Number	D06RH21680
Grantee Organization	Southeast Texas Health System (SETHS)
Organization Type	Non Profit but Taxable Corporation
Address	P.O. Box 947, Goliad, TX 77963
Grantee organization website	www.seths.info
Name of Network	Southeast Texas Health Organization
Network Director	Name: Shannon Calhoun
	Title: Executive Director
	Phone number: 361-645-1762
	Fax number: 361-645-1743
	Email address: scalhoun.sths@att.net
Project Period	2011 - 2014
Funding level for each budget period	May 2011 to April 2012: $179,039
	May 2012 to April 2013: $179,720
	May 2013 to April 2014: $179,989

Network Partners		
Partner Organization	Location	Organizational Type
Columbus Community Hospital	Columbus, Texas	Hospital
Lavaca Medical Center	Hallettsville, Texas	Hospital
Stamford Memorial Hospital	Stamford, Texas	Hospital
Matagorda Regional Medical Center	Bay City, Texas	Hospital
Memorial Medical Center	Port Lavaca, Texas	Hospital
Brazosport Regional Health System	Lake Jackson, Texas	Hospital
Bayside Community Hospital	Anahuac, Texas	Hospital
El Campo Memorial Hospital	El Campo, Texas	Hospital

Community Characteristics

A. Area

Counties served: Colorado, Lavaca, Chambers, Brazoria, Matagorda, Calhoun, Wharton, Jones and Goliad

B. Community description

The Network service area has a total service population of 502,342 (source: US Census 2009 est.). The 9 counties served by the project are overwhelmingly rural and are home to an older and poorer population than much of the rest of Texas and the US. Most of the service area is located in the "settlement region" of Texas. Today, the region features a mix of small employers, ranches and large gas/oil refinery operations, with the largest employers in the network counties being local government and hospitals. The region's rural counties have difficulty in attracting jobs and in achieving economies of scale in the delivery of basic health and human services. Of the 8 participating hospitals in the Network, 5 are located in rural counties. Most of the counties are situated along the Gulf of Mexico between Houston and Corpus Christi. A combination of demographic patterns, hard economic realities, and persistent health manpower shortages challenge the region's rural hospitals and rural and public health clinics. Providers in the service area are challenged by a combination of insufficient and declining reimbursement, low health insurance participation rates and stagnant local economies and incomes. These realities limit their ability to invest in the health information technology (IT) enhancements that would lower their operating costs and improve the quality of the services they offer.

C. Need

The Network was founded on its members' convictions that collaboration is crucial for the region's safety-net providers to not only survive but to improve the region's health system and health status. The SETHS Health Information Network was developed with reference to intensifying health information technology development. The purpose (need) of this project is to implement and sustain system-level health information exchange among 8 community hospitals in order to ultimately improve the health status of individuals and populations.

Program Services

A. Description

Activities conducted through the SETHS Health Information Network include:

- Completed a baseline strategic business plan that included the current state of health IT, member organization analysis, gap analysis and creation of a development and operations plan that included a return on investment (ROI) analysis
- Detailed analysis of the costs associated with building a network HIE (health information exchange) and data warehouse (as part of strategic business plan)
- Engaged network business and clinical leadership in the implementation of HIE/CDW (health information exchange/clinical data warehouse)
- Sustain network HIE/CDW service lines

B. Role of Network Partners

Network Partners commit to:

- Supporting Network Director and Project Director by providing guidance and leadership
- Supporting the Network's purpose through in-kind and cash commitments, where in-kind support includes a 10% project time commitment from each member's IT director and cash commitments include purchasing the direct interface into the Network's HIE
- Working with the Network evaluator and sub-contractors to complete the strategic business plan and reports (as needed)
- Governing the SETHS Health Information Network and actively participating in monthly board meetings

Outcomes

A. Outcomes and Evaluation Findings

- The completed Network Strategic Business Plan (NSBP) connected a health information exchange (HIE) network with a clinical data warehouse (CDW) technology creating analytics capacity that supports the interests of key stakeholders and population health improvement. The emphasis is on sustainability of an HIE network and CDW that will support ongoing quality and performance improvement, disease management, data utilization supporting the ability of SETHS member hospitals to meet the needs of its patient populations and the increasing expectations of payers and regulators.
- SETHS Network hospitals continue to be at different stages of EMR development. Further compounding the issue, the hospital and associated clinics that have adopted, or are in the process of adopting, an EMR have chosen different vendors. SETHS's commitment to pursuing an HIE architecture that is agnostic to various types of EMRs has been well-founded.
- SETHS is emphasizing use of the CDW to capture quality and cost information that can support the value proposition for its rural hospital and clinic members.
- The NSBP points to wide variation in tools used by SETHS members to process data. The consistency in the use of such data should serve to enable SETHS members to help guide the development of the CDW.
- The plans to extend HIE/CDW analytics to supporting diabetes and CVD and other illnesses are nicely aligned with extending the value of the project to a variety of areas to improve quality in population health.
- The gap analysis in the NSBP suggests SETHS members may be somewhat behind in the readiness to meet increasing reporting requirements emerging from CMS, insurers and from Meaningful Use assessors.

B. Network Collaboration

Collaboration is the basis of Southeast Texas Health System. By nature, SETHS is built on "trust and consensus." The SETHS Corporation is managed much like a cooperative, in which their members actively participate in setting their policies and in making

decisions. Members contribute equally to and democratically control the capital of the organization. Benefits to members are in proportion to their engagement with the cooperative and mutual support of activities.

Historically, SETHS develops a product or service which is then affirmed by board action. For those projects that are initially supported by grant funds (which are used for infrastructure and not sustainability), they are planned and budgeted for a proof a concept period. Once the proof of concept (which includes the consideration of value to others) is made, the products and services are offered to "customers." Specific projects managed by SETHS, such as HIE, will be overseen by a workgroup and/or committee which would include any stakeholders not represented by the SETHS board.

Challenges & Innovative Solutions

The Network's biggest challenge is that the national landscape for Health Information Exchange continues to change and evolve. The project supported by this grant focused on HIE that supports data collection, aggregation and analysis to respond to healthcare reform; basically requiring the members to try a proactive model (rather than reactive). This chaos in the industry creates lack of clarity in setting the targets for return on investment and sustainability, as well as the technology design and parameters, which we tried to incorporate from the start. To resolve this challenge, the project staff was committed to incorporating flexibility in the plan design while still moving forward on the set timelines. The Network continues to seek collaboration with other entities to manage costs associated with the HIE.

Sustainability

A. Network Structure

Southeast Texas Health System (SETHS) is a Texas nonprofit corporation equally owned by 9 hospitals. Formed in 1994, SETHS' purpose is to collaborate to create economies of scale and scope in the delivery of healthcare in the region. *"The Members share common goals of operating a cost-effective, quality integrated healthcare delivery system to provide a continuum of health care services and products that offer greater efficiency, economy, quality and availability of such services than the individual providers can offer alone." (SETHS Bylaws 1997).* Southeast Texas Hospital System is a Texas nonprofit corporation "doing business as" Southeast Texas Health System (SETHS). SETHS' subsidiary is Southeast Texas Physician Organization, a nonprofit health organization under the Texas medical Board Chapter 177 Section 162.001. SETHS is owned by 9 independent hospitals. SETHS, as stated in its bylaws, is governed by a board of directors who are the appointed representatives from each of the Member/owner hospitals. Generally, the representative is the CEO or CFO of the Member hospital. Southeast Texas Physician Organization (SETPO) is the physician arm and subsidiary of SETHS, and is governed by a board of physicians who represent the markets of SETHS' Members.

SETHS has historically used grants to support infrastructure development for specific projects while requiring membership contribution/participation from the beginning. All budgets include membership matches and contributions so that the transition out of a grant period is successful and the project is sustained. SETHS is managed much like a cooperative, where members actively participate in setting their policies and making decisions regarding the business. Members contribute equally to, and democratically control, the capital of their company. The HIE will be managed in the same manner, where the members contribute funds and efforts to the HIE project during the grant period. Once the grant period is over and proof of concept is sound, the project will transition to a rural utility cooperative model. Staffing is generally outsourced to the HIE vendor or contracted Project Lead and Project Managers.

B. On-going Projects and Activities/Services To Be Provided

The parent network, SETHS, has been sustainable without network grant funding for many years. The project developed with this grant is moving to a revenue generating HIE service and currently has 6 customers. Customers of the HIE service will provide network sustainability thru monthly subscription fees.

In addition to the HIE services provided, SETHS has other revenue-producing products and services it offers. These include managed care contracting, a preferred provider organization (PPO), an independent physician association (IPA) and an outpatient diabetes self-management training program (DSMT). The startup cost for the DSMT program, named DOTS (diabetes outpatient training sites), was partially funded thru a small healthcare quality improvement HRSA grant and continues to be sustained.

C. Sustained Impact

The sustained impact of this grant is that it has provided the foundation for rural physicians and hospitals to engage in the healthcare transformation by preparing for Accountable Care Organization (ACO) participation and by developing and implementing a health information exchange. This not only sustains the activity funded by the grant but also provides promise for rural healthcare safety-net communities to be sustained. This will improve the health of residents in the communities served for years to come.

Implications for Other Communities

There are issues specific to rural providers that must be taken into account when designing, implementing and sustaining rural systems and infrastructure. The SETHS experience during this grant has helped define and plan strategies to address issues relating to establishing an HIE/CDR and preparing for advancement of ACO's and payment reform.

Also, the most important outcome for SETHS is that ANY grant funded activity and participation in that activity is based on the assumption that none of the hospitals get access to the project for free. Grant activity is viewed as funding for infrastructure building and a sustainable business model is included in the application as well as matches in cash and in-kind contribution. Requiring participation in time and money creates a valued ownership in the project.

Virginia

Giles Free Clinic

Organizational Information	
Grant Number	D06RH21670
Grantee Organization	Giles Free Clinic
Organization Type	Health Clinic
Address	219 Buchanan St. Pearisburg, VA 24134
Grantee organization website	www.nrvfreeclinic.org
Name of Network	Giles County Health Network (G-NET)
Network Director	Name: Michelle Brauns
	Title: Executive Director
	Phone number: 540-381-0820
	Fax number: 540-382-3391
	Email address: mbrauns@nrvfreeclinic.org
Project Period	2011 - 2014
Funding level for each budget period	May 2011 to April 2012: $181,245
	May 2012 to April 2013: $180,000
	May 2013 to April 2014: $180,000

Network Partners		
Partner Organization	Location	Organizational Type
Giles Free Clinic	Pearisburg/Giles County/VA	Charity Health Clinic
Carilion Giles Community Hospital	Pearisburg/Giles County/VA	Critical Access Hospital
NRV Cares	Pearisburg/Giles County/VA	Child abuse prevention organization
New River Community Action	Pearisburg/Giles County/VA	Head Start/CHIP Community service organization
NRV Community Services	Pearisburg/Giles County/VA	MH, Substance abuse services
Family Dental Clinic	Christiansburg/Montgomery County/VA	Charity Dental Clinic
Giles Health and Family Center	Pearisburg/Giles County/VA	Adult/Child daycare and transportation services

Community Characteristics

A. Area

The Giles Health Network (G-NET) serves rural Giles County, Virginia. Giles County, part of the New River Valley Planning District, is located within the far southwestern part of Virginia. This area is commonly referred to as Rural Appalachia. The area is bordered on the south by the Blue Ridge Mountains and the north by the Alleghany Mountains. One of the oldest rivers in America, The New River, runs through this region. West Virginia borders Giles County on the northwest boundary. Giles County is approximately 357 square miles. The area is comprised of the following towns: Pearisburg, Narrows, Glen Lyn, Rich Creek, and Pembroke. Of these towns, Pearisburg, Narrows, Glen Lyn, and Rich Creek are federally designated as rural census tracts. Pearisburg is the County Seat.

B. Community description

Giles County is a picturesque region of Appalachian America, with rolling hills, cliffs, rivers and streams. It is quite rural and topographically isolated, and is culturally insulated due to the predominant Appalachian culture which devalues prevention behaviors and professional health intervention. The population base of 17,358 exhibits high indicators of poverty, unemployment,

uninsurance and child abuse—all much higher than statewide averages. The entire County is a medically underserved area where cancer and diabetes as well as hypertension and heart disease rates are very high.

C. Need

G-NET is a community-based, vertical health network that serves a target population of low-income, under- and uninsured residents of Giles County. Due to the County's geographic isolation, cultural insulation, and poverty, residents have limited financial and physical access to medical care, dental care, and mental health care. Transportation and provider shortages have been identified as primary barriers to the receipt of health care services. G-NET aims to expand access to health care services in Giles County, and to facilitate the addition of non-emergency medical transportation services and cultural training of medical professionals.

Program Services

A. Description

The Vision of G-NET is that Giles County, Virginia is a community of healthy and productive people, made possible through accessible and equitable essential health care services for residents of all ages, races, cultures, ethnicities, religions, and income levels.

The Mission of G-NET is to facilitate and expand the delivery of health care services to the people of Giles County through the development of a vertical health network that integrates existing and future health care services administratively, clinically, and financially, and expands access to essential health care services.

Through a Strategic Planning process, four distinct goals were articulated to achieve this vision and mission. The first goal focuses on expanded access to health-related services for the target population. Included under this goal are primary care services at the Giles Free Clinic, oral health care services for adults and children at the new Family Dental Clinic of the New River Valley, behavioral health services delivered by multiple partners at the Giles Free Clinic, and parenting education delivered by NRV Cares. Expanded access is accomplished by implementing agency-specific and inter-agency efficiencies and securing new resources for G-NET member organizations. Securing the funding to implement a new non-emergency medical transportation system for indigent patients was also included as a key objective.

The second goal relates to ease of access to health-related services. Key objectives include the creation of a "No Wrong Door" system entry process, development of a communications plan to promote health service consumption, electronic sharing of medical records, and Appalachian cultural competency training for staff and volunteers of G-NET organizations.

A third goal concerns the sustainability of G-NET beyond the three years of federal grant funding. Objectives here include the creation of a Sustainability Strategy, and exploration of the benefits of distinct non-profit status for G-NET.

The fourth and final goal focuses on cost savings and increased revenue for G-NET member organizations. Objectives under this goal relate to staff sharing, diversion of inappropriate admissions to the hospital's Emergency Department, and the pursuit of new public and private funding opportunities for the Network as a whole and individual member organizations.

B. Role of Network Partners

Each G-NET member organization assigned one staff person, typically the Executive Director or CEO, to sit on the Network Governing Board, which met monthly over the first year and bi-monthly thereafter. Each organization, through their Governing Board member, brought unique energies and expertise to the Network planning and implementation process.

The Giles Free Clinic, as the lead organization and grantee, managed the G-NET Governing Board meetings, arranged the Strategic and Sustainability Planning process, secured Network office space, and hired/supervised the Network staff and consultants.

All G-NET member organizations participated in the Strategic Planning and Sustainability Planning process. Each contributed to the Network's development and success with expertise specific to their missions, but most importantly, with a new-found sense of camaraderie brought about by regular and in-depth planning sessions, "big picture" thinking, and creative system-wide problem solving.

Some Network members were involved primarily in specific Network projects (such as NRV Cares adding parenting classed taught in Giles County at the G-NET office), while others represented their specific client population in the planning for all Network initiatives (such as New River Community Action representing Head Start families in the planning for increased dental access). Network member Giles Health and Family Services assumed a large role, in that they were a key player in the development of the non-medical transportation service (G-REACH) that was planned and implemented by G-NET. Network member Carilion Giles Community Hospital (the County's Critical Access Hospital), was active in the G-NET project to educate residents on appropriate usage of the emergency department.

Outcomes

A. Outcomes and Evaluation Findings

Highlights of the *process* evaluation include:

1. Since May 2011, a total of 20 G-NET Governing Board meetings have been held. Attendance has been exceptionally good. At 100 percent of the meetings held, over 75 percent of the Board members were present. A quorum has been achieved at all meetings.
2. Overwhelmingly, G-NET Governing Board members feel: That the meetings are a good use of their time, that the Governing Board is making progress toward meaningful collaboration, that they understand their responsibilities and assignments, that they are allowed to express ideas at the meetings, that their ideas are received with respect and thoughtful consideration, that G-NET will accomplish its goals, and that the meetings are well organized and pleasant to attend. One-hundred percent of responses after 18 meetings were either "Highly Agree" or "Agree" with the above statements. No responses of "Disagree" or "Highly Disagree" were received.
3. The Network developed a comprehensive Four-Year Strategic Plan, and stuck closely to that Plan throughout the 3-year grant period. A large majority of Action Steps were completed as planned within the first 3 years, and the remainder are on track for completion in the 4th year.
4. G-NET successfully branded itself, including launching its own website, and has become a recognizable source of health information, education, and access for the community.

Highlights of the *outcome* evaluation include:

5. G-NET has successfully addressed the transportation barrier by implementing a new program, G-REACH, which was funded by a subsequent HRSA Rural Health Care Services Outreach Program grant.
6. G-NET has actively addressed the limited oral health access in the County by researching need, and designing and submitted a grant proposal for an expanded Network initiative specifically dedicated to expanding oral health access in Giles County.
7. G-NET has sponsored three annual Appalachian Cultural Competency Trainings for health professionals, each a full-day workshop. In total, 140 health professionals and volunteers have completed the training. The training consistently receives excellent evaluations from participants.
8. Since the inception of G-NET (CY13 compared to CY11), the Giles Free Clinic has witnessed a 36.0% increase in total number of medical visits provided, and a 14.6% increase in unduplicated patients served.
9. Since the inception of G-NET (CY13 compared to CY11), the total number of patients who received behavioral health services at the Giles Free Clinic has risen by a dramatic 218.2 %. The number of behavioral health visits has risen 106.4%.
10. Since the inception of G-NET (FY13 compared to FY11), the number of Giles County at-risk parents who completed the *Parenting Young Children* curriculum increased from 0 to 20.
11. Since the inception of G-NET (FY13 compared to FY11), the number of low-cost, non-emergency medical transports to uninsured passengers increased from 0 to 589.

B. Network Collaboration

Process evaluation results indicate that G-NET Governing Board members value the Network and their participation on the Governing Board, feel positive about their work, and believe that G-NET will accomplish its goals. Satisfaction with both the process of Network governance and current outcomes is high across all members.

As evidenced by the exemplary meeting attendance history, all members of the Governing Board are highly active in G-NET. Their organizations are also highly aware of activities, and often participate. G-NET has become a widely-known entity, and is highly regarded County-wide. As an example, when G-NET held the ribbon-cutting ceremony for G-REACH (the medical transportation program), all member organizations sent staff and volunteers. The lawn in front of the G-NET office was full of people of all ages

and circumstances, all with different needs or working in different health fields. The speakers at the event included a US Congressman and a Virginia House of Delegates Member, and the local Mayor. This was truly a successful collaboration that was worthy of the outpouring of congratulations that it received.

Collaboration goes beyond celebrations. Member organization staff attend Advisory Group meetings for G-REACH, and help with arrangements for educational events, collateral distribution, and website management. All member organizations have committed to sending a majority of staff and volunteers to the annual Appalachian Cultural Competency Trainings held by G-NET, and most have already accomplished that goal. Coming together in October each year for that training is a distinct honor and pleasure for everyone in attendance, and fosters a collaborative mindset.

G-NET is governed by a formal Governing Board. All of the G-NET Member Organizations appoint one member to the G-NET Governing Board. This member is most typically the CEO of the organization, preferred because of the decision-making authority typically held by a person holding this position. Turn-over of a representative has occurred only twice, both times due to retirement of the member. The authority of the G-NET Governing Board members, and their longevity on the Governing Board, are critical to the efficient decision-making and follow-thorough that G-NET realizes.

The success of implementing the G-REACH Program is illustrative of the ability of G-NET to collaborate on the implementation of a program that is evidence-based, and to adapt it to the unique cultural and geographic attributes of Giles County. The G-NET Strategic Plan outlined medical transportation as a priority area for Network focus. G-REACH has fulfilled that priority.

Challenges & Innovative Solutions

Challenges included the transition of the CEO at the Critical Access Hospital during the grant period. The Network was fearful that the successor would not be as engaged, invested, or participative in the Network as his predecessor. Fortunately, the new Director of the Hospital is extremely engaged, and has embraced the Network and its activities as his personal top priorities moving forward.

Dental care access was a programmatic challenge. Initially, the Network proposed that the G-REACH transportation service would provide transportation from Giles County to the Family Dental Clinic (a charity dental clinic) in Christiansburg, Virginia, 44 miles away. The Giles County population has not made use of this arrangement , making a local affordable oral health clinic even more of a necessity. In response, G-NET developed the G-SMILE Program, a new initiative that will provide a 2-chair dental operatory at the Giles Free Clinic facility in the heart of Giles County. Hopefully, G-SMILE will become a reality in the summer of 2014.

Sustainability

A. Network Structure

G-NET will continue, and will grow stronger. Management will continue as it is now, with the Giles Free Clinic employing the Network staff, and the G-NET office remaining in place. The Network Governing Board will continue to meet bi-monthly to prioritize projects, assign tasks, and plan for future collaborative initiatives. G-NET will create new programming, always focusing on those individuals and families who have barriers to accessing health care services within Giles County.

In the two years since the Network's Strategic Plan was developed, a Giles County Comprehensive Needs Assessment has been completed, and much has changed in the national and state health care environment. Healthcare advocates are hopeful that Medicaid will be expanded in Virginia in the summer of 2014. And in September 2013, the Giles Free Clinic (along with its parent organization, the Free Clinic of the New River Valley) was successful in obtaining designation as a Community Health Center under HRSA's Bureau of Primary Health Care. The official transition from a free clinic to a Community Health Center occurred on January 8, 2014. Pursuit and successful receipt of Community Health Center designation for the Giles Free Clinic was a central component of the Sustainability Plan for G-NET as a whole.

B. On-going Projects and Activities/Services To Be Provided

G-NET is currently focusing on the problem of oral health access, with a new program named G-SMILE. Every Network member organization will have a role in the development and success of G-SMILE. G-SMILE will achieve efficiencies through integration of services, and strengthen the rural health care system in Giles County as a whole. Two oral health promising practices will be adapted. The first creates community collaborations to educate and add people to the dental care pipeline. The second focuses

on the integration of dental and medical care at the Giles Free Clinic (now the Giles Community Health Center). G-SMILE will solve logistical problems for Network organizations, and greatly enhance acceptability of and access to oral health services for people served by all Network member organizations. Ultimately, the health status of the entire County will improve.

C. Sustained Impact

Central to the Sustainability Planning that has occurred, the Governing Board identified the many positive impacts of G-NET. These include impacts in collaboration (moving beyond turfism, avoidance of duplication, maximizing limited resources), improved service models (a new medical transportation system, appropriate ED diversion, system-wide referrals for parenting classes), increased capacity in the local system (joint planning for a Community Health Center, health navigation services, increased behavioral health services, increased productivity at the Giles Free Clinic), new policies (a fee policy for G-REACH, an ED diversion plan), and changes in knowledge, attitudes and behaviors (Appalachian cultural competency increased, needs assessment data being widely used, better and more frequent information sharing).

Implications for Other Communities

G-NET is a formal, established, and integrated vertical health network that has combined the functions of the seven member organizations to improve the health status of rural Giles County, Virginia. Since its formalization in 2011, G-NET has implemented evidence-based, collaborative strategies for the health improvement of Giles County, Virginia residents.

The topical areas of achieving efficiencies and strengthening the rural health system as a whole can best be accomplished as a group effort. In an isolated community such as Giles County, the tendency is for non-profits to compete over the few resources available. Turfism is often the status quo. Networks alleviate this turfism. G-NET has been successful at maximizing limited rural health resources, and bringing together those organizations that might have before “fought over scraps” of funding.