

# Grantee Sourcebook

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## Rural Health Network Development Grant Program, 2014 - 2017

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## Sourcebook Overview

The Rural Health Network Development (RHND) *Grantee Sourcebook* tells the story of the fifty-four 2014-2017 RHND grantees by highlighting their grant projects' achievements and solutions to challenges during the life of their grant.

The document begins with the "Background and Purpose" section, providing a description of the RHND Program Grant funding opportunity and is followed by a high-level summary of grant project accomplishments in terms of impact on rural communities, including sections on "Impact of Networks Across the Country" and "Impact Beyond the Networks". A directory listing of grantees is also provided. The listings are organized first by state and then by grant project focus areas. These listings allow for easy navigation through the document.

The second part of the *Grantee Sourcebook* includes individual grantee profiles, organized in alphabetical order by state. These profiles include:

- Network Description
- Contact Information
- Mission and Vision
- Member Types
- Environmental Analysis
  - Population Needs
  - Population Served
  - Blocks and Levers
- Grant Project Description
  - Background
  - Strategic Objectives
  - Key Initiatives
- Challenges and Innovative Solutions
- Network Continuation
- Project Officer's Contact Information

The information published within the *Grantee Sourcebook* was gathered through:

- Input directly from the RHND grantees through Network TA Assessments conducted by the Rural Health Innovations (RHI) network technical assistance (TA) team throughout the 2014-2017 program
- RHND grant project final reports, provided as reference documents to RHI network TA team from the Federal Office of Rural Health Policy (FORHP)
- RHND Year 3 Performance Information Management System (PIMS) Report, published in 2018

## Background and Purpose

The purpose of the RHND Grant Program, funded by the FORHP, is to assist health-focused networks in developing and maintaining sustainable networks with self-generating revenue streams. These networks implement activities that benefit both network partners and the communities served by the network; increasing access and quality of rural health care and ultimately improving the health status of rural residents.

The RHND Grant Program provided federal funding up to \$300,000 annually over three years of the program (2014-2017) to 54 rural health networks. Each network consisted of at least three separately owned health care providers who signed a Memorandum of Agreement or a similar formalized collaborative agreement. While specific network activities varied, each network was required to focus on at least one of the three legislative charges described below.

### **Legislative Charge I: Achieve Efficiencies**

Topical Area I: Integrated health networks will focus on integrating health care services and/or health care delivery of services to achieve efficiencies and improve rural health care services.

### **Legislative Charge II: Expand access to, coordinate, and improve the quality of essential health care services**

Topical Area I: Integrated health networks will collaborate to expand access to and improve the quality of essential health care services by focusing on projects and/or network activities directly related to the evolving health care environment.

### **Legislative Charge III: Strengthen the rural health care system as a whole**

Topical Area I: Networks will improve population health by implementing promising practices, evidence-informed and/or evidence-based approaches to address health disparities in their communities.

Topical Area II: Integrated Health Networks will collaborate to achieve population health goals through the use of technology.

## Impact of Networks Across the Country

Through analysis of grantee final reports and summarized PIMS results, some common themes emerged regarding network impacts. Following is a summary of key findings and common themes, organized by legislative charge. It should be noted that a distinct separation of impacts by legislative charge is challenging, as an improvement in one area tends to meld into another. For example, improved integration of health care services often leads to improved access and quality of care. However, all of the impacts feed into the overall goal of improving the rural health care system and the health of the populations it serves.

### **Legislative Charge I: Achieve Efficiencies**

Grantees rose to the challenge of achieving efficiencies primarily through improved integration of health care services. Examples of programs' successes include:

- Connecting chronic disease patients with outpatient support services
- Coordination between providers and schools
- Increasing emergency department diversions with hospital referrals for oral health care
- Integration of behavioral health through either "warm handoffs" from clinicians to behavioral health professionals, or co-locating primary care services at mental health centers
- Integrating social service support (e.g., financial and transportation assistance) into medical practice through referrals
- Training, certification, and employment of Community Health Workers to serve as vehicles for care integration of medical, behavioral, and social services

In order to achieve efficiencies, many of the networks participated in or supported at least one quality improvement initiative during the grant period. Care coordination was the most common target of quality improvement initiative.

### **Legislative Charge II: Expand access to, coordinate, and improve the quality of essential health care services**

By the end of the grant period, new programs or services were implemented because of network activities funded through the RHND program. These programs and services provided new or expanded access. Examples of programs' successes include:

- Improved access to oral health, behavioral health, health education, and health care enrollment
- Improved quality of care for patients with chronic disease or with comorbidities, those at risk for stroke, or diabetes
- Use of telemedicine to improve access to mental health providers and medical specialists

The most commonly reported new or expanded services were health education, health promotion/disease management, case management, and mental/behavioral health.

### **Legislative Charge III: Strengthen the rural health care system as a whole**

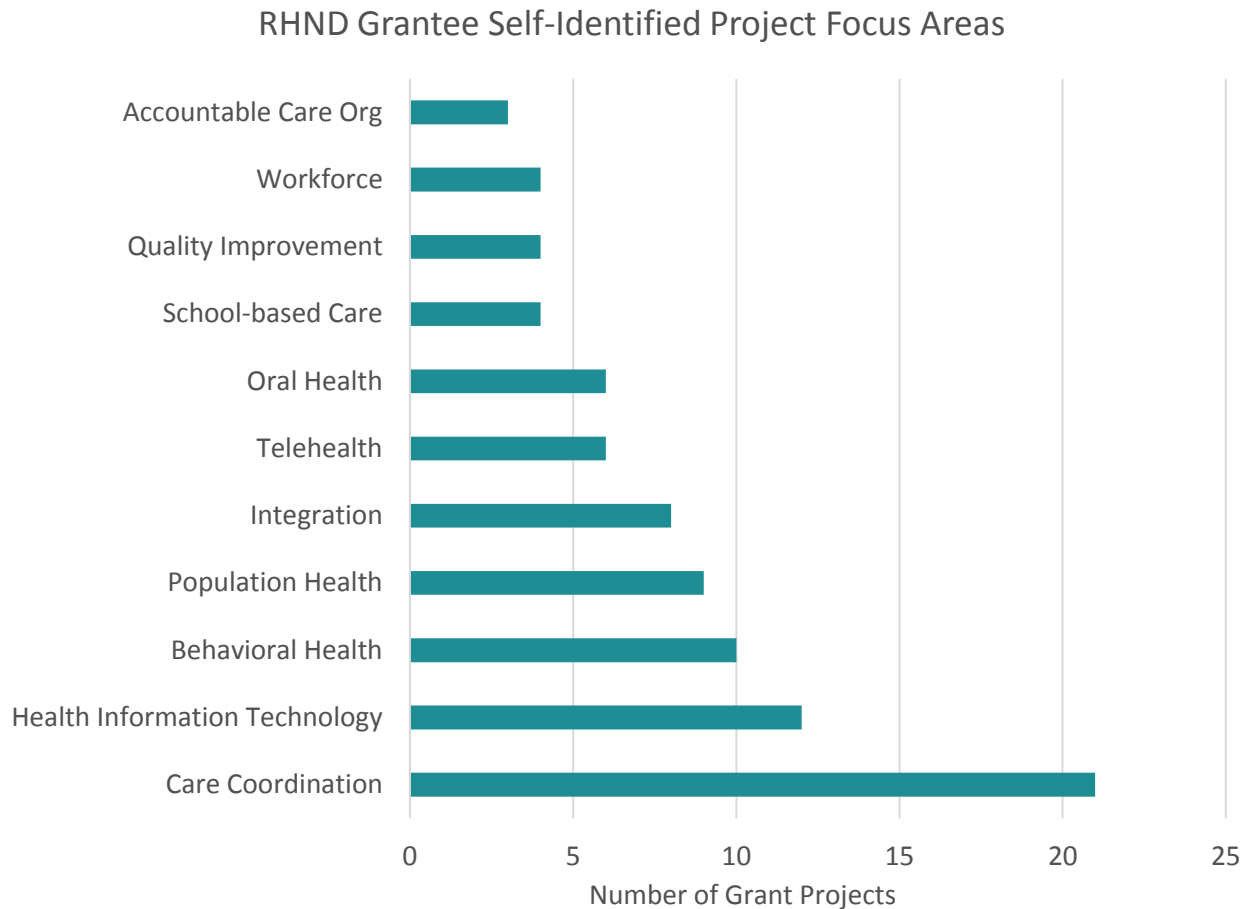
Technology played a critical role in grantees' efforts to strengthen the rural health care system. Many award recipients indicated that they had implemented, expanded or strengthened at least one form of Health Information Technology (HIT) during the course of the grant period. The most commonly reported change was to electronic medical records. Other identified changes were telehealth/telemedicine and health information exchange. Common technology-related successes include:

- Improved data analytics and reporting capacity
- Standardized data collection practices across network members

## Breadth of Grantee Projects Focus on Improved Health

The 54 grantees self-identified areas of project focus. The 10 focus areas, all of which aim at improving health and rural communities, are derived from the three legislative charges, and are listed below. Note: many grantees identified more than one focus area.

Figure 1. Self-identified focus areas of the RHND projects.



The grantee project focus areas included in Figure 1 corresponds to the listing of Grantees by Focus Area section included within this *Grantee Sourcebook* and as part of the Individual Grantee Profiles section.

## Impact Beyond the Network

### Unexpected Reach

When grantees were asked about the unexpected impact of network activities, a common theme of *unexpected reach* emerged. In some cases, this “reach” expanded impact of the network to a broader geographic area than originally intended, and in other cases, it expanded benefits to groups beyond those originally targeted. Examples of unexpected reach include:

- Development of telehealth expertise, in one instance resulting in a tele-dental billing model that will be replicated in other areas of health care statewide. In another instance, a grantee was recruited to lead a statewide consortium tasked with creating the first statewide credentialing program for telehealth professionals in the country.
- Formation of statewide Community Health Worker (CHW) organizations in more than one state as a direct result of grantee work.
- Streamlining of billing processes, in one case creating significant savings for county taxpayers by diverting the costs of providing health care during incarceration from county taxpayers to individuals’ Health Management Organization (HMO’s).

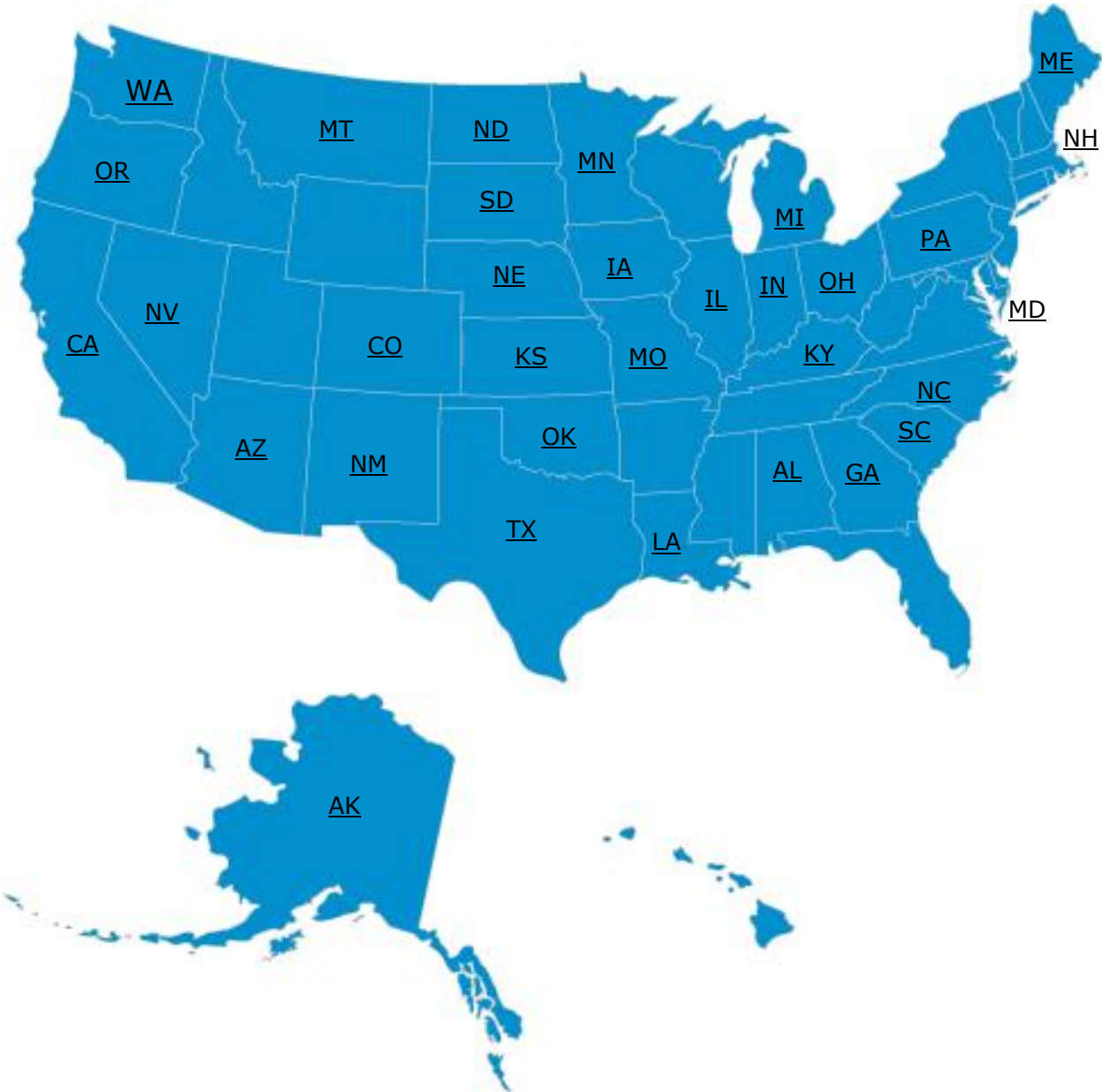
### Relationships Outside the Network

Another commonly reported unexpected outcome was the development of relationships outside the network, sometimes across state lines. Examples of these types of relationships include:

- A collaborative relationship developed between two networks in different states as a result of a request for guidance about Accountable Care Organizations (ACO’s); demonstrating a common practice of information and knowledge sharing.
- Another grantee built relationships with providers in adjacent states that led to the streamlining of transfer and referral processes across state lines, allowing telehealth services to be delivered in locations where it was previously unavailable.
- Partnerships formed between networks and academic institutions. These relationships have allowed networks to expand their clinical services and expertise while attracting practitioners to their regions.



# Grantees by State



## Grantees by State

### Alabama

North Baldwin Rural Health Network

Get Healthy Talladega County Network (GHTCN)

### Alaska

Prince of Wales Health Network

### Arizona

Arizona Rural Women's Health Network

Santa Cruz County Adolescent Wellness Network

### California

CA299 Health Collaborative

Health Leadership Policy Network

North Coast Clinics Network

### Colorado

Tri-County Health Network

Western Healthcare Alliance

### Georgia

South Georgia Regional Prevention Coalition

Teledentistry Network

### Illinois

Illinois Rural Health Network

### Indiana

Affiliated Service Providers of Indiana, Inc.

Indiana State Rural Health Network (InSRHN)

### Iowa

Wright Health Partners

### Kansas

Kansas Frontier Community Health Improvement Network

### Kentucky

Kentucky Rural HIT Network

Western Appalachian Kentucky Health Care Access Network

## Louisiana

Emergency Rural HIT Project

## Maine

Maine Rural Health Innovations Network (MRHIN)

## Maryland

Mountain Health Alliance

## Michigan

MI-Connect Network

Michigan Resuscitation Consortium

## Minnesota

Northern Minnesota Network

## Missouri

Effective Care Transitions for Rural Missouri

## Montana

Monida Healthcare Network

Northcentral Montana HIT Alliance

## Nebraska

Region 3 Behavioral Health Network

## Nevada

Nevada Rural Hospital Partners

Nevada Rural Health Network

## New Hampshire

Community Health Access Network (CHAN)

North Country Health Consortium

## New Mexico

New Mexico Primary Care Training Consortium

New Mexico Rural Hospital Network

## North Carolina

Foothills Health Network

## North Dakota

ND Critical Access Hospital Quality Network

## Ohio

Integrating Professionals for Appalachian Children (IPAC)

## Oklahoma

Rural Health Network of Oklahoma

## Oregon

Coast to Cascades Community Wellness Network

Northeast Oregon Network

## Pennsylvania

Keystone HIE (KeyHIE)

## South Carolina

Palmetto Care Connections

Upper Midlands Rural Health Network

## South Dakota

One Connect Emergency

## Texas

Texas Rural Accountable Care Organization (TRACO)

## Vermont

Behavioral Health Network of Vermont, d.b.a. Vermont Care Network

## Virginia

Giles County Health Network (G-NET)

## Washington

Children's Village Trustees

Critical Access Hospital Network (CAHN)

Medical Information Network North Sound (MIN-NS)

Washington Rural Health Collaborative

## Wisconsin

Rural Wisconsin Health Cooperative (RWHC)

Safetyweb Network

## Grantees by Focus Area

(Grantees may appear in more than one category)

### Accountable Care Organization

New Mexico Rural Hospital Network  
Texas Rural Accountable Care Organization (TRACO)  
Western Healthcare Alliance (WHA)

### Behavioral Health

Nevada Rural Hospital Partners  
Children's Village Trustees  
Critical Access Hospital Network (CAHN)  
Illinois Rural Health Network  
Kansas Frontier Community Health Improvement Network  
MI-Connect Network  
Monida Healthcare Network  
Prince of Wales Health Network  
Rural Wisconsin Health Cooperative (RWHC)  
Tri-County Health Network

### Care Coordination

Affiliated Service Providers of Indiana, Inc. (ASPIN)  
Arizona Rural Women's Health Network (AzRWHN)  
Children's Village Trustees  
Foothills Health Network  
Get Healthy Talladega County Network (GHTCN)  
Illinois Rural Health Network  
Indiana State Rural Health Network (InSRHN)  
Integrating Professionals for Appalachian Children (IPAC)  
Kansas Frontier Community Health Improvement Network  
Kentucky Rural HIT Network (KRHIT)

Keystone HIE (KeyHIE)  
Mountain Health Alliance  
Nevada Rural Hospital Partners  
North Baldwin Rural Health Network (NBRHN)  
North Country Health Consortium (NCHC)  
Northcentral Montana HIT Alliance  
Northeast Oregon Network (NEON)  
Western Healthcare Alliance (WHA)  
Western Appalachian Kentucky Health Care Access Network  
Wright Health Partners  
Upper Midlands Rural Health Network

## Integration

Critical Access Hospital Network (CAHN)  
Effective Care Transitions for Rural Missouri  
Kansas Frontier Community Health Improvement Network  
MI-Connect Network  
Monida Healthcare Network  
Santa Cruz County Adolescent Wellness Network  
Rural Wisconsin Health Cooperative (RWHC)  
Tri-County Health Network

## Oral Health

Coast to Cascades Community Wellness Network  
Effective Care Transitions for Rural Missouri  
Giles County Health Network (G-NET)  
MI-Connect Network  
Mountain Health Alliance  
Teledentistry Network

## Population Health

Foothills Health Network

Health Leadership Policy Network (HLPN)

Indiana State Rural Health Network (InSRHN)

Michigan Resuscitation Consortium (MiResCu)

Mountain Health Alliance

North Coast Clinics Network (NCCN)

Prince of Wales Health Network

Maine Rural Health Innovations Network (MRHIN)

Western Appalachian Kentucky Health Care Access Network

## Quality Improvement

Community Health Access Network (CHAN)

Nevada Rural Hospital Partners

North Coast Clinics Network (NCCN)

Washington Rural Health Collaborative

## School-Based Care

Get Healthy Talladega County Network (GHTCN)

MI-Connect Network

Santa Cruz County Adolescent Wellness Network

South Georgia Regional Prevention Coalition

## Telehealth

Nevada Rural Hospital Partners

One Connect Emergency

Palmetto Care Connections

Rural Health Network of Oklahoma

South Georgia Regional Prevention Coalition

Teledentistry Network

## Workforce

CA299 Health Collaborative  
Nevada Rural Health Network  
New Mexico Primary Care Training Consortium  
North Country Health Consortium (NCHC)

## Health Information Technology/Health Information Exchange

Behavioral Health Network of Vermont d.b.a. Vermont Care Network  
CA299 Health Collaborative  
Emergency Rural HIT Project (E-RHIT)  
Kentucky Rural HIT Network (KRHIT)  
Keystone HIE (KeyHIE)  
Medical Information Network North Sound (MIN-NS)  
ND Critical Access Hospital (CAH) Quality Network  
Northern Minnesota Network (NMN)  
Region 3 Behavioral Health Network  
Rural Wisconsin Health Cooperative (RWHC)  
Safetyweb Network  
Texas Rural Accountable Care Organization (TRACO)  
Washington Rural Health Collaborative



# Individual Grantee Profiles

Alphabetical by State

## ALABAMA (2)

### Get Healthy Talladega County Network (GHTCN)

Sylacauga Alliance For Family Enhancement

#### **Network Description**

Grant Number: D06RH26841

Organization Type: Information not available

Address: 78 Betsy Ross Lane/P.O. Box 1122 – Sylacauga, AL 35150

Website: [www.gethealthytalladegacounty.org](http://www.gethealthytalladegacounty.org)

Year Formed: 1999

Network Contact:

Nancy Dickson

Director

(256) 245-4343

[dicksonn@safesylacauga.com](mailto:dicksonn@safesylacauga.com)

Members:

Medical centers, university, city and county schools, public health, extension services.

Mission:

To develop a collaborative network to promote health and wellness in Talladega County through education, engagement and the implementation of strategic health and wellness initiatives.

Vision:

To achieve a sustained culture of health and wellness within Talladega County.

Member Needs:

- Create synergy across all community providers.
- Connect people with needs to resources to ensure successful transitions in care.
- Create a healthy Talladega County with measurable and sustainable outcomes.
- Decrease hospital readmission through care management.
- Electronic case management tool
- Telehealth capacity

Governance: The Governance Committee is made up of a designated representative of each of the primary partners who have signed Memoranda of Understanding with the fiscal agent/lead agency (SAFE). Primary Partners designate one member to the Governance Committee and one alternate who can serve as a decision maker on behalf of their organization. Ex-officio members of the Governance Committee are Community of Practice Chairpersons. Members of the Governance Committee choose a Chairperson who presides at Governance Committee meetings. Meetings of the Governance Committee are held every other month at a time and date set by the committee.

## Environmental Analysis

Geographical Area: Talladega County

Population Need: Improving connections for residents to appropriate health care resources and services, improving connections for health care providers to patients' health maintenance information, and educating the public on existing health care resources and services.

Blocks:

- Participation and engagement: The Community of Practice Model is predicated on participation and engagement, the creation of social capital, and a joint enterprise that creates a shared understanding of what binds them together. This requires time, training, and capacity-building to accomplish the work. Engaging providers and stakeholders in this work is critical and requires commitments of time outside of the day-to-day responsibilities of these individuals. The challenge will be availability and time. As the Communities of Practice move forward, flexibility and function must be addressed by the membership with sensitivity to the scheduling challenges in a healthcare and community provider environment.
- Complexity of disease management for individuals with multiple chronic conditions: Limited income, low health literacy, transportation, and other environmental stressors may challenge participants to improve or modify their behaviors. In these cases, the optimal scenario may be limitation of further deterioration of their conditions and a strong early prevention model.
- Resources: In rural Talladega county, resource-sharing is the norm. However, both financial resources and human resources are challenging from a sustainability perspective as Network partners and COP members seek the needed staff and funding for the implementation of *Get Healthy Talladega County*.

Levers:

- Experienced leadership: The SAFE Executive Director is a recognized leader, not only in Talladega County but across the state, and is very effective at building coalitions.
- Existing wellness programming: GHTC started wellness-related programming through a 2009 Outreach grant by implementing the WAY program in the schools, developing a social media campaign, and promoting the development of school gardens and physical activity challenges, while arming parents with the skills and knowledge to support wellness in the home and community. GHTC has maintained many of these elements solely through community support.
- Collective impact approach: Through Get Healthy Talladega County's collaboration with a cross-section of community, county and state-level organizations, the one-stop-shop center in Talladega County has served as a model for strengthening families and support services. Network

partners will be able to build on this model to improve communication among health providers and to streamline access to the appropriate aging and disability resources in the community.

## **Grant Project Description**

Project Period: 2014-2017

Focus Areas: Care Coordination, School-Based Care

Background: With a fourteen-year history of successful collaboration and partnership, the Get Healthy Talladega County Network (GHTCN) is committed to expanding and enhancing our current relationships in order to improve the health and wellness of our residents. The diversity and shared leadership among the collaborating partners position us to reshape our network structure and to respond more effectively to the evolving health care environment.

Three years ago, the East Alabama Regional Planning and Development Commission began a comprehensive needs assessment and planning process called CLEAR Plan 2030. Margaret Morton, Executive Director of Sylacauga Alliance for Family Enhancement, was a member of the coalition for this HUD/DOT-funded project. This process identified the following healthcare-related needs in East Alabama: improving connections for residents to appropriate health care resources and services, improving connections for health care providers to patients' health maintenance information, and educating the public on existing health care resources and services. The Goals of the GHTCN are based on the findings of the CLEAR Plan 2030.

Strategic Objectives and Key Initiatives:

- Establish a formal structure for the Get Healthy Talladega County Network
- Strengthen and support a culture of active, healthy living for students and their families in Talladega County.
- Improve the coordination of care for Talladega County residents with chronic disease, disability, and/or aging issues.

## **Challenges & Innovative Solutions**

The biggest barrier to completing the goals was primarily due to staffing changes with the network director as well as with the network partners. There were 3 network director changes during the course of the grant. Those changes primarily occurred during the 2nd and 3rd year of grant funding and set us back in terms of momentum and leadership. However, because of the long history of working together as a network, we were able to overcome the majority of barriers. We have a network of leaders who are intentional, who are visionary leaders, who work together extremely well to make sure that we are doing to do our best to manage the resources and develop strategies that work to benefit our residents and our communities.

## **Network Continuation**

Value Proposition: Transitions in Care Community of Practice, School/Community Wellness Community of Practice, Electronic Care Record, Communications Community of Practice, Evaluation Community of Practice.

Network Revenue Streams: Through the network's collaborative networks, funding streams and in-kind contributions have been ascertained to continue and expand the work of the community garden as well as to continue the work being made in several of the school gardens. Several additional grant awards have been secured for a few of the elementary schools to complete their gardens. Additionally, plans are underway to create an education classroom in the community garden to lead and facilitate STEM learning in a hands-on environment for students as well as a plan to develop a business incubator and sustainability model for the garden involving selling produce.

## **Project Officer**

Jayne Berube  
(301) 443-4281  
jberube@hrsa.gov

## ALABAMA (2)

### North Baldwin Rural Health Network (NBRHN)

Gulf Health Hospitals, Inc. d.b.a. North Baldwin Infirmary

#### Network Description

Grant Number: D06RH27772

Organization Type: Hospital

Address: 1815 Hand Ave. Bay Minette, AL 36507

Website: <http://www.livebettertogetherswal.org/north-baldwin-rural-health-network/>

Year Formed: 2011

Network Contact:

Tracy McDowell

Network Director

(251) 580-1776

[Tracy.mcdowell@infirmaryhealth.org](mailto:Tracy.mcdowell@infirmaryhealth.org)

Members:

Hospital, Clinic, Long-term care, Behavioral or Mental Health organization, Home Health organization, Pre- K-12 School

Mission:

The North Baldwin Rural Health Network and its members will work to address the needs of our communities by acting within available resources and consistent with agreed upon strategic priorities, to: promote clinical integration, achieve health status improvement, facilitate administrative integration.

Vision:

By working together as a network of providers, we will help our communities become the healthiest in America.

Member Needs:

- Improving patient outcomes by providing the most complete information at the point of care
- Providing integrated care across the continuum resulting in improved care transitions
- Improving patients' access to their personal health record, increasing their participation and understanding of the impact of their healthcare choices;
- Optimizing care quality with decision support tools
- Analyzing data to understand cost and clinical effectiveness
- Providing real time population health indicators to develop community wide health improvement initiatives

Governance: The network's governing body includes a board/steering committee that includes the president of North Baldwin Infirmary, the lead applicant, and members representing post-acute providers, specialty care providers, behavioral

health, primary care providers and emergency care. The network director reports to the president. The network director and network staff provide updates on network initiatives to the membership using existing scheduled meetings such as the Medical Staff meetings.

## **Environmental Analysis**

Geographical Area: Rural North Baldwin County and Escambia County, Alabama

Population Need: The network formed to address some critical unmet health needs in Baldwin and Escambia counties. Perinatal care and chronic disease (e.g. COPD, heart disease and diabetes) prevention and management are the major focus of our network and the programs that have been established. Key topics in the community health needs assessment include:

- Achieving a healthy weight
- Access to care
- A care transitions program to include more providers and focus on chronic care management
- Improved perinatal outcomes

Blocks:

- Inconsistent member engagement
- Primary care follow up has been poor with patients post discharge
- Patient transportation issues
- Marketing that communicates the value of the network to the community and providers
- Pharmacy, other community members and payers may be needed to fully develop the care transitions program; currently not in the network

Levers:

- Care Transition Coach is onboard and has been successful working with COPD and CHF patients
- Quality Specialist is collecting data to measure quality outcomes and identify areas that need improvement
- Lactation consultant has become certified; NBI is seeking Baby Friendly designation
- Expansion into Atmore has been successful
- Diverse network
- Telemedicine has been initiated with a goal for expansion

## **Grant Project Description**

Project Period: 2014-2017

Focus Area: Care Coordination

Background: The North Baldwin Rural Health Network (NBRHN) was formally established in 2011 with funding from HRSA from the Rural Health Network HIT

program. Our strategy as a network is to continue to support members in their efforts to sustain and further develop their EMR. The Rural Health Network Development program is allowing this IT focus to include network expansion into neighboring communities, the development of a care transitions program to reduce readmissions, the recruitment of a Lactation Consultant to increase education and improve perinatal outcomes and finally increase patient and provider engagement in community health. The NBRHN is developing a health care delivery system that at its core is patient centered, evidence based and uses technology to achieve higher levels of quality and connectivity between patient and provider. This project will strive to improve engagement and ultimately health outcomes in our targeted patient populations.

### **Challenges & Innovative Solutions**

We achieved our goals and objectives for our program although some initiatives took longer to implement than we anticipated. We believe that we have laid a good foundation for growth and expect our network to continue to mature over the coming years. With the exception of the childbirth and lactation program, we have only begun to gather enough data to fully evaluate all of our programs impact.

Strategic Objectives and Key Initiatives:

- Clinical Integration
- Achieve Health Status Implementation
- Facilitate Administrative Integration

### **Network Continuation**

Value Proposition: Provide lactation consulting services and childbirth education to increase breastfeeding rates in our communities, Achieving Baby Friendly designation, establish a Baby Café in each community, Care Transitions Program, Bedside Medication Dispensing, PCPs participating in chronic care management and patient centered models, Establish and expand patient engagement activities in the community, Telemedicine

Network Revenue Stream: The North Baldwin Rural Health Network members has been successful in establishing programs that either have a reimbursement component or that may be able to be sustained through our membership collaborations. These collaborations would include the provision or direct or in-kind support to accomplish the program goals. We will continue to seek grant and sponsorship support for our programs when needed to cover other initiatives the network seeks to implement.

### **Project Officer**

Marcia Colburn  
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mcolburn@hrsa.gov



## ALASKA

### Prince of Wales Health Network

Peacehealth - Ketchikan Medical Center

#### Network Description

Grant Number: D06RH27784

Organization Type: Regional Medical Center

Full Address: West Wind Plaza Craig, AK 99921

Website: [www.powhealthnetwork.org](http://www.powhealthnetwork.org)

Year Formed: 2007

Network Contact:

Gretchen Klein

POWHN Executive Director

(907) 617-7635

[info@powhealthnetwork.org](mailto:info@powhealthnetwork.org)

Members:

Businesses, Behavioral Health Non-Profit, Community Health Centers, Public Health Centers, and a hospital system.

Mission:

The mission of the Prince of Wales Health Network is to collaborate to improve healthcare on Prince of Wales Island.

Vision:

Our vision is for a sustainable and continuing partnership between the healthcare providers and communities of POW, resulting in improved access to care and optimal health outcomes for Island residents.

Member's Needs:

- Overweight/obesity and sedentary lifestyle
- Lack of healthy eating
- Lack of telecommunication services to support health education and increase capacity in outlying POW communities
- Unintentional injury
- Vaccination rates

Governance: The Network has seven-member agencies: PeaceHealth (a non-profit corporation), Southeast Alaska Regional Health Consortium (a non-profit tribal health consortium), Alaska Island Community Services (a non-profit healthcare organization), Craig Public Health Center (a State of Alaska Department of Health and Social Services Public Health Center), Community Connections (a non-profit social services support organization), Whale Tail Pharmacy, and Island Care Services. Decisions for the Prince of Wales Health Network (POWHN) are made by a Steering Committee, which is comprised of representatives from each member organization. Representatives from each of these agencies bring leadership strengths based on their executive (or ownership) roles and experiences. These Network members understand the

community context within which the Network operates, have the ability to think strategically about the Network's future, and are able to think tactically about how the Network can go about accomplishing its mission and tasks. Each agency has one vote and is required to give a cash commitment annually as well as in-kind support to the Network. Each agency is designated to help with each goal, and objective of the grant. Due to the extent of the HRSA work plan requiring expertise in various areas of health and wellness, it was critical to place special providers in key positions. For example, chairpersons were established for the following Task Forces: Immunization, Mass Vaccinations Fairs, Tele-Health and Tele-Education, Nutrition, Screen Time Reduction, Wellness, and Local/Traditional Foods Programs. This helped delegate the work-load allowing for increased involvement by local providers and engaging new circles of influence.

## **Environmental Analysis**

Geographical Area: Residents of Price of Wales Island, Alaska

Population Need: The healthcare system on POW is fragile. Health care organizations struggle with acute workforce shortages. Recruitment and retention of providers is challenging. Employees are expected to handle multiple roles and provide a high degree of after-hours coverage. The isolation and distance from major medical centers can be intimidating. Providers new to the island are challenged to find adequate housing, and the overall cost of living is high. It is also a challenge to provide a full array of high quality health care and behavioral health services to local residents.

The mission of the Prince of Wales Health Network (POWHN) is to collaborate to improve healthcare on Prince of Wales Island (POW). The mission is accomplished in part through: 1) increasing access to primary care and behavioral health services, 2) reducing the incidence of childhood obesity, and 3) strengthening the health care delivery system through expanded interagency communication and collaboration. The POWHN's vision is for a sustainable and continuing partnership between the healthcare providers and communities of POW, resulting in improved access to care and optimal health outcomes for Island residents. Given the challenges of providing a full array of high quality health care and behavioral health services to residents, the POWHN is essential for facilitating communication and collaboration among providers.

Analysis: Given the challenges of providing a full array of high quality health care and behavioral health services to local residents, the POWHN is essential for facilitating communication and collaboration among providers. Network members strive to accomplish three critical tasks:

- Take steps to avoid healthcare crises from occurring in the first place;
- Take unified, collaborative action when a healthcare crisis or significant change in the healthcare services occurs on POW; and

- Identify service gaps, and facilitate integrated and collaborative responses by the Network's partnering providers and other health care deliverers

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Behavioral Health, Population Health

Background: The Prince of Wales Health Network (Network) is an evolving network that has been in existence since 2008. The Network was formed to explore the possibility for long-term collaboration among network members with the intent of improving health care services on Prince of Wales Island (POW). The first years of the Network's existence were focused on developing relationships among members, building a structure for collaboration, and developing a strategic plan. The Network's members see tremendous value in the relationships that have formed and the activities carried out through the structure of the Network. At its June, 2010 strategic planning retreat, Network members identified continuing to expand the Network's membership and infrastructure to facilitate improved collaboration and expansion of Network activities as its top priority.

Strategic Objectives and Key Initiatives:

- Increasing access to primary care and behavioral health services
- Reducing the incidence of childhood obesity
- Strengthening the health care delivery system through expanded interagency communication and collaboration.

## **Challenges & Innovative Solutions**

This year the leadership team was very busy, and many of the member organizations' staff did not have capacity to help at the level that was needed. There were too many diverse goals and objectives, and it led to confusion of the direction of the Network at times during the last 3 years. During this 3-year grant period an early priority was to brand the Network, solidify and expand relationships, and build up a donor base from 0 to over 200 supporters. This is necessary to achieve the needed local level of awareness and volunteer support required to accomplish the 8 objectives and meet the fundraising goals. Unfortunately, we fell short on both accounts. Accomplishing the work plan activities as well as the fundraising efforts took extensive time by the Director. In addition, timing to complete some of the objectives conflicted with limited school year and summer schedules of volunteers and colleagues. The requirements to complete additional business plans, strategic plan development, and evaluation plans, though valuable processes for the members to participate in, further increased the work-load taking time away from accomplishing other project activities. As a result, the Goal 2 objective C BMI was approved to be eliminated by HRSA Program Director as network staff was becoming over capacity with the number of goals and objectives in this grant, and efforts being

expended on the required fundraising component. Communicating, and asking for support from consultants, volunteers, staff, TA support, and HRSA program manager allowed adjustments to be made, and final outcomes more realistic to achieve.

### **Network Continuation**

**Value Proposition:** The overall value proposition of the Network is: The Prince of Wales Island (AK) Health Network is an independent, and sustainable island-wide organization that provides networking opportunities and coordinates island-wide and community-level efforts that focus on improving health care on the island. Two priority products and services have been identified by the Network Steering Committee (from the January and March 2016 meetings):

- Networking activities and service coordination among Network partner agencies. (e.g., quarterly steering committee meetings).
- Promotion of community wellness activities.

**Network Revenue Stream:** Following a series of sustainability planning sessions, the Network Steering Committee determined that with reduced finances, the Network member organizations would continue to provide in-kind and cash contributions and that the Director position would be reduced to approximately 10 hours per month to coordinate networking activities. In this scenario, the key resources are the Network members and Director (10 hours per month), with minimal administrative infrastructure. This scenario is based on receiving income primarily from member agency contributions, with limited additional revenue from services provided by the Network Director on a fee-for-service basis. This scenario supports the Value Proposition: associated with providing Networking activities and service coordination (e.g., quarterly Steering Committee meetings). Based on limited funding and resources, the Network does not anticipate expanding services at this time.

### **Project Officer**

Jayne Berube  
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## ARIZONA (2)

### Arizona Rural Women's Health Network (AzRWHN) Canyonlands Healthcare

#### **Network Description**

Grant Number: DO6RH27766  
Organization Type: Health Center  
Full Address: 827 Vista Avenue, Page, AZ 86040  
Website: [www.azrwhn.org](http://www.azrwhn.org)  
Year Formed: 2006  
Network Contact:  
Leah Meyers  
Director  
(602) 288-7544  
[leahm@aachc.org](mailto:leahm@aachc.org)

#### Members:

Clinic, University/College, Area Health Education Center (AHEC), Social service organizations, Public Health

#### Mission:

To build our network partners' capacity to cultivate and promote innovative policies, practices and services that improve the health of women in Arizona.

#### Vision:

Women in rural Arizona will experience optimal health and wellness.

#### Member Needs:

- Provider training and education
- Recruitment and retention of providers
- Access to care
- Improve women's health
- Teen wellness

Governance: There are 17-member organizations that follow the agreed upon AzRWHN Operating Procedures for the Network structure. The structure includes an oversight body, called the Leadership Team, which is voted on annually by the members. The full Network membership meets quarterly in person and the Leadership Team holds monthly calls. AzRWHN also has committees, which are staff driven and include members who volunteer to participate on the committee.

#### **Environmental Analysis:**

Geographical Area: Rural areas across Arizona

Population Need: Canyonlands Healthcare is a rural Federally Qualified Health Center and member of the Arizona Rural Women's Health Network (AzRWHN or the Network). The Network is a professional statewide collaborative that began in 2006 and works to address health concerns and disparities of rural Arizona

women; specifically by improving access to services and increasing information and availability of resources and services in rural areas. Rural women in Arizona face significant health needs and challenges. These needs are multifaceted and compounded by scarce or non-existent resources and limited access to care and services. The Network has done significant work to understand and address these needs, including completion of a needs assessment in 2013 to prioritize network activities. The assessment identified sexual violence as a critical health issue for Arizona's rural women. AzRWHN's proposed project will build on the Network's existing efforts to increase the capacity of Network members and partners to create and promote policies and linkages, resulting in enhanced overall health for Arizona's rural women. Specifically, the Network will 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; and collaborate with partners to increase the number of Sexual Assault Nurse Examiner (SANE)-trained RNs and forensic exam sites in rural Arizona. The service area for the project covers 9 rural counties in which Canyonlands Healthcare and other Network members and partners provide services.

**Blocks:**

- Current member engagement—the same members continue to come to the table
- Lack of brand recognition
- Lack of education for health care providers and understanding of women's health in rural communities
- Only 1 funder; only 3- year grant
- Keeping current members engaged and galvanized

**Levers:**

- Strong director and coordinator—now have two staff (quality and quantity)
- Good partnering and collaboration—reduces reinventing the wheel
- Staff has connections and experience in the communities
- Develop business model and sustainability plan
- There is a workforce development effort for community health workers to help reach more women

**Grant Project Description**

Project Period: 2014-2017

Focus Area(s): Care Coordination

Background: The Arizona Rural Women's Health Network (AzRWHN or Network) began in 2006 as a group of influential leaders across the state concerned about the health disparities that rural Arizona women experience. The Council was

formally organized to address the lack of health care information, services, and education provided or developed for rural healthcare providers and the women they serve.

The Network strives to improve the health of all women living in rural areas of Arizona. Since 2006, various health promotion, training and education events have been held throughout rural areas. In the fall of 2012, the Network conducted a comprehensive needs assessment in order to identify a critical and pressing rural health topic. The assessment revealed services, resources and education related to sexual violence in rural areas were of tremendous need in rural Arizona. In 2014 Canyonlands Healthcare applied for and received a HRSA Rural Health Network Development Grant with an emphasis on addressing sexual violence in rural Arizona. With this grant, AzRWHN strives to support community efforts working in this field to address sexual violence and women's health by bridging the gaps and providing training for health workers specific to the needs of rural Arizona women.

**Strategic Objectives and Key Initiatives:** The Network will 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; and collaborate with partners to increase the number of Sexual Assault Nurse Examiner (SANE)-trained RNs and forensic exam sites in rural Arizona.

### **Challenges & Innovative Solutions**

The biggest barrier for this project was to expand forensic exam sites in rural communities. Although many providers were supportive of the idea to increase access to exams for sexual assault victims; it was hard to get the buy-in from management to allow the use of front-line staff time and/or the use of their space. Since an exam may take five to eight hours, this would take staff away from patients for a long period of time, as well as tie-up the use of an exam room which are both scarce resources in a rural community. It was also a barrier to get rural nurses their clinical hours after the forensic exam training, which could be done online. There are very few opportunities to get clinic skills training, especially in a rural community. The best option was to spend five days in an urban program setup to provide this opportunity and guidance, which meant flying to another state. This was even harder when we tried to propose that nurses get trained for pediatric forensic exams. The pediatric exam training requires an additional year of training and extra clinical hours to be able to conduct these exams.

### **Network & Continuation**

Value Proposition:

- Provide the sexual violence curriculum for CHW and promotoras training to improve the health care response.

- Collaborate with health providers to develop rural forensic exam sites and deliver well-women care in all facilities.
- Support Network members by facilitating and engaging in collaboration, problem solving and sharing resources to enhance the response to women’s health.
- Plan and provide a Women’s Health Symposium annually.
- Increase outreach and visibility of AzRWHN and our work in order to increase our reach in rural communities.

Network Revenue Stream: The Network has been successful in receiving an additional HRSA grant to continue our work. Staff applied for another grant in collaboration with one of our member programs to continue our sexual violence activities, and are still waiting on the final word for this opportunity. Thanks to our Chair’s connection, we also received a corporate sponsorship for the annual Symposium. Staff and the Leadership Team continue to keep an eye out for new opportunities and collaborations that will diversify our revenue stream.

**Project Officer**

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## ARIZONA (2)

### Santa Cruz County Adolescent Wellness Network Mariposa Community Health Center, Inc

#### **Network Description**

Grant Number: D06RH21674

Organization Type: Federally Qualified Health Center

Full Address: 1852 N. Mastick Way, Nogales, AZ 85621

Website: [www.adolescentwellness.net](http://www.adolescentwellness.net)

Year Formed: 2007

Network Contact:

Cassalyn David

Director

(520) 375-6050 Ext 1370

[cdavid@mariposachc.net](mailto:cdavid@mariposachc.net)

Members:

FQHC, AHEC, school districts, county School Superintendent's office, community-based nonprofits, outpatient behavioral health agencies

Mission:

To promote adolescent wellness through advocacy, education, and collaboration with youth, schools, and community organizations serving youth, ages 12-25.

Vision:

To be the collaborative voice and catalyst for adolescent wellness in Santa Cruz County.

Member Needs:

- Increased efficiency for referral and follow-up
- Improve the health and well-being of their clients, patients, or students
- Improve satisfaction of their employees and those they serve
- Increase the quality of their services
- Improve community outreach and health
- Reduce costs
- Referral tracking system

Governance: The AWN governance structure, as outlined in the Operating Procedures, includes voting representatives from the 11 AWN member organizations, as well as 2 voting representatives of the AWN's Positive Youth Leadership Team (PYLoT). AWN member organizations sign memoranda of understanding, and the PYLoT members sign participation contracts. Each includes commitments to roles, responsibilities as defined in the Operating Procedures. Certain AWN member organizations have funded contracts for the

provision of Network deliverables. AWN members meet monthly, and all contribute in-kind resources such as meeting space and staff time.

## **Environmental Analysis**

Project Year: 2014-2017

Population Need: Information not available.

Geographical Profile: All of Santa Cruz County, Arizona, including the communities of Tubac, Rio Rico, Nogales, Patagonia, and Sonoita-Elgin.

Blocks:

- Communication: New members, non-member community partners, and boots-on-the-ground individuals need to be continuously integrated and informed
- Sustainability: AWN funding is currently grant-based
- Expertise: Limited experience with policy change among members
- Adolescent wellness is very broad, both in content areas and strategies
- Schools face uncertainty and limited resources—in these conditions, health issues can fall to a lower priority than academics.

Levers:

- Members represent diverse organizations and fields. They are well-positioned and possess key skills and perspectives.
- Strong partnerships
- State and national organizations and resources
- Member roles are clear and participation is enthusiastic
- AWN has an established, successful youth group
- Schools recognize the central role health plays in academic success.
- Schools share our goals and are willing to participate.
- Positive reputation and track record of valuable accomplishments
- Diverse funding opportunities available

## **Grant Project Description**

Focus Area(s): Integration, School-Based Care

Background: The Santa Cruz County Adolescent Wellness Network (AWN) is located on the U.S.-México border in Arizona. The mission of the AWN is to promote adolescent wellness through advocacy, education and collaboration with schools and community organizations serving youth ages 12-25. The vertical health network consists of education, primary care, behavioral health, and social service organizations as well as a youth leadership program. Partners work together toward two goals:

- Goal 1 - integrate and enhance community and school services to address adolescent health disparities.
- Goal 2 – develop and sustain a system of school-linked health care to improve adolescent access to care and health status.

The system of school-linked health care will increase health care insurance coverage and enhance access to preventative care and treatment to improve the health of this low income, Hispanic/Latino rural population.

Strategic Objectives and Key Initiatives:

- Integrate and enhance community and school services to address adolescent health disparities.
- Develop and sustain a system of school-linked health care to improve adolescent access to care and health status.

### **Challenges & Innovative Solutions**

The network encountered delays in executing contracts with one of the three partnering school districts for school linked health care (SLHC). Three local school districts signed MOUs to participate in the program, however in one district the initial contract experienced lengthy reviews by district lawyers, insurers, and boards that were longer than anticipated. The contract with this district was signed in July 2015. The other two partnering districts executed contracts on schedule.

We worked closely with district administrators to understand any questions or concerns regarding the contracts. There were not specific barriers that would affect implementation of our program, rather a matter of clearing bureaucratic approvals and that arose following significant staff turnover.

AWN continues to explore ways to involve older adolescent and young adult voices in our programs and decision-making. Early in the project period, the Network created membership opportunities for adolescents aged 18-24, but did not receive any applications. This will be an ongoing area of concentration during the extension year.

### **Network Continuation**

Value Proposition:

- Improve individual and community health by supporting and integrating adolescent wellness services
- Increased availability of local, regional, and nationwide data and information related to adolescent health and wellness
- Increased awareness among youth and families of the availability of health insurance, primary care, and other social and health services
- Reduce payor costs through care coordination for high-risk patients, and increased preventive health utilization at the population level
- Coordination between primary care and schools will result in improved patient/student health and outcomes.

- Better outcomes and coordination for the patient will result in higher levels of patient satisfaction.
- A more complete view of a child’s health situation will be available when the school is engaged, allowing for more accurate diagnoses and higher levels of patient compliance.
- The school will be referring children who need medical attention to providers. Working with the program ensures you are an active participant in that process, maintaining existing patients and also receiving new referrals.
- By improving the health of our community’s children, we help improve the overall health of our community.
- Researching methods to provide secure messaging or referral tracking system, data collection, and reporting.

Network Revenue Stream: The network has not completed creation of revenue streams. We will continue to pursue this goal during our no-cost extension year. We will be reaching out to private primary care practices to offer our school-linked health care system and explore the potential to generate revenue by providing the service to them. We also continue to explore opportunities to generate revenue from consulting and sharing our youth development and school-linked models with peer organizations.

**Project Officer**

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## CALIFORNIA (3)

### CA299 Health Collaborative Mountain Valleys Health Centers

#### **Network Description**

Grant Number: D06RH28030

Organization Type: FQHC, CAH, Hospital District, RHC

Full Address: P.O. Box 277, Bieber, CA 96009

Website: <http://ca299health.org/>

Year Formed: 2011

Network Contact:

Eileen Lisa Tremaine

Director

(530) 524-5420

[etremaine@mtnvalleyhc.org](mailto:etremaine@mtnvalleyhc.org)

Members:

FQHC, three CAHs, two Hospital Districts, and two RHCs.

Mission:

In collaboration with partners and providers, the CA299 Health Collaborative plans, initiates, and implements innovative solutions for emerging and unmet health needs that one provider alone could not undertake to provide the residents of far northern California with access to affordable quality healthcare with unrelenting attention to clinical excellence, patient safety, and an unparalleled passion and commitment to those we serve.

Vision:

The CA299 Health Collaborative will be a premier health partnership working to achieve the highest level of health and wellness for the residents of far northern California through providing leadership and guidance, through joint alliances and partnerships with healthcare entities and professionals, leading to patient outcomes that exceed their expectations and satisfaction.

Member Needs:

As a direct result of the health care reform happening within the state, the Collaborative members are facing a time of significant change and challenges. With the implementation of the EHR and health care reform through the Affordable Care Act, the member organizations and their staff are being pulled and pushed through great change and increased workloads. All member organizations have worked to meet the challenges and have succeeded, however, there is not a lot of resources left to expand into population health and coordination of services. This HCP program is being developed as a direct result of the members' needs to meet this challenge in an effort to "keep up" with the payment reform changes.

Member organizations squeak by with limited contribution margins and, what revenue is generated is used for current building needs (both CAHs are required to earthquake retrofit their hospitals) and physician recruitment, leaving very little for program development. The funding provided through the Development Grant has enabled the Collaborative's member organizations to continue their quest in meeting the Triple Aim through collectively working to develop process and programs that will expand those efforts. The grant is viewed as seed money that will enable the members and staff to develop a sustainable organization that will continuously meet the members' needs through collective solutions to regional health issues.

Governance: The Collaborative has an Executive Committee in charge of making decisions on behalf of the Collaborative. Members are elected by the Collaborative membership by a minority vote.

### **Environmental Analysis**

Geographical Area: Residents of far northern California

Population Need: In February 2011, MVHC received support from the California Healthcare Foundation's Strategic Restructuring Program for preliminary discussions around the formation of the CA299 Health Collaborative. The grant program provided consulting support from three California consulting firms to begin the process of identifying strategic restructuring opportunities. This program brought the Collaborative members together to begin talking about the needs of the community and their organizational needs that can be better served through the Collaborative.

Blocks:

- Limited Funding

Levers:

- Collaborative member organization leaders are engaged

### **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): HIT/HIE, Workforce

Background: The CA299 Health Collaborative was established through a joint assessment by Canby Family Practice Clinic, Last Frontier Hospital District, Mayers Memorial Hospital District, McCloud Healthcare Clinic, Mountain Communities Healthcare District, Mountain Valleys Health Centers, and Surprise Valley Hospital District. A subsequent agreement was established to collaborate on projects of mutual concern, to coordinate resources, and ultimately develop and maintain an integrated health network.

These seven organizations initially agreed to jointly:

1. Form a rural health network to be known as the CA299 Health Collaborative (“Collaborative”).
2. Provide a forum for the exchange of information among organizations and individuals to identify and work to address emerging and unmet regional needs.
3. Develop innovative health care solutions through facilitating partnerships with healthcare agencies in the region.
4. Develop sustainable solutions.
5. Work where the interests and needs of its members align with those of the community.
6. Monitor the availability and delivery of health care services in the region.
7. Develop programs and services, through shared resources and collaborative partnerships that meet the triple aim of better care for individuals, better health for populations, and lower per capita costs.

Strategic Objectives and Key Initiatives:

- Continued development of the Collaborative’s Specialty Care Network that will enable the health care facilities to collectively contract for services
- Joining and effectively implementing the North State Health Connect Health Information Organization’s Health Information Exchange (HIE)
- Development of a Regional Transitional Care Program to improve patient health outcomes as they transition from the hospital back to their primary care provider

## **Challenges & Innovative Solutions**

It was extremely difficult to select a Health Information Exchange and there was a lot of fear from the members that it would not be sustainable.

### **Network Continuation**

Value Proposition:

#### Primary Care Physician Recruitment

- Increase the organization’s capacity to recruit needed providers.
- Improve access to patient care through increased providers.

#### Health Information Exchange

- Increase the organization’s capacity to exchanged needed information for patient care.
- Improve outcomes through exchange of information.

### Care Coordination

- Have a program in place that works to assure patients living in the member communities return to their community for care following a hospitalization or other health care services outside the area.

### Quality Reporting

- Improve pay for performance incentive dollars.
- Reduce staff time required for reporting.
- Improve reporting through improvements in data validation.

### Specialty Physician Recruitment

- Have a program in place that works to assure patients living in the member communities return to their community for care following a hospitalization or other health care services outside the area.

### Healthy Communities Program (HCP)

- Screening of community members, 18 years and older, to identify certain unmet health-related social needs;
- Referral of community members to increase awareness of community services;
- Provision of navigation services to assist high-risk community members with accessing community services; and
- Encouragement of alignment between clinical and community services to ensure that community services are available and responsive to the needs of community members.
- Increasing community members' awareness of community resources that might be available to address their unmet health-related social needs;
- Increasing the connection of at-risk community members with unmet health-related social needs to community resources through navigation services;
- Optimizing community capacity to address health-related social needs through quality improvement, data-driven decision making, and coordination and alignment of community-based resources; and
- Improving three clinical quality measures: Two for Diabetes (DM) – NQF 0059: Diabetes Care: Hemoglobin A1C Poor Control (>9.0percent) and NQF 0018: Controlling High Blood Pressure; One for Cardiovascular Disease (CVD) - NQF 0018: Controlling High Blood Pressure

Network Revenue Stream: Yes, mainly support is coming from the members on an as needed basis to continue work of the collaborative.

### **Project Officer**

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## CALIFORNIA (3)

### Health Leadership Policy Network (HLPN)

St. Helena Hospital

#### **Network Description**

Grant Number: DO6RH26826-02-00

Organization Type: Hospital

Full Address: 15630 18th Avenue, Clearlake, CA 95422

Website: [www.healthleadershipnetwork.org](http://www.healthleadershipnetwork.org)

Year Formed: 2002

Network Contact:

Susan Jen

Director

(707) 279-8827

[s.jen@mchsi.com](mailto:s.jen@mchsi.com)

Members:

County organizations, Healthcare, County Office of Education, Senior Support Services, Lake Family Resource Center, People's Services (disabilities), Redwood Community Services, Planned Parenthood, North Coast Opportunities, Center for Life Choices, Lake Transit

Mission:

Providing innovative leadership to build system connections among service agencies and healthcare providers that identify best practices and seeds of change.

Vision:

Partners creating a healthier, thriving Lake County

Member Needs: Information not available.

Governance: Information not available.

#### **Environmental Analysis**

Geographical Area: Residents of Lake County, California

Population Need: The need for the project is driven by our county's persistent health ranking at the bottom of California's 58 counties for poorest health and the concomitant need to increase impact of cross-sector collaboration aimed at making a shift in this poor health profile. Although there are collaborations that address various health issues, this Project was developed to fill the need for a collaborative venue in which to begin aligning action around a common purpose and measures; a venue to look at the big picture of community wellness through a "whole person" lens, and to increase opportunity for care coordination across partners—not from the traditional medical perspective, but in terms of integrating wellness activities into our cross-sector endeavors. The Project also steps into filling the need for inter-connecting current work being done within a

more deliberate and cohesive approach to increase scale. Organizations frequently collaborate to implement a project in which there is a common purpose, however the scale of these efforts is typically insufficient for the desired magnitude of impact. Turning the dial on a county health ranking has various levels of complexity and challenge. Network engagement with these challenges requires an organizing focus, shaping and positioning collaboration for making change, as well as providing clarity around roles, contributions, resources, and accountability toward achieving the systems, environment and policy shifts that are put in motion.

Environmental Analysis: Information not available.

- High enthusiasm and impetus to make transformative change; opportunity to develop shared promotional strategies
- Cross-sector buy-in to moving the dial on the county's poor health ranking, but need common agenda and shared mindset to implement strategic actions
- Limited human resources, many people wearing multiple hats within organizations creates challenges on time availability to create and implement common agenda
- Keen interest in and awareness of need for cross-sector shared data exchange

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Population Health

Background: The Health Leadership Network (HLN) (also known as the Health Leadership Policy Network) was launched to develop a venue for public and private entities to respond to priority health issues in Lake County, California, and to work collaboratively in improving population health. The HLN has been in operation since 2002, and is the only consortium of its kind in the County. HLN efforts focus on systems, policy and environmental change. The entity does not typically provide direct services. Rather, the HLN is a vehicle for members to achieve collective impact by collaborating and aligning their efforts in the implementation of countywide, cross-sector initiatives.

Strategic Objectives and Key Initiatives:

- Develop and implement a Best Practice Framework that promotes resiliency as a means to strengthen health care, address community health needs and improve population health.
- Establish a methodology to sustain implementation of the Best Practice Framework, long-term follow-up on health needs priorities, and methodology to measure progress

## Challenges & Innovative Solutions

A major barrier for small rural areas is recruiting people with expertise to implement various aspects of the Project. Our community has had a void in the area of tobacco cessation programming over the past decade. The medical community and Public Health compensated for this by establishing consistent referral to 1-800 cessation helplines. We were anxious to explore opportunities for increasing access to smoking cessation. However, it was a challenge to identify someone to take on the Tobacco Coordination component as well as the Data Exchange component. Because a period of time passed while we were recruiting for these positions, one strategy we used to fill positions was utilizing the unspent (encumbered) funds to increase the compensation and FTE. This was a way to increase the candidate pool. Regarding Tobacco Coordination, another strategy used to overcome this barrier was to structure the Tobacco Coordinator position within the Hospital's (our fiscal sponsor) Wellness programs which enabled access to support of an Addictionologist within the cessation programs offered. This also facilitated natural collaboration with other wellness activities and tobacco reduction projects in the community. In both positions we used our networking contacts with Project partners to fill the positions. Partnership Health Plan was an important resource in eventually locating someone to fill the Data Coordination (HIE) component of the Project.

There are on-going data collection challenges. The challenge hinges on time, expertise and staffing available to support data collection. We do not have access to an epidemiologist or expertise in data analysis. There is no system in place to collect basic information related to program results, effective practices, or lessons learned among programs serving similar populations and having similar goals. In spite of these challenges, nearly 60% of members believe the HLN should focus on shared data collection and collaborative analysis. When we wrote application for this project we had planned to implement a countywide Well-being Index as the centerpiece of this Project's shared data component. However, that presented barriers of cost and complication related to integrating a new and unfamiliar assessment tool within service delivery. Our key strategy to overcome barriers to achieving our data sharing goals was collaboration with Partnership Health Plan (PHP regional managed care provider). PHP, a network partner, was facing a challenge in automating use of the SHA (Staying Healthy Assessment) among healthcare providers. The SHA is a requirement for the MediCal population in California, but providers were reluctant to add it into their patient assessments due to extra time involved. Providers were using the SHA as a paper screen, filed in patient charts. This greatly limited accessibility to SHA information. It was mutually beneficial for our Project to partner with PHP in automation of the SHA and to use it to seed a data repository. The SHA encompasses 7 areas of health and well-being and aligns with the Impact Areas included in the Wellness Roadmap. It made sense to build on an assessment already in use and also required among managed care patients—45% of our county's population. PHP matched the \$60,000 allocated in our HRSA budget to launch data exchange utilizing SHA. HRSA funding was used for consultant time needed to coordinate elements of this project component and to formulate a

workgroup that would facilitate agreements and data repository design. PHP funds contributed to various IT aspects of launching HIE, training needs, and analysis as data becomes available.

### **Network Continuation**

Value Proposition:

The services would be applicable to all Health Leadership Network (HLN) participants, as the general customer

The services would include:

- Utilization of the Wellness Roadmap as a tool/framework for responding to priority recommendations from the county health needs assessment and turning the dial on the county's poor health ranking
- Utilizing the HLN as a forum for shaping a common agenda and shared value of health as needed elements in creating a culture of health
- Utilizing the HLN as a forum for cross-training on best practices related to the Wellness Roadmap's 10 impact areas
- Creation of shared data exchange architecture among HLN partners
- Analysis and dissemination of aggregate data and increasing access to local, real-time data
- Creation of a "results library" relevant to partner achievements

Network Revenue Stream: It has been successful at obtaining grants to expand and enhance its work, but not at creating revenue streams to support its staff and core operations.

### **Project Officer**

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## CALIFORNIA (3)

### North Coast Clinics Network (NCCN)

North Coast Clinics

#### Network Description

Grant Number: D06RH27781

Organization Type: Health Center Controlled Network (501c3)

Full Address: 1036 5th Street, Suite C, Eureka, CA 95501

Website: <http://www.northcoastclinics.org/>

Year Formed: 1994

Network Contact:

Trisha Cooke

Director

(707) 444-6227

[trisha@northcoastclinics.org](mailto:trisha@northcoastclinics.org)

Members:

There are 3 federally qualified health center members with a total of 14 sites.

Mission:

The community clinics located in Humboldt, Trinity and Del Norte counties have joined together as the North Coast Clinics Network (NCCN) to accomplish the following purposes:

- to coordinate the development of cooperative business plans which improve the quality of care and efficiency of Network members,
- to advocate for innovative Business and Health Information Technology (HIT) strategies that integrate all community providers into a comprehensive and accessible system of high quality health care,
- to promote public knowledge and understanding of the important role of community clinics and the challenges of building healthy & well communities in rural areas.

Vision:

Rural residents on the North Coast will lead healthier lives as a result of collaborative partnerships with health and wellness providers and through education and access to family-centered integrated health systems.

Member Needs: Information not available.

Governance: NCCN is governed by a 5-person Board of Directors consisting of each clinic corporation's Executive Director and one member's CFO, whose respective boards are comprised of community members and consumers of clinic services. The NCCN Board consists of a President, Vice President, Treasurer, Secretary, and two Members at Large. The roles and responsibilities of the Board officers are outlined in the Network Bylaws. The Board of Directors also has a separate Finance Committee who reviews the financial statements and reports their findings to the Board on a regular basis. NCCN's network members

are responsible for attending bimonthly Board of Director's Meetings and quarterly Finance Committee and DHHS meetings. At the meetings the members discuss challenges, develop collaborative ideas and evaluate the financial status of the network. NCCN used this information to establish programs to assist the clinics. In addition to the meetings, NCCN communicates with the clinics on a regular basis to provide them with information about legislation, funding and community programs.

## **Environmental Analysis**

Geographical Area: Residents of the North Coast of California (Humboldt, Trinity and Del Norte counties)

Population Need: The community clinics located in Humboldt, Trinity and Del Norte counties have joined together as the North Coast Clinics Network to accomplish the following purposes:

- to coordinate the development of cooperative business plans which improve the quality of care and efficiency of Network members,
- to advocate for innovative Business and Health Information Technology (HIT) strategies that integrate all community providers into a comprehensive and accessible system of high quality health care,
- to promote public knowledge and understanding of the important role of community clinics and the challenges of building healthy & well communities in rural areas.

Blocks:

- Mega Health Systems: hospital mergers and the role of primary care within their systems.
- Access to services limited in rural environment: increase in insured population without access to existing providers.
- Limited supply of new providers: fewer providers pursuing primary care and aging clinician population strains current health system.
- The New Aging: increasing number of older individuals with complex chronic conditions.

Levers:

- Consumers take charge: insured consumers and active community action to create healthy communities.
- Healthcare Everywhere: the transition from acute care facilities to retail environments.
- Value through Data: harnessing data big data to improve care and outcomes.
- Volume to Value: emergence of risk based healthcare resulting in increased importance of quality metrics and incentive programs.
- Increasing value of network collaboration: consortia acts as convener for the integration of medical, behavioral, public health, and social determinants interventions

## Grant Project Description

Project Year: 2014-2017

Focus Area(s): Population Health, Quality Improvement

Background: In 1992, a lunchtime group of clinic directors and administrators began holding regular, informal meetings to share information and concerns regarding the potential implementation of managed care, in the hope of structuring effective strategies and responses to the many changes in the health industry. The North Coast Clinics Network (NCCN), a Health Center Controlled Network (HCCN), evolved from that group and has become an effective consortium of community health centers encompassing California's rural, isolated regions of Humboldt, Del Norte and Trinity counties. In 1995, NCCN incorporated as a nonprofit organization and was recognized as a 501 (c) (3) by the IRS.

The NCCN member health centers collectively strive to improve access to high quality medical, mental and dental health care for all people, regardless of their ability to pay, and NCCN exists to assist member clinics in their efforts to meet the needs of this community and the needs of the clinics themselves through information sharing, community education, shared administrative activities, and direct services projects. NCCN continues to be recognized as a convener, facilitator, and thought leader across the region. The Network successfully implements effective programs, advances innovative solutions, and leads local initiatives to improve the health system and the rural populations it serves.

Strategic Objectives and Key Initiatives:

- Effectively integrate the population health data analytics tool, PopIQ into the consortium
- Appropriately train Network and clinic staff on the Model of Improvement by providing technical assistance to clinic staff on evidence-based strategies to improve population health through the use of data and patient engagement
- Create a culture of continuous QI through the collection, aggregation, and analysis of clinical and operational performance measures
- Foster peer networking and expertise exchange through a QI Peer Network and regional stakeholders
- Engage in evaluation and sustainability activities in order to ensure the long term viability of an effective QI program at the Network level.

## Challenge & Innovative Solutions

- Changes in and/or Upgrades to individual EHR systems impacted network population health tool at the network and require new data mapping.
  - Worked with member health centers and EHR vendors to identify changes in upgrades to lessen mapping issues.

Established validation processes to ensure confidence in the data.

- Engaging members in Medicaid managed care Quality Improvement Program (QIP).
  - The Network conducted monthly networking and training sessions for health centers staff, educating QI staff on metrics, measure definitions and strategies to maximize the QIP.
- Staff turnover at health centers and consortium.
  - Updated policies and procedures coupled with extensive training plan to support cross-training on systems
- Competing demands for Federal Reporting from members.
  - Align grant goals with Federal reporting standard to reduce intensity of reporting
- “Buy-in” from senior leadership and physicians on value of network data aggregation. Consortium support rather than individual organizational support.
  - Educated C-level staff on the importance of leveraging disparate isolated systems into network level for training, education and regional Best Practice identification.

### **Network Continuation**

Value Propositions: Dashboard development, training and education, quality improvement (QI) coaching, QI and data analytics tool development, best practice research, QI peer network(s), and community coalition builder and participant.

Network Revenue Stream: Information not available.

### **Project Officer**

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## COLORADO (2)

### Tri-County Health Network (TCHNetwork)

Tri-County Health Network

#### **Network Description**

Grant Number: D06RH27792

Organization Type: Information not available.

Full Address: 238 E. Colorado Ave, Ste. 8 Telluride, CO 81435

Website: [www.tchnetwork.org](http://www.tchnetwork.org)

Year Formed: 2010

Network Contact:

Lynn Borup

Network Director

(719) 480-3822

[lynn@telluridefoundation.org](mailto:lynn@telluridefoundation.org)

Members:

FQHCs, Rural Health Clinic, hospital, clinics, mental health system/provide, community foundation

Mission:

To improve the quality and coordination of healthcare services in rural southwestern Colorado, by increasing access to healthcare, integrating healthcare services and lowering costs through collaboration and innovation.

Vision:

It is the collective vision of TCH Network, its Board of Directors, Network Members, staff and community stakeholders, to eliminate barriers to healthcare for our designated "Medically Underserved Community" population of over 53,000 in the tri-county area we serve.

Member Needs:

- Access to resources (capital and human)
- Full integration of behavioral health services and screenings
- Support in continuous quality improvement methods & processes
- Communication plan to promote outcomes and best practices
- Help operationalizing health information exchange

Governance: TCH Network's organizational bylaws dictate that leaders from our Network partners make up the composition of the Board of Directors. The Board has 9 voting Members: one Executive Administrator from each partner and one representative appointed by the Telluride Foundation. These senior leaders are referral partners, champions and in-kind donors. The Board oversees all financial and programmatic decisions of this program. The Board meets quarterly, with the addition of electronic communication and/or conference calls between Board meetings, to advise about program status. The Network Members are meaningful collaborators, bringing unique expertise to the Network. They are

united around the common goal of providing quality health care to patients and to improve the health of each community by the pursuit of excellence in patient care. Their focus is on providing access to the unmet health needs of the region's population.

### **Environmental Analysis**

**Geographical Area:** Residents within a rural remote three-county region (San Miguel, Ouray, and Montrose counties) in southwest Colorado

**Population Need:** The unmet health needs of our rural population faces are significant. Our region is a designated Health Professional Shortage Area, qualifies as a Medically Underserved Community, and serves Medically Underserved Populations. These designations signify an at-risk community with too few providers and pockets of extreme poverty.

**Blocks:**

- Lack of sustainability through funding diversification
- Lack of identified general operations funding
- Lack of longevity
- Clinical partners unwillingness or perceived inability to make changes to accommodate new program requirements

**Levers:**

- Track record of successful and diverse programming, resulting in continued organizational growth and financial viability
- Successful receipt and execution of grant awards on federal, state and foundation levels
- The populations and regions served are those that are currently focused upon by funders
- Integrated into the communities we serve with clear understanding of the populations within
- Innovative thinking and effective collaboration

### **Grant Project Description**

**Project Year:** 2014-2017

**Focus Area(s):** Behavioral Health, Integration

**Background:** Incorporated in 2010, Tri-County Health Network (TCHNetwork) is a nonprofit vertical network of healthcare providers with a mission to improve the quality and coordination of healthcare services in rural southwestern Colorado, by increasing access to healthcare, integrating healthcare services and lowering costs through collaboration and innovation. TCHNetwork was founded by the Telluride Foundation, a 501(c)(3) nonprofit community foundation, which identified the need and a plan to challenge healthcare obstacles facing our rural population. It is the collective vision of TCHNetwork, its Board of Directors, Network Members, staff and community stakeholders, to eliminate barriers to healthcare for our designated "Medically Underserved Community" population of

over 53,000 in the tri-county area we serve. By using an innovative approach of integrated and collaborative programming, we strive to create accessibility, affordability and availability where it was previously non-existent.

Strategic Objectives and Key Initiatives: Fully integrating behavioral health professionals into four primary care clinics; electronically screening each patient for behavioral health concerns through an electronic evidence-based application; employing peer support specialists (Recovery Support Specialists, or RSS) in the field to act as an extension of the clinics; utilizing telepsych services to extend access; and generating cost savings while improving outcomes to improve population health.

### **Challenges & Innovative Solutions**

Barriers, more so challenges, in implementing our programming included Clinical Adoption (the willingness of the primary care clinic staff to engage fully in working with the BHT, making warm hands, & screening all patients); Change in Leadership (turnover of 5 Board members, who are critical leads of the programming, in Year 1); Technology Challenges (1 clinic changing EMRs, cost-prohibitive to implement bidirectional interface of EMRs with HIE and Patient Tools); Hiring Challenges (inability to timely recruit licensed BHTs into our region Year 3, hiring qualified staff to replace program manager Year 2), and Stigma related to discussing problems and seeking behavioral health care.

Solutions in overcoming these barriers included: adjusting the timing of full implementation for some program components, replacing program components with others that achieve similar goals (recovery support specialist program with MHFA, EMR/HIE/Patient Tools interface with Teletherapy), revising budgets to compensate for program changes, and continual education of the community around importance of good mental health and its commonality to help reduce stigma.

The biggest unachieved objective, for which we have requested a no-cost extension, is the full integration of a BHT in our last clinic. The hiring process was significantly delayed with the BHT not coming onboard until July.

### **Network Continuation**

Value Proposition:

- Skippy - Provides basic preventive oral healthcare for all children, regardless of ability to pay
- Entitlement Enrollment - Providing personal education & entitlement enrollment (Medicaid, CHP+, SNAP) assistance at convenient community locations
- Insurance Assistance - Providing personal education and enrollment assistance at convenient community locations to help individuals/families enroll in commercial health insurance through the marketplace

- Heart Healthy Screening -Providing biometric testing at throughout the region to help underserved individuals at risk for developing diabetes &/or heart disease. Individual peer support to manage lifestyle changes to improve personal health is also offered.
- Chronic Disease Outreach - Trained patient health navigator are integrated into primary care clinics to outreach/navigate/act as a liaison to patients with chronic disease; increasing education & self-efficacy
- Latino Healthcare Fund - Fund to cover deeply discounted cost of preventive healthcare for Hispanic uninsured in San Miguel County
- Healthy Living classes - 6-weeks series of classes to teach & support living w/chronic disease & making good lifestyle choices resulting in reduction in the # of visits to docs & better mgmt of the chronic condition
- Cooking Matters- 6-weeks series of cooking/nutrition classes teaching low-income adults & families shopping & preparing healthy meals on limited budget
- Senior Services Collaboration - In-home resource assessment & counseling/coordinating services for seniors living in poverty & adults with disabilities supporting independence and improved quality of life
- Regional Medical Shuttle- Shuttle services to medical providers; enabling access to medical care not provided in our area. Allows providers to refer to specialists, decreases no-shows
- Integrated Behavior Healthcare & Screenings - Support of PC clinics to implement BH screenings as routine standard of care; identify patients in need of BH care, while evolving clinics toward integrated BH services
- Mental Health First Aid - 8-hour course providing tools to understand & identify risk factors & warning signs of MH issues; providing skills to intervene, defuse & appropriately refer people in crisis

Network Revenue Stream: We have diversified our revenue streams to include local governments as a new funding source, implementation of "Friends of TCHNetwork", an annual pledge campaign, that Network Members are contributors, billing insurance companies for applicable services, providing fee-for-service programming, and launching a volunteer program that has helped to increase donations. Through the expansion of our portfolio we have been able to continue and expand our programming.

**Project Officer**

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 mcolburn@hrsa.gov

## COLORADO (2)

### Western Healthcare Alliance (WHA)

Valley View Hospital Association

#### Network Description

Grant Number: D06RH27793

Organization Type: Association

Full Address: 715 Horizon Dr Suite 401 Grand Junction, CO 81506

Website: [www.wha1.org](http://www.wha1.org)

Year Formed: 2015

Network Contact:

Marguerite Tuthill

970-986-3677

[Marguerite.tuthill@communitycarealliance.com](mailto:Marguerite.tuthill@communitycarealliance.com)

Members:

PPS hospitals, CAHs, FQHCs, RHCs, Independent Practices

Mission:

The Community Care Alliance prepares healthcare organizations for success in the future, where medical communities will be rewarded for achieving better care, healthier people, and smarter spending.

Vision:

The Community Care Alliance (CCA) will develop a centralized and efficient infrastructure consisting of IT and analytics, practice transformation support, training and best practice guidance, quality monitoring and reporting, care coordination models, health and benefits programs, and management services to meet the varying needs of its members and their clinically integrated networks (CINs). CCA will seek active partnerships with other rural networks throughout the nation, in order to increase economies of scale and bolster the primary goal of providing cost effective population health management solutions for member-owners.

Member Needs:

- Negotiate population health management contracts with payors on behalf of its member-based provider network
- Support its members in developing and managing innovative population health initiatives focusing on improving medical quality for the contracted payer populations, reducing their per-capita costs
- Providing the individual member hospitals with new revenue sources and models to promote their continued sustainability and local self-determination.

Governance: The Network is governed by a Board of Managers with 11 members. All members have 1 vote. The Network is sole-member owned by the Western Healthcare Alliance but has handed over most of the governing

decisions to the Board of Managers. The Board approves the annual budget, the strategic plan, and reviews performance and financial data of the Medicare Accountable Care Organizations (ACOs) managed by the Network. The Board also assists with recruiting members for the clinical integration and medical leadership committees for the ACOs.

### **Environmental Analysis**

Geographical Area: Colorado Counties: Delta, Montrose, Gunnison, Garfield, Eagle, Pitkin, Moffat, Rio Blanco, San Miguel, Hinsdale and Ouray

Washington Counties: Jefferson, Grays Harbor, Mason, Klickitat and Pend Oreille

#### Blocks:

- Potential repeal of the Affordable Care Act
- Financial vulnerability of CCA members
- Low provider engagement with practice transformation work
- Local health plan purchased by a national payor
- Turnover of member organization's leadership
- All members operate in healthcare professional shortage areas (HPSAs)

#### Levers:

- High engagement of care coordinators and project managers at Network members' practices
- One medical community developed a transition of care program for the community with the ACO playing a central role
- Community members and leadership are focused on opportunities to decrease the high total cost of care without sacrificing quality
- The healthcare industry in general is moving towards value-based reimbursement which adds urgency to our work
- The Quality Payment Program creates urgency to begin working on practice transformation and preparing for value-based reimbursement
- Need: Assist the members of the Western Healthcare Alliance, a 26-member 501(c)(3) rural health organization network, in transitioning to value-based reimbursement. The members wanted to aggregate their respective primary service area markets into a single market to engage in population health payor contracting. The Community Care Alliance was developed to pursue the development of value-based models for members

### **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): ACO, Care Coordination

Background: The members of the Western Healthcare Alliance, formed in 1989, have actively pursued the formation of the Community Care Alliance (CCA) to allow its members to aggregate their rural populations and gain experience in population health management. The populations served will include Medicare beneficiaries, commercially insured enrollees, and self-funded members for both member and community employers, and potentially Medicaid beneficiaries in the longer term.

The CCA will develop a centralized and efficient infrastructure consisting of IT and analytics, practice transformation support, training and best practice guidance, quality monitoring and reporting, care coordination models, health and benefits programs, and management services to meet the varying needs of its members and their clinically integrated networks. The CCA will also seek active partnerships with other rural networks throughout the nation, in order to increase economies of scale and bolster the primary goal of providing cost effective population health management solutions for its member hospitals.

Strategic Objectives and Key Initiatives: To form a new network-based accountable care Pilot Program designed to provide an innovative alternative payment and care delivery system called a Community Care Organization (CCO).

- Success for ACOs in the Medicare Shared Savings Program (MSSP)
- Demonstrated improvement of participating practices' and physicians' performance in advance of and related to the Quality Payment Program's Merit-Based Incentive Payment System (MIPS) metrics
- Empirically-evidenced lower cost and higher quality of care provided to all defined populations
- Improved quality of care and well-being of the beneficiaries in the communities served by our CINs, ACOs, and practice transformation organization (PTO)
- Improved financial well-being of healthcare organizations providing care in rural areas through additional revenue sources and increased retention/market share

### **Challenges & Innovative Solutions**

Significant Barriers: Provider engagement has been a difficulty for the Alliance. Provider engagement is necessary for value-based endeavors to succeed since the decisions made at the committee and board levels regarding clinical care protocols and quality performance benchmarks must be implemented at the practice level. The Alliance decided to review committee attendance at Board meetings to prompt provider engagement in those meetings. It has worked: we are now seeing many more providers attending, and participating in, the meetings.

Unachieved Objectives: The Alliance is still working on entering into a contract with a commercial payor. The Alliance has spoken to a couple payors but are still in preliminary stages of negotiations. We hope to have a contract in place by the

end of 2018. The decision to create the Medicare Shared Savings Program Accountable Care Organizations and pursue the ACO Investment Model funding put the commercial contract plan on hold for three years.

The ACOs did provide a learning opportunity for the Community Care Alliance and membership in value-based contracting, as well as some concrete results to take to commercial payors when negotiating contract terms. The Alliance is now engaging employers in three different rural communities on the Western Slope of Colorado to develop direct to employer contracts for each community.

### **Network Continuation**

Value Proposition:

- Accountable Care Organization (ACO) Management Services
- Information Technology and Data Analytics
- Care Coordination Education
- Practice Transformation Organization
- Health Benefits Plans
- Quality Reporting Services
- Network Management

Network Revenue Stream: Yes, the Network has developed Per Beneficiary Per Month and Hospital Participation fees to sustain the Network. In addition, the Network is developing additional product lines in 2018 to offer in 2019 that will bring in additional revenue not accounted for in 2018 budgets.

### **Project Officer**

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## GEORGIA (2)

### South Georgia Regional Prevention Coalition

Bleckley County Board of Education, Inc

#### Network Description

Grant Number: D06RH27765

Organization Type: Board of Education

Full Address: 242 East Dykes Street Cochran, Georgia 31014

Website: Information not available

Year Formed: 2000

Network Contact:

Regina Smith

Director

(478) 934 4300 ext. 6

regina\_smith@bleckley.k12.ga.us

Members:

Hospital, Behavioral or Mental Health organization, Pre- K-12 School, University/College, Social service organizations, Faith-based organizations

Mission:

Our mission is to work together toward a common purpose of building strong, safe, healthy and drug-free rural communities where all youth and families reach their maximum potential and become productive citizens.

Vision:

The vision of the South Georgia Regional Prevention Coalition is to live in communities that are strong, safe, healthy and drug free where all youth and families reach their maximum potential and become productive citizens.

Member Needs:

- A regional standardized approach to implementing primary and specialty care services utilizing the telehealth model at each of our SBHCs.
- On-site behavioral health services.
- On-site oral health services.
- Consumer assistance in enrolling for the local SBHC services which will result in access to health care services.
- Standardized clinical protocols at the SBHC sites to ensure the provision of quality clinical services.
- Strong sustainability plan.

Governance: Our network is governed by the South Georgia Regional Management Team which includes a representative from each school district we serve, the district public health directors, local hospital administration and the director of each local Family Connection collaborative director in each county. The team meets monthly (the first Friday of each monthly) with the 4 collaborative directors and two times per year with the entire group. The collaborative directors take information back to each local monthly meeting to

ensure the network stays connected and informed in regard to rural health issues and progress of our 4 school systems in regards to implementation of the Rural Health Network Development initiative.

## **Environmental Analysis**

Geographical Area: Bleckley, Dodge, Tattnall and Turner Counties in Georgia

Population Need: Many of our local children and their families currently have no access to health care services (including behavioral health and oral health services) other than the emergency department of our local and regional hospitals. Consequently, many of the most at-risk students have inadequate access to essential health and wellness services until it becomes a health and/or academic crisis.

Blocks:

- Poverty, illiteracy and child abuse rates are among the highest in the nation.
- Our health indicators are among the worst in the nation.
- All of our counties are officially designated HPSAs.
- Many of our local children and their families have no access to health care services.

Levers:

- Since 1994, our collaboratives have been awarded a combined total of over \$30 million in direct funding to support local prevention programming.
- Our four public school systems have 17 fully equipped school-based health centers with state of the art telehealth equipment.
- Our four public school systems have agreed to provide the services of their existing school nurses, counselors and educators to staff the school-based health centers in each county.
- All four community collaboratives have agreed to support coalition related activities by establishing them as permanent line items in their strategic plans that are submitted to the State of Georgia annually. A variety of federal, state and private funders use these plans as a mechanism to award periodic funding to promising innovative initiatives.

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): School-Based Care, Telehealth

Background: The South Georgia Regional Prevention Coalition is a regional prevention coalition serving a four county region in rural middle/south Georgia. Our counties include: Bleckley, Dodge, Tattnall and Turner. The South Georgia Regional Prevention Coalition was officially formed in January 2000. In 2000, our local collaboratives realized that we were not working in isolation within our county boundaries. Instead, our local strategic plans are very similar because the needs identified by our communities are similar. We also realize that by working together we can achieve economies of scale, a greater knowledge base by sharing of information, continuous quality improvement, service enhancement for our under and uninsured residents and a greater likelihood of securing resources (including grant resources) to finance essential local safety net services. Since 2000, our local county collaboratives have developed and utilized a standardized comprehensive strategic planning, needs assessment, evaluation and resource development approach.

#### Strategic Objectives and Key Initiatives:

- Integrate behavioral health and oral health in school-based primary care settings.
- Create and implement the same clinical protocols that will assist in the improvement of the delivery of healthcare services for primary care and mental/behavioral health services.
- Provide consumer assistance/patient navigation for facilitating enrollment in the health insurance marketplace.
- Use telehealth services for specialty and primary care consultation.
- Develop and implement an effective sustainability plan for sustaining network related SBHC services.

#### **Challenges & Innovative Solutions**

Our biggest barrier has been to find qualified licensed mental health professionals to work in our initiative to serve students. There are very few licensed providers in our rural areas and the ones that are available work in areas where the salary is much higher than what our initiative budgeted to pay for these positions in a school system setting with a school work calendar.

#### **Network Continuation**

##### Value Proposition:

- Use of telehealth services for specialty and primary care (the SBHCs located in the four public school systems).
- Provision of behavioral health services (the SBHCs located in the four public school systems).
- Provision of oral health services (the SBHCs located in the four public school systems).
- Provision of consumer assistance in enrolling for SBHC services (the SBHCs located in the four public school systems).
- Standardized SBHC clinical protocols (the SBHCs located in the four public school systems).

- Sustainability plan (the SBHCs located in the four public school systems).

Network Revenue Stream: We are not currently working on creating revenue streams but our long-term plan is to implement some type of pay or reimbursement for services in our school-based health centers.

**Project Officer**

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## GEORGIA (2)

### Teledentistry Network

Georgia Department of Public Health

#### Network Description

Grant Number: D06RH26840

Organization Type: Department of Public Health

Full Address: 1101 Church St., Waycross, GA 31501

Website: [www.sehdph.org](http://www.sehdph.org)

Year Formed: 2006

Network Contact:

Matthew Smith

Director

(912) 285-6224

[matthew.smith@dph.ga.gov](mailto:matthew.smith@dph.ga.gov)

Members:

Clinic, public health agencies, school systems, teaching hospital and university, private dental providers

Mission:

The mission of the network is to provide a system of care to meet the oral health needs of individuals living in South Georgia.

Vision:

Improving access to dental care in underserved areas by utilizing technology to leverage existing resources

Member Needs:

- Increased access to dental providers
- Extend services of specialty providers
- Enhanced collaboration with Network partners
- Replication of best practices
- Policy/procedure development
- Transferability of network model
- Quality assurance in care for patients served through new services model
- Improvement of care through high risk consultation
- Access to dental care for complex cases
- Ensure a dental home
- Enhance network sustainability
- Increase likelihood of Teledentistry replication
- Increase skill and competency of tele-dental staff
- Reduce costs and improve efficiency
- Potential for network expansion
- Remaining innovative

Governance: Our network is governed by the South Georgia Regional Management Team which includes a representative from each school district we serve, the district public health directors, local hospital administration and the director of each local Family Connection collaborative director in each county. The team meets monthly (the first Friday of each monthly) with the 4 collaborative directors and two times per year with the entire group. The collaborative directors take information back to each local monthly meeting to ensure the network stays connected and informed in regard to rural health issues and progress of our 4 school systems in regards to implementation of the Rural Health Network Development initiative.

### **Environmental Analysis**

Geographical Area: Rural south Georgia counties of Brantley, Charlton, Clinch, Johnson, Laurens and Wilcox

Population Need: Tooth decay is one of the most preventable childhood diseases, yet oral health care remains the most prevalent unmet health care need for children, especially low income children. Because of the lack of providers, rural areas have additional barriers to dental care when compared to other locations. The targeted network counties are designated Health Professional Shortage Areas (HPSA) and dental HPSAs by the Health Resources and Services Administration (HRSA). The network will build on lessons learned by each partner in providing dental services to poor, rural populations. Many rural areas could benefit from teledentistry and the plan is to make the network processes transferrable and sustainable.

Blocks:

- No current reimbursement for tele-dentistry
- Hygienists not recognized as provider of dental services
- Unable to recruit dentist in rural area
- Lack of understanding of tele-dentistry

Levers:

- Diverse, multi-level partnerships supporting project and initiatives
- History of telemedicine and tele-dentistry in SEHD-sustained past initiate pilot phase
- Infrastructure (equipment, technology, network) in place for years to come
- Additional programmatic funding available to project-(oral health/Ryan White-HIV)

### **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Oral Health, Telehealth

Background: The Teledentistry Project is a partnership of two rural Georgia public health districts (Southeast and South Central Health Districts), Georgia Regents University School of Dentistry and a private practice dentist in the target area, Dr. Jon Drawdy, DMD. The mission of the network is to provide a system of care to meet the oral health needs of individuals living in South Georgia.

The Ware County Board of Health/Southeast Health District (SEHD) has been providing telemedicine services since 1994 and teledentistry services for the past nine years. The Laurens County Board of Health/South Central Health District (SCHD) provides traditional dental services through a public health dentist who works in a fixed clinic in Laurens County, Georgia and through a mobile unit that visits various community sites including other health departments and Head Start programs within the district. Through this project, both health districts seek to further apply the innovative technology of teledentistry to overcome the access barriers that exist in rural, South Georgia.

Strategic Objectives and Key Initiatives:

- To build teledentistry preventive services in Johnson, Laurens and Wilcox counties used to create a mechanism for improving follow-up services for children and adults who receive teledentistry preventive services in Brantley, Charlton and Clinch Counties
- To develop a teledentistry rotation for dental students at GRU

### **Challenges & Innovative Solutions**

- No reimbursement of teledental services
- Hygienists were not recognized as providers of dental services
- Unable to recruit dentists in our rural area

Billing for services using teledental technologies was one of the largest barriers we faced during the development of the teledentistry program. During our pilot and throughout the expansion of the program as a proof of concept, the billing of dental services performed by our hygienists required the direct oversight of a dentist working locally in the facility in order to be accepted by insurance and Medicaid providers. Our teledentistry program provided that oversight using a remotely connected dentist over our video conferencing systems and interconnected peripheral devices, such as industry standard intra-oral cameras and digital x-ray. Due to this, the three barriers listed above adversely affected our ability to secure reliable revenue streams to sustain the program.

We were able to overcome this barrier through continued advocacy for a change in billing policy to our state legislature, Georgia Department of Community Health, and the State of Georgia Board of Dentistry. We were able to show, through our efforts, the value and effectiveness of our model of care to provide dental services to an underserved and vulnerable population of school aged children using our existing telehealth platform. This led to a change in policy for Georgia allowing hygienists to bill for services without the need for direct

supervision, opening the door to more flexible models of care in dentistry throughout the state.

A major goal of our project was the recruiting and employment of a local dentist to support our program and provide reconstructive services that our hygienists preventative and educational services did not cover. In the end, we weren't able to complete this objective due to a lack of rural dental providers with a specialty in pediatric dentistry. This eventually led to our organization seeking out contracted services with local providers to fill the gap in care. This has proven to be a more effective and cost-efficient method of meeting these needs, and these contracted services continue to present date.

### **Network Continuation**

Value Proposition: Teledentistry services, Network collaboration, Development of teledentistry protocol for adoption by the GA Dept. of Public Health, Augusta University provision of oversight and consultation, Local dentist on staff with public health agency, establishment of billable codes, and outsourcing of dental billing

Network Revenue Stream: Yes, after the course of three years in our network grant, our primary goal of getting Medicaid billing codes established for teledental services by hygienist professionals was successful. We have only started billing this year with the billing codes being brand new, so the revenue stream has only just started. We do estimate that it will be capable of funding the network after our grant cycle has ended.

### **Project Officer**

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## ILLINOIS

### Illinois Rural Health Network

Kreider Services Incorporated

#### **Network Description**

Grant Number: D06RH26838

Organization Type: Social services organization

Full Address: 500 Anchor Road, Dixon IL 61021

Website: [www.florissacenter.org](http://www.florissacenter.org)

Year Formed: 2011

Network Contact:

Laura Watters

Director

(815) 288-6691 Ext 226

[wattersl@kreiderservices.org](mailto:wattersl@kreiderservices.org)

Members:

Hospital/medical clinic, community mental health organization and a developmental disabilities provider

Mission:

To be an accessible system of care that promotes early identification of and provides resources and services for children at risk for developmental, medical, emotional, social, and/or behavioral difficulties, enhancing families' ability to ensure the healthiest outcomes for their children while strengthening and promoting inclusive practices in our community.

Vision:

A community where children and families flourish through collaborative efforts.

Member Needs:

- Early identification and intervention
- Referral and access to receive appropriate services;
- Opportunities to improve developmental, social and behavioral skills
- Improved efficiencies/reduction of replication of services
- Educational opportunities for providers and families.
- Inclusive opportunities for recreation, socialization and support
- On-going assessment and identification of needs & gaps, with steps for implementation of additional resources to families, community and providers.

Governance: Currently the board meets quarterly and consists of representatives from Kreider Services, KSB Hospital and Sinnissippi Centers. Kreider Services, as the fiscal agent for the HRSA grant has 3 members on the board (not counting the project director) while KSB and Sinnissippi each have 2 representatives on the board.

## **Environmental Analysis:**

Geographical Area: Primary target for services is Lee, Ogle, Carroll and Whiteside Counties, but we have served children from a total of 14 counties throughout Northwestern Illinois.

Population Need: Agencies working separately were not able to network in a multidisciplinary, holistic approach for each individual. This resulted in referrals made, but lacking coordinated follow up with involved service providers. Diagnosis may or may not result in treatment. The lack of pediatric specialties in these counties area have left families not knowing where to go, with limited local resources available to assist them in overcoming barriers such as transportation.

There is a growing number of children birth to 18 who are presenting complex needs that require a comprehensive and multi-disciplinary approach. Last year, Communities that Care (CTC) tabulated screening data from 8,460 of the estimated 87,879 children between the ages of 0-18 who reside in Carroll, Lee, Ogle and Whiteside counties. 29% of the children screened in 2012 indicated positive for developmental and/or social emotional concerns.

Other significant findings of the CTC are: 1.) children birth to five are struggling with social and emotional concerns at a much higher rate (8%) when compared with other areas of development, and, 2.) most children and youth 6-18 screening positive require monitoring and linkage with community or school based programs. The overall rise in positive screens indicates current diagnostic, assessment and treatment interventions are not adequate to meet the needs of this population.

### **Blocks:**

- Communication
- Qualified providers
- Funding
- Family participation
- Political advocacy
- Interpretation and sharing of data

### **Levers**

- Collaborative relationships/
- Commitment, passion
- Combined services/build on successes
- Grant collaboration for funding
- Combined services
- Shared value of working together
- Data base planning

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Behavioral health, care Coordination

Background: The project is being lead by the Illinois Rural Health Network (IRHN), consisting of the following organizations in northwest Illinois: Kreider Services (includes The Autism Program and Early Intervention), KSB Hospital and Medical Group, Sinnissippi Centers, Lee County Health Department, Lee County Special Education Association, Ogle County Educational Cooperative and Cindy Belleque (Parent Representative).

The overall goal of this project is to use the collaborative and synergistic impact of partner organizations coming together to make specialized pediatric services more accessible and decrease the time for children to receive an accurate diagnosis and needed treatment; thus improving the rural healthcare system for the targeted population of children birth to 18 years of age. The PDC will take a holistic approach in assessing each child with additional focus on family needs assessment and providing services to better equip families with tools needed to improve family health.

Strategic Objectives and Key Initiatives:

- Develop a governance structure and diversified funding streams to ensure long-term sustainability of Florissa.
- Establish a system of care that provides supports and resources to children at risk and their families.
- Educate professionals (physicians, service providers, school personnel, child welfare professionals) about issues related to children at risk and their families.
- Educate the community about issues related to children at risk and their families.

### **Challenges & Innovative Solutions**

While we have been successful in expanding our services, and offering more services including the incorporation of a Pediatrician, we have not yet been able to create a system in which only one intake form is completed and unified billing exists. Clients see all the service providers at one site, but the registration process and billing processes for KSB and Florissa are still separate. With each service provider having their own governing guidelines to follow, it made the process too difficult to overcome at this point. We are hopeful that during the expansion of the network with the next HRSA grant while working toward a Pediatric medical home that we can continue to work towards resolution.

The issues of different governing bodies and separate entities also impacted financial sustainability. We offer services that can be considered covered under Medical insurance or behavioral health. At times which it is covered under may only be determined once a diagnosis is given. Therefore getting enrolled often involves multiple steps to insure we are enrolled on both the medical and behavioral health side. This is also the case with Medicaid. Within the network we have providers enrolled and billing three different types of Medicaid. Florissa cannot bill all of these types of Medicaid without first getting enrolled with the state of Illinois as that type of provider. We continue to collaborate to work on

how best to meet client needs while maximizing revenue options available through the various funding stream of the different partners.

We had hoped to offer a service of multi-disciplinary consultation for area providers. The goal of this was to get a group of diverse providers together once a month to review a difficult clinical case which would be presented by an area provider struggling with a specific child/family. We were successful in implementing this and the group met several times with cases being presented by Ogle County Educational Cooperative and Sinnissippi Centers. However, as we moved forward when it was offered, no one step up with a case to present and therefore the consultation got canceled several months in a row. At this point we have decided not to continue pursuing this since there did not seem to be interest. If area providers indicate an interest in our system wide meetings, then we will re-consider offering this type of consultation at that time.

### **Network Continuation**

Value Proposition:

- Provide Direct Therapies and services to children/families, enhancing their ability to ensure healthiest outcomes.
- Promote Early Intervention/identification of children at risk provides for appropriate service interventions.
- Provide screenings to ensure early identification and intervention.
- Conduct assessments to ensure accurate diagnosis and appropriate treatment recommendations.
- Provide multi-disciplinary Case Consultation to provide additional resources providers and for complex cases.
- Provide training that promotes best practice/evidenced based interventions.
- Provide and promote a community educated in inclusive practice and disability awareness.
- Host Family events and support groups to enhance the families' ability to network, socialize as a family in an inclusive setting and glean support from others with similar life stories.
- Family and Community Resource room provides resources for families, professionals, and the community at large to promote awareness, understanding and inclusion.
- Establish a system of care (including providers and parents) that provides the supports/resources families are looking for.

Network Revenue Stream: The network has been relatively successful in creating revenue streams. There have been struggles with some revenue streams such as Medicaid because of the complexity of the Medicaid system. At this point, we estimate that insurance billings can cover much of our expenses. However, we do provide a significant amount of charity care for those with Medicaid and the uninsured/ underinsured. The grant from the state of Illinois assists with much of the charity care and we continue to seek out grants from private foundations to assist with program funding. Additionally, we held our first annual 5K to raise funds and awareness for our program as well as a golf

outing and have a Gala scheduled for September. We are pursuing other fundraising ideas also.

**Project Officer**

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## INDIANA (2)

### Affiliated Service Providers of Indiana, Inc. (ASPIN)

Affiliated Service Providers of Indiana Inc.

#### Network Description

Grant Number: D06RH28031

Organization Type: Community Mental Health Centers and Addiction Treatment Providers

Full Address: 850 N. Harrison Street, Warsaw, IN 46580

Website: [www.aspin.org](http://www.aspin.org)

Year Formed: 2015

Network Contact:

Kathy Cook

Director

(317) 471-1890

[kcook@aspin.org](mailto:kcook@aspin.org)

Members:

Community Mental Health Centers and Addiction Treatment Providers

Mission:

The mission of ASPIN is to provide innovative educational programs, resource management, program development, and network management in collaboration with all healthcare entities to address health disparities and whole health management. The ASPIN Health Improvement Project's Network will support whole health initiatives, resulting in healthy communities and a sustaining network.

Vision:

The ASPIN Health Improvement Project (AHIP) seeks to improve the health of persons in thirteen rural counties served by a subset of five ASPIN members.

Member Needs:

- Communication about current and pending challenges and opportunities
- Implementation and funding for projects that benefit the members and communities
- Sharing peer knowledge and understanding
- Opportunity for collaboration-grants/info sharing
- One on one contact/data outcomes
- Training in multiple areas
- Clarification of practical applications for information presented
- Open/Supportive communication
- Networking/Support/Innovation
- Establishment of a Navigator Committee

Governance: Member CEOs forming the ASPIN Health Improvement Project (AHIP) provide governance of the ASPIN Network as defined by By-Laws and Policies already in place. Information on AHIP is provided by the Network Director Kathy Cook, CEO during the regularly scheduled monthly Board Meetings to update the group on process and outcome measures. The ASPIN Director of Finance, Lori Billstrand, provides financial updates. Policies generated from the project must be approved by a unanimous vote of the ASPIN Board of Directors. The ASPIN Network is CARF-accredited and has been in existence since 1995. The network includes seven community mental health centers and three addiction providers. The providers listed below are coming together in the ASPIN Health Improvement Project as they collectively serve the thirteen identified HPSA/MHPSA counties targeted. These five providers have been a part of the ASPIN Network since its inception; they annually sign participation agreements with ASPIN and pay dues; they approve all policies and by-laws; meet monthly; allocate staff to the Performance Improvement Committee, the CFO Committee, Navigator committee, Human Resources Committee and various ad hoc and time-limited advisory groups. Each is an accredited not-for-profit organization that operates independently and passes annual financial audits.

## **Environmental Analysis**

Geographical Area: Residents of 13 underserved, rural counties in Indiana

Population Need: Affiliated Service Providers of Indiana, Inc. (ASPIN) is a mature network whose members include seven community mental health centers and three addiction providers serving approximately 69,000 Indiana citizens annually. The whole health and well-being of clients served by ASPIN providers who live in thirteen underserved, rural counties is at great risk due to high levels of existing chronic diseases, inadequate numbers of health professionals, inadequate numbers of mental health professionals, higher poverty, and higher rates of uninsured citizens.

Blocks:

- Uncertainty of ACA changes
- Uncertainty of Indiana Medicaid changes
- Negativity
- Low income
- Geographic spread
- Inter-agency referrals/communication
- Limited medical resources

Levers:

- Many organizations approaching us as potential partners
- ASPIN currently holds numerous grant funds supporting network vision
- ASPIN has a good reputation as a statewide navigator network
- ASPIN has a good working relationship with the State of Indiana's Division of Mental Health and Addictions (DMHA) and Family Social Services Administration (FSSA)

- ASPIN is certified by the state as both a CHW and navigator certification trainer and conduct these regularly
- ASPIN Board members are supportive and participate in network activities.

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Care Coordination

Background: The ASPIN Health Improvement Project (AHIP) seeks to improve the health of persons in thirteen rural counties served by a subset of five ASPIN members. This will be achieved by increasing integrated health care through the cross-training of mental health case managers as certified community health workers and utilizing ACA Marketplace Navigators to increase access to health insurance for persons served. In addition, the network itself will be strengthened through monitoring and reporting of return on investment data for its membership.

Affiliated Service Providers of Indiana, Inc. (ASPIN) is a mature network whose members include seven community mental health centers and two addiction providers serving approximately 58,000 Indiana citizens annually. The whole health and well-being of clients served by ASPIN providers who live in the thirteen underserved, rural counties targeted by AHIP is at great risk due to high levels of existing chronic diseases, inadequate numbers of health and mental health professionals, higher poverty, and higher rates of uninsured citizens. The five members of the AHIP Network have been a part of the ASPIN Network since its inception; they annually sign participation agreements with ASPIN and pay dues; they approve all policies and by-laws; meet monthly; allocate staff to the Performance Improvement Committee, Clinical Roundtable, CFO Committee, and various ad hoc and time-limited advisory groups. Each is an accredited not-for-profit organization that operates independently and passes annual financial audits. An MOU is in place from each provider for this project. These providers are Bowen Center (Wabash and Whitley Counties), Four County Counseling Center (Cass, Miami, and Pulaski Counties), Hamilton Center (Greene and Parke Counties), and Wabash Valley Alliance (White, Montgomery, and Fountain Counties).

Strategic Objectives and Key Initiatives:

- To ensure that persons in rural communities served by ASPIN providers have access to primary care and preventative health services with assistance from case managers dually trained as community health workers to assist in monitoring and referral
- To ensure that persons in rural communities served by ASPIN providers have health insurance coverage through direct placement of additional Navigators and through expanded Indiana Navigator training offerings



- To ensure that the integrated behavioral health and primary care needs of persons served by ASPIN are monitored through ASPIN
- To ensure that ASPIN membership understands the value of the Network in terms of return on investment and its influence on the health of persons served in order to perpetuate the functioning and growth of the ASPIN Network

### **Challenges & Innovative Solutions**

Challenge – Navigator Turnover: Because of the political turbulence about the ACA during the last year and with the change of administration, the program had significant turnover with its Navigator staff.

Solution: Experience with other outreach staff had demonstrated that two factors will enhance retention: sufficient pay and dedication to the mission. ASPIN is offering an hourly rate of \$13.50 per hour, significantly above the Indiana minimum wage of \$7.25 per hour. In rural Indiana, that wage is strong for persons who are not required to have a college degree. In terms of dedication to the mission, this will be assessed during the interview process. ASPIN’s experience managing a statewide Navigator program assists it to assess this factor through interview questions with greater accuracy.

### **Network Continuation**

Value Proposition: Community Health Worker Training, Indiana Health Navigator Training, Continuing Education (CE) Training, Navigator Services, Return on Investment Annual Report, Health Measures,

Network Revenue Stream: The ASPIN Network currently earns income from multiple sources including membership fees, workshop fees, investments, grants, state contracts, and private contracts. Over the last five years ASPIN has finished annually with a positive Net Profit, due primarily to investment income and contract awards. Diverse funding structures remain in place after the AHIP project period. Grant funding will be off-set by expenses related to grant personnel, supplies, contractual, and travel expenses associated with the work plan. Sustainable funding opportunities will be created via grant funding through fee-based Navigator certification and continuing education training capabilities which will add to ASPIN’s diverse funding structure.

### **Project Officer**

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## INDIANA (2)

### Indiana State Rural Health Network (InSRHN)

Indiana Rural Health Association

#### **Network Description**

Grant Number: D06RH26832

Organization Type: Non-Profit

Full Address: 1418 N 1000 W. St., Linton, IN 47441

Website: [www.indianaruralhealth.org](http://www.indianaruralhealth.org)

Year Formed: 2009

Network Contact:

Cody Mullen

Network Coordinator

(812) 478-3919 ext 233

[cmullen@indianarha.org](mailto:cmullen@indianarha.org)

#### Members

Critical Access Hospitals and Rural Prospective Payment System (PPS) Hospitals

#### Mission:

This mission of the Indiana Statewide Rural Health Network (InSRHN) is to create a network of rural providers dedicated to improving their ability to deliver high-quality health care to rural residents.

#### Vision:

To provide support to rural entities in the development of formal health care networks in order to coordinate; improve and expand access to quality essential health care services; and enhance the delivery of health care in rural areas.

**Governance:** The InSRHN leadership team includes both paid staff and member representation. The InSRHN staff includes a Network Director, Phil Ellis, MBA, with extensive experience leading complex organizations. Ellis has total oversight for all InSRHN initiatives and reports to the executive director of IRHA, Mr. Don Kelso, MBA. Cody Mullen, PhD(c), provides leadership over the InSRHN current network development grant. Mullen has experience in project development and execution. With the direct network staff, the executive director of the IRHA oversees the network. Kelso has direct oversight of the network and reports to the IRHA board of directors. In addition to the staff members of the network, the network has a leadership/decision making body consisting of all member hospital CEOs. This group has the authority to make all strategic initiatives and direction of the network. They are the advisory board to the staff leadership of the network. A smaller sub-set of the hospital CEOs sit on the CEO Advisory panel. This panel is there for monthly checks on the network and support to the staff when a quick question is raised. Finally, some of the hospitals CEOs currently serve on the IRHA Board of Directors. Each of these entities are addressed in detail in the following sections.

#### Member Needs:

- Reevaluation of the InSRHN marketing plan
- Community Health Needs Assessments
- Development of a business and sustainability plan
- Development of a network evaluation plan and tools

### **Environmental Analysis**

Geographical Area: Patients living in rural Indiana that have a diagnosis of congestive heart failure, diabetes, and/or Chronic, Obstructive Pulmonary Disease (COPD)

Population Need: The funding was requested to support an initiative that will strengthen the rural healthcare system in Indiana and achieve the triple aim of better health, better health care, and lower costs. The initiative trained and deployed teams of specialized health coaches equipped with evidence-based remote patient monitoring technology in rural primary care settings, focusing on the three most prevalent and costly chronic diseases among adults in rural Indiana: diabetes, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF). Goals of the project are to: (1a) Improve the physical health, behavioral health, and overall quality of life for patients in rural communities throughout Indiana with diabetes, chronic obstructive pulmonary disease, and/or congestive heart failure (CHF) while decreasing the cost of care for these conditions; (1b) Pilot test the chronic disease care management program in communities in two rural regions served by InSRHN members; and (2) Expand the chronic disease care management program throughout communities in the Indiana Statewide Rural Health Network (InSRHN) and ensure ongoing efficacy and sustainability. InSRHN members (hospitals) will serve at the “anchor” sites for the program, but principal patient coaching, care coordination, and health provider team liaison activities will be conducted by care managers located on site in the primary care setting. The overall mission of InSRHN is to create a network of rural providers dedicated to improving their ability to deliver high-quality health care to rural residents. Its vision is: To provide support to rural entities in the development of formal health care networks in order to coordinate; improve and expand access to quality essential health care services; and enhance the delivery of health care in rural areas.

#### Blocks:

- Disconnect
- The network is only as good as our ability to participate
- Time to deal with the larger picture
- Rural issues are fate... population and society is weighing more resources into the larger populations.
- Rural is in the minority. Need to figure out how to battle that. Make our voice louder across the country.
- Network composition – independent verses system. Inability to leverage regional partnerships
- Not everyone is at the table (partnering with mental health facilities)

- Missing a huge opportunity to be more than a buying group, be more of an integrated effort, joint ventures (Labs, insurance initiatives)
- Lack of participation
- Constantly redefine ourselves, need to take a step back and refocus

Levers:

- Leverage resources/discounts/partnerships
- Networking with peers
- Direct access
- Backbone of IRHA
- Grant opportunities available that we cannot go on our own
- Experience of staff/access
- Access to resources and staff expertise
- Getting the rural work out and navigating
- Rural relationships and depth
- Advocacy efforts – we can react
- InSRHN can leverage partnerships
- Value, best practice sharing, educational opportunities and networking with peers. Developing strategies.
- Focus on cultural and economic health care delivery

## Grant Project Description

Project Year: 2014-2017

Focus Area(s): Care Coordination, Population Health

Descripton: This current Rural Health Network Development grant will allow for additional services and education be provided to this network. This project, using consultation and training provided by the Iowa Chronic Care Consortium's evidence-based Certified Health Coach program, multi-disciplinary clinical personnel will be trained as health coaches to work proactively with patients to improve their understanding, activation, and self-management of their chronic conditions and associated comorbidities. The coaching will be supplemented through patient-directed remote monitoring using a tailored telehealth care management platform. Behavioral health and overall quality of life will be assessed as critical elements of overall individual and population-level health.

This project will focus on patients living in rural Indiana that have a diagnosis of congestive heart failure, diabetes, and/or Chronic, Obstructive Pulmonary Disease (COPD). The project also has two primary objectives: Objective 1a: Improve the physical health, behavioral health, and overall quality of life for patients in rural Indiana with COPD, diabetes, and/or congestive heart failure (CHF) while decreasing the cost of care for these conditions; Objective 1b: Pilot the chronic disease care management program in two rural regions served by InSRHN members in year 1, we plan to add four more regions in year 2, and add an additional two to four regions in year 3; Objective 2: Expand the chronic disease care management program throughout the InSRHN and ensure ongoing efficacy and sustainability.

Strategic Objectives and Key Key Initiatives:

- (1a) Improve the physical health, behavioral health, and overall quality of life for patients in rural communities throughout Indiana with diabetes and/or congestive heart failure (CHF) while decreasing the cost of care for these conditions;
- (1b) Pilot test the chronic disease care management program in communities in two rural regions served by InSRHN members;
- (2) Expand the chronic disease care management program throughout communities in the Indiana Statewide Rural Health Network (InSRHN) and ensure ongoing efficacy and sustainability.

## **Challenges & Innovations**

The major barrier that was faced in achieving the goals and objectives of the program was to ensure all critical members at each network site were on the same page and supported of the program. It was found that to have a successful project each of these groups at a facility needed to adopt the program: hospital/clinic administration, clinicians (MD, DO, NP, PA), clinical support staff, and administrative support staff. While early in the adoption of this program it was difficult to know this, each year as new facilities were added to the program this was critical in success and confirmed. We did not have any unachieved objectives for this program funding period.

## **Network Continuation**

Value Proposition:

InSRHN has worked hard since its creation in 2007 to ensure that it met the needs of our rural partners through various avenues. The InSRHN leadership team has approached this in two different ways:

Direct Financial Savings-This is mostly achieved through our shared contracts with various companies that have been established amongst the InSRHN hospitals. These contracts include Cardinal Pharmacy for after hour pharmacy access, Alliant Purchasing for shared group purchasing contracts through Premier, and discounted rates with talent acquisition companies. Hospitals have the option to participate in these contracts; it is not required for membership. Hospitals that have participated have found that their return on invest in joining the network is quickly recouped in the first month or two. The Indiana Rural Health Association also offers our members discounted participation in various services offered including Community Health Needs Assessments.

Indirect Financial Savings-The other area that InSRHN works on to support our members and ensure they receive value through membership in the network include shared learning opportunities, joint grant writing, and advocacy work. Through the network, we have nine (9) different roundtables for shared learning across our members. These roundtables range from position specific, like CEO or CFO, to topical specific, like care coordination and meaningful use. These roundtables are a mix of virtual and face-to-face opportunities for members to

engage with fellow members to share best practices and have a sounding board for ideas. The network also supports our members through collaboration together to pursue various federal, state, and local grant opportunities. This allows hospitals to participate in various funding mechanisms but be able to network with their peers for a more robust application. Finally, the network has worked with both external and internal advocacy navigators to both bring the rural voice to local and state policy discussions and also to assist our members in getting their voice heard.

Network Revenue Stream: The InSRHN was self-sustaining prior to receiving the RHND funding in May of 2014. The addition of the funding allowed for members, who wanted, to expand their offering of health coaching, remote patient monitoring, and chronic care management services. The grant funds supported their training and implementation of the program and then the added cost to offer the service (software and staff time) was covered through reimbursement from Medicare through CPT 99490 (Chronic Care Management). The money for these services do not go towards overall network operations but instead services purchased by the hospital to support their offerings.

### **Project Officer**

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# IOWA

## Wright Health Partners Iowa Specialty Hospital-Clarion

### Network Description

Grant Number: D06RH27767  
Organization Type: Hospital  
Full Address: 1316 South Main Street Clarion, IA 50525  
Website: Information not available  
Year Formed: 2008  
Network Contact:  
Ashley Recknor  
Director  
(515) 532-9240  
ashley.recknor@iaspecialty.com

Members:  
CAH, City Government, Private Practice, Care Center, K-12 District, and a Community College

Mission:  
To provide an exceptional health care experience.

Vision:  
To always be a progressive health care system that is a benchmark for all others.

Member Needs:

- Partnership for education and support for payment systems and changes
- Electronic Medical Record support and integration
- Recruitment of providers and staff needs
- Ability to define payment model and regulations with third party payment models.

Governance: The network's governing body consists of a head representative from each network member who take part in biannual meetings to determine the direction of the network. The network director takes direction from this board and in turn steers the network in day to day operations.

### Environmental Analysis

Geographical Area: Residents of Wright, Cerro Gordo, Franklin, Hancock and Webster Counties in Iowa

Population Need: The original need for the project grew from the need to reduce barriers to accessing and using the healthcare system. Wright Health Partner's service populations faced higher than average rates of uninsured/underinsured population and a higher than normal percentage of that population didn't seek care due to costs. The care coordination program was brought in to address this issue and work with the area population to reduce barriers to care. This fits well

with the network's overall mission of delivering the highest quality of healthcare. This directly benefited our network members by bringing in more patients and connecting those patients to resources that allowed them to pay for services. The overall increase in revenue has been felt by network members.

Blocks:

- Replacement of / recruitment of new Family Practice providers to rural area
- Continual need to prove high quality of care with changing systems
- Cost and feasibility of fully integrating EMR
- Culture to provide ACO model of care

Levers:

- Patient satisfaction
- Agility to move to respond to changes
- Reputation of high quality of care
- Wide range of services
- Engaged leadership, management, and provider teams

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Care Coordination

Background: Iowa Specialty Hospital-Clarion, formerly Wright Medical Center, initiated the cooperative medical relationship with the Orthopedic Specialists, formerly Orthopedic and Sports Medicine Specialists, in 2006. Belmond Medical Center, now known as Iowa Specialty Hospital-Belmond, signed a management agreement with Wright Medical Center in 2007. In July of 2010, Wright Health Partners (WHP) was formally created with a Memorandum of Understanding (MOU) to improve the healthcare needs of Wright County and the surrounding counties. Family practice clinics co-located at each hospital facility work to ensure primary care coverage to this medically underserved area. In addition, hospital facilities offer on-site specialty clinics providing services in cardiac, obstetrics/gynecology, orthopedic, otolaryngology, podiatry, neurology and mental health specialties. Since 2010, WHP has expanded into Cerro Gordo, Franklin, Hancock and Webster counties and added a private Women's Health Clinic.

Strategic Objectives and Key Initiatives:

- To improve the overall quality of health by implementing a sustainable evidenced-based care coordination program across Wright Health Partners network and area partners
- To increase access to coordinated quality care for all patients within the network through system optimization and coordinated scheduling
- To demonstrate financial management proficiency for the evolving health care environment that parallels and supports quality healthcare delivery



## **Challenges & Innovative Solutions**

One of the largest barriers the network faced was finding the right person to fill the care coordinator roll. We had high turnover initially due to the demands of the job. It takes a particular type of person to fill this role, and once we had narrowed that position down it became easier to determine if the potential hire was a good fit.

## **Network Continuation**

Value Proposition:

- High Quality Family Practice services (Iowa Specialty Hospitals and Rural Health Clinics - 2)
- Local access to Inpatient and Outpatient services (Iowa Specialty Hospitals - 2) – streamlined services
- OB and high-risk Women’s Health services (Gabrielson Clinic)
- Conservative and surgical Orthopedic services (Orthopedic Specialists) – less unnecessary calls and visits
- Non-surgical and surgical services for weight loss and obesity services (Iowa Weight Loss Clinic)
- Long term care and skilled nursing services (ABCM Care facility) – improving communication
- Associates and trade service education (North Iowa Community College)
- High school education and population health with wellness interventions (Belmond School Systems) – new services

Network Revenue Stream: The care coordination project funded by this grant has achieved self-sufficiency by initiating payment for the care coordination services and has been taken over by the network’s hospital partners as they employ the care coordinators and take care of the billing aspect.

## **Project Officer**

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## KANSAS

### Kansas Frontier Community Health Improvement Network Great Plains Health Alliance, Inc

#### Network Description

Grant Number: D06RH28033

Organization Type: not-for-profit 501 (c)(3)

Full Address: 625 3rd St, PO Box 366, Phillipsburg, KS 67661

Website: Information not available

Year Formed: 2017

Network Contact:

Janet Hamilton

Director of Special Projects

hamiltonj@healthfund.org

620-662-8586

Members:

Critical Access Hospitals/Rural Health Clinics, Hospital management company, Private Philanthropy, Behavioral/Mental Health Center

Mission:

To engage energetic, forward-thinking rural communities to work together to design, implement, and evaluate new methodologies for health care delivery and sustainability in rural and frontier Kansas.

Vision:

Identifying and implementing transformational strategies to provide sustainable healthcare in rural Kansas.

Member Needs:

- More influence with reimbursement for care coordination, MH integration
- Coverage for change in administrators
- More service integrity across sites – clarity of vision – learning community activity
- Pass along more information about lessons learned so each member doesn't have same pains
- Potential for network-funded positions to act as regional informational hubs?
- Negotiation power i.e. telemedicine technology, EHR purchases, MH integration provider contracts – sites have difficulty on their own
- Need all members (not just some) to be willing to take risks – not just expecting the usual suspects to take them for everyone.

Governance: Governing body is comprised of a President, Secretary and Treasurer. Board of Directors is comprised of a designated representative from each of the member health care providers. Associate members are accepted by vote of the Directors. Member organizations are listed below. Each health care

provider member pays dues, provides a designee to meetings, and is responsible to the Network to carry out agreed upon goals.

## **Environmental Analysis**

Geographical Area: Residents of rural and frontier Kansas

Population Need: Member CAHs and Rural Health Clinics are all located in frontier communities in western Kansas. Frontier communities have a population of less than six persons per square mile. Communities were encouraged (by the United Methodist Health Ministry Fund) to conduct community planning sessions to determine what sustainable processes were needed to continue the provision of effective health care for these isolated areas. Seven communities originally responded and jointly determined the need for care coordination, telehealth availability, and mental health integration into primary care practices. A hospital network was formed with the intent to strengthen each community's delivery of health care.

Blocks:

- Concerns the network has too small impact to influence legislation.
- Too many barriers to integration (i.e. pay, culture, etc.)
- Fear of new methodologies, distrust of change to the system.
- Competing and multiple priorities and requirements among the partners.
- Fear of losing individuality of these small communities.

Levers:

- Sharing resources among providers
- Engaging external stakeholders who have experienced success.
- Aligning healthcare (providers, staff, patients) to provide seamless care.
- The Learning Community Function (a place to gather and disseminate best practice, novel approaches)
- Commitment to shared vision and goals.
- Greater collaboration among smaller providers may allow more influence on policy that could affect rural health.

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Behavioral Health, Care Coordination, Integration

Background: The Kansas Frontier Community Health Improvement Network (hereafter referred to as: the KFCHIN Network or the Network) uses care coordination, integration of behavioral health in a primary care setting, and enhanced rural infrastructure for new health care technologies to improve and sustain frontier health care systems.

Our network was originally conceived through the work of a Rural Health Advisory group (then called The Kansas Rural Stakeholders Group) started in 2011 by the United Methodist Health Ministry Fund (the Health Fund), a statewide health philanthropy with a rich history supporting rural health, with partners throughout the state. This group recognized the need for transformation or at the very least transition to a different model for delivery of healthcare to rural populations. Rather than prescribing a model, the coalition sought community feedback via a Request for Participation whereby rural communities could indicate their interest and potentially become involved in a privately funded pilot project.

The members of KFCHIN originally came together as communities who would form Healthy Futures Community Taskforces then tasked identifying key barriers to rural health and developing their model. They were supported during this phase by the Kansas Leadership Center, which provided facilitation services for the community taskforces during the planning phase of the initial private RFP as well as providing project mentors/coaches for the four project managers. The release of the HRSA Network Development grants coincided with the private project's kick-off event in 2013 and an Administrative Board (composed of local/private funders and external reviewers of the initial application) made the recommendation that the Network apply for the HRSA grant.

Strategic Objectives and Key Initiatives: Achieve efficiencies through the integration of primary care and mental health services at both types of service providers through additional mental health service provision; Improve essential health care services through the development of local essential health care services systems which may include community case management services and the examination of new funding mechanisms; Strengthen the rural health care system as a whole through the use of technology – specifically, expanded consultative services initially to hospital emergency departments through 24/7 centralized telemedicine hub coverage.

### **Challenges & Innovative Solutions**

Each member hospital has adopted, to some degree programming and or staff positions to carry out Care Coordination activities. Of the few hospitals that identified telehealth as a viable option, the equipment has been purchased. To date, only two hospitals have successfully integrated behavioral health into the local primary care practice.

A state-wide barrier to telehealth is a major health insurer's resistance to parity and pay parity in Kansas. Any change will require state legislative action, which is being planned at this time for possible action in the 2018 Kansas Legislative Session. Resistance to mental health integration (in lieu of co-location) has come from some practicing physicians and the lack of qualified mental health providers (that are eligible for Medicare, Medicaid and private insurance reimbursement) in these very small and rural communities.

## **Network Continuation**

Value Proposition:

- Network as Group-Negotiating body – personal/interactive assistance
- Network staffing/coverage – network members – interactive/co-creation
- Service integrity/clarity of vision – interactive
- Learning community - interactive
- Network-housed positions to act as regional hubs – remote/personal assistance/co-creation
- Network as risk-agent - remote

Network Revenue Stream: Multiple Kansas philanthropies have supported the Network and paid the start-up costs for some of the grant approved services.

## **Project Officer**

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## KENTUCKY (2)

### Kentucky Rural HIT Network (KRHIT)

Kentucky Rural HIT Network

#### **Network Description**

Grant Number: D06RH27776

Organization Type: Hospital

Full Address: 440 Old Whitley Road, Suite 208, London, KY 40744

Website: [www.krhit.org](http://www.krhit.org)

Year Formed: 2011

Network Contact:

Shannon Adams

Project Manager

(606) 401-6233

[sadams@krhit.org](mailto:sadams@krhit.org)

#### Members:

Hospital, Clinic, Long-term care, Behavioral or Mental Health organization, Home Health organization, Faith-based organization

#### Mission:

To facilitate and coordinate the development of an interconnected, secure data sharing network in support of quality rural health care for the medically underserved and to assist providers in the alignment of local efforts with emerging state and national guidelines.

#### Vision:

To provide the people of rural, southeastern Kentucky access to a full continuum of quality health services.

#### Member Needs:

- Care coordination
- Quality improvement
- EHR adoption/implementation
- Training in health information exchange
- Internet connection/speed
- Quality improvement resources
- Webinars conferences and trainings

Governance: KRHIT is a 501c3 organization. Organization bylaws have been in place since the KRHIT network was formed in 2011. The organization is governed by a Board of Directors that includes nine to thirteen members. The Board consists of no fewer than 51% network members, and all directors live and/or work in the network service area. The Board meets on a quarterly basis at a minimum.

## Environmental Analysis

Geographical Area: Adults in Knox, Laurel and Whitley Counties affected by the diagnoses of congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and/or pneumonia

Population Need: The target population includes 126,369 residents in Knox, Whitley and Laurel counties in southeastern Kentucky. Focused activities will be conducted for those diagnosed with and who have been hospitalized for COPD, Chronic Heart Failure and Pneumonia. The proposed project was designed in response to the need of rural healthcare providers to meet the demands of a changing healthcare environment while maximizing limited resources. The high level of patient needs and poor health outcomes make it nearly impossible to achieve these goals without collaboration. The overall goal of this project is to expand access to and improve the quality of essential health care services by focusing on projects and /or network activities directly related to the evolving health care environment.

### Blocks:

- Changes to Medicaid expansion
- Possible Affordable Care Act Repeal
- Workforce shortage
- Public infrastructure is lacking
- Economic climate of the region and sociocultural determinants of health in region
- No Health Information Exchange and limited interest

### Levers:

- Highly motivated and driven staff
- Regional Healthcare Coalition
- Newly formed Accountable Care Organizations
- Increased collaboration among providers
- Promise Zone/Increased federally funding and emphasis on collaboration
- Shaping Our Appalachian Region (SOAR) Initiative for the region

## Grant Project Description

Project Year: 2014-2017

Focus Area(s): Care Coordination, HIT/HIE

Background: Kentucky Rural Health Information Technology, Inc. (KRHIT) is an established rural HIT network serving nine counties in southeast Kentucky, with a governing board comprised of community medical leaders. The mission of the program is to create a healthy community by increasing access to quality care utilizing services provided by network members. KRHIT has a vision of providing the people of rural, southeastern Kentucky access to a full continuum of quality

health services. KRHIT believes that its vision can be achieved by facilitating and coordinating the development of an interconnected, secure data sharing network in support of quality rural health care for the medically underserved and to assist providers in the alignment of local efforts with emerging state and national guidelines.

#### Strategic Objectives and Key Initiatives:

- Improving performance on quality measure for hospitals, skilled nursing facilities, home health agencies
- Improving the quality and safety of health care by improving care transitions from hospital to other settings and reducing hospital readmissions
- Improving coordination of care
- Facilitating enrollment in Kentucky's health insurance marketplace (kynect) by providing in-person assistors (kynectors).

### **Challenges & Innovative Solutions**

Information not available.

### **Network Continuation**

#### Value Proposition:

- Members:
  - Formal Members- patient navigation, reduced cost of care, increased quality, care coordination, filling care gaps
  - Informal Members - patient navigation, referrals to them for services/increased business, care coordination
- Services:
  - Patient Navigation- meeting patients' non-health related needs, communication across providers, support for patients, reduced cost of care, overcoming barriers to accessing care, comprehensive approach to meeting needs, increases patient engagement
  - Regional Healthcare Coalition- coordinating across organizations, community-wide collaboration to meet needs, QI information and training

Network Revenue Stream: Information not available.

### **Project Officer**

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## KENTUCKY (2)

### Appalachian Kentucky Health Care Access Network Montgomery County Health Department

#### **Network Description**

Grant Number: D06RH27779

Organization Type: County Public Health

Full Address: 117 Civic Center Mount Sterling, KY 40353

Website: [www.akhcan.org](http://www.akhcan.org)

Year Formed: 2006

Network Contact:

Gina Brien

Director

(859) 498-3808

[ginal.brien@ky.gov](mailto:ginal.brien@ky.gov)

Members:

Local health departments, State Department of Public Health, AHEC, Hospitals, FQHC, universities, Regional Health Information, Health Information Exchange, providers, evaluators

Mission:

It is the Network's mission to increase the number of Community Health Workers (CHWs) in the Commonwealth of Kentucky by expanding our Network to include partners throughout Western Appalachian Kentucky and developing training programs and supporting a certification process for all CHWs. By increasing the number of CHWs, Kentucky will provide better healthcare access for their low-income, uninsured, and underinsured rural and Latino populations.

Vision:

The vision of the Western Appalachian Kentucky Health Care Access Network is to increase and improve healthcare access for all low-income, uninsured and underinsured residents, documented and undocumented, of rural Kentucky.

Member Needs:

- Support and advocacy for CHW service reimbursement
- Promotion of CHW benefits to providers
- Support and advocacy for continued transformation of healthcare from volume based to value based
- Development of CHW training program
- Network sustainability

Governance: The AKHCAN has an Executive Committee. This committee serves in a leadership role for the Network and meets more frequently than the Network as a whole. During these meetings, the Executive Committee assesses the status on work plans, identified ad hoc committees, assesses Network functioning, and insures communication of relevant information to all members. The AKHCAN Executive Committee meets four times annually.

## **Environmental Analysis:**

Geographical Area: Appalachian Kentucky, with a special emphasis on the Latino population

### Population Need:

- Lack of healthcare providers
- Lack of medical insurance and pharmaceutical access
- Unmet needs of the target population
- Health disparities experienced by the Latino population
- Medically underserved area and medically underserved populations
- 1 in 3 Kentuckians are medically disenfranchised

### Blocks:

- CHWs are not yet reimbursable and there are other disincentives to implementing a CHW program.
- There is low availability of culturally sensitive and well-trained CHWs.
- There isn't much provider engagement or buy-in of the CHW concept and ideas.
- There is tenuous political support for the continued transformation of healthcare from volume based to value based system.
- A specific CHW program outline is not available and it is a challenge to build modules that are flexible enough to be customized to specific communities.

### Levers:

- The Network's expertise for developing and implementing CHW programs
- A Network shared vision of CHWs as a solution for population health.
- This is a time of change with a shift toward value in healthcare.
- We know how to talk about CHW "features and benefits."
- Funding is currently available to provide CHW training.

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Care Coordination, Population Health

Background: Our Network was created to accomplish our mission in a multi-county area of rural Appalachian Kentucky with a special emphasis on the Latino population. Through case management and the utilization of the Community Health Worker (CHW) model, the Network hopes to accomplish the goals of identifying and managing chronic disease among the target populations and providing an evidence base that shows the potential for replication of the CHW model in other rural communities. The Network is in a unique position to address these healthcare needs as we have been working diligently over the last 12 years to identify the healthcare needs not only faced by Latinos residents in a

three-county region of Kentucky, but also the needs of rural residents in general.

Strategic Objectives and Key Initiatives: The development of a CHW educational training center designed to provide health departments in a rural 32-county region of Appalachian Kentucky with a cadre of CHWs.

### **Challenges & Innovative Solutions**

A couple of challenges have presented themselves during this project. First, according to Goal #2, Objective #1 in the Work Plan, the Network was going to provide partial funding for a part-time CHW Program Manager at the Kentucky Department for Public Health (KDPH) by the end of Year 1 of the grant period. Currently, KDPH has a part-time employee committed to this role, but the person has changed throughout the three years and remained vacant part of the time due to hiring freeze and requirements for hiring at the state level. KDPH did not believe they would keep the position in the beginning. Therefore, the Network had to amend the Work Plan and remove this objective from the Dashboard.

Second, since the beginning of this grant period, a new governor had been elected and new commissioners have been appointed to KDPH and state Medicaid Office. As a result, the State Plan Amendment (SPA) to the state Medicaid Office, specifically Medicaid payment for CHW services, could not move forward. Moreover, the commissioner seat for the Department of Public Health was vacant from December 2015 through July 2016. It has most recently been vacated in September 2017 and filled again November 2017. There is someone supportive of the state CHW Workgroup's plan who is the Deputy Commissioner at the Department for Public Health. However, this person's hands are tied in that every action taken by the department must be approved at the Commissioner's level. This affects the operations of the CHW Workgroup which forces them back and forth between being idle and active, which delays progress of the Network as it relates to the goals and objectives for certification and reimbursement within the Work Plan.

### **Network Continuation**

Value Proposition:

- Guide to Training Requirements: A guide to training requirements for CHWs, which lists various resources on how to obtain training from approved trainers and/or modules
- State CHW Association: A functioning state-wide CHW association
- Benefits of CHWs: Promotional materials on the benefits of utilizing CHWs, which details the clinical data outcomes and is distributed to payors and providers
- Sustainable Network: A sustainable Network, which will continue to promote the value of CHWs
- Replication: A product or service outline that can be replicated across the state and used as a model for other states

Network Revenue Stream: The Network has no projected revenue; however, continued in-kind contributions of time, expertise, and resources, along with an increased CHW workforce and development of a CHW network, will all support sustainability of the Network and its functions. Through a Return on Investment study funded by the Kentucky Department for Public Health (KDPH) and information provided by Network members, we can show that by using CHWs to educate on proper health care utilization and helping clients establish a medical home, we decrease the amount of uncompensated care by clients using emergency departments for non-emergent needs as well as for care due to improper self- management of a chronic disease. In addition, we were able to obtain a second round of HRSA Network Development Grant Funding in order to expand the work of this project in 32 counties to 102 counties in Kentucky.

**Project Officer**

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# LOUISIANA

## Emergency Rural HIT Project (E-RHIT)

Louisiana Rural Ambulance Alliance, Inc

### Network Description

Grant Number: D06RH6839

Organization Type: Statewide Membership Organization

Full Address: 5010 Highway 1, Napoleonville, LA 70390

Website: <http://www.louisianaambulancealliance.org/>

Year Formed: 2011

Network Contact:

Donna Newchurch

Project Director

(985) 513-3593

[donna@newchurchassoc.com](mailto:donna@newchurchassoc.com)

Members:

- 28 EMS Providers
- Statewide HIE
- Statewide Emergency Response Network
- Statewide EMS Membership Organization
- Statewide Traffic Records System

Mission:

The E-RHIT Network mission is: to establish a network of engaged providers committed to improving access to information and better health outcomes for rural residents of Louisiana. Its mission is to support, facilitate, and establish an electronic health information technology opportunity for rural EMS providers that is driven by quality and supported by data.

Vision:

Our richly diverse health care community are to be positively impacted by the functions, deliverables, and outcomes of the E-RHIT Network.

Member Needs:

- IT support
- Financial support
- Training / continuing education
- Data
- Coordination.

Governance:

- The following members compose the Governing Board; they bring the contributions detailed in their missions / charges.
  - Louisiana Rural Ambulance Alliance is a statewide membership driven, not for profit organization which serves as a convening point for EMS providers with similar delivery issues; LRAA is representative of all rural pre-hospital providers in the state.
  - Louisiana Emergency Response Network is an office of the Louisiana Department of Health and Hospitals charged with

facilitating and implementing a statewide electronic data collection system.

- Louisiana Health Care Quality Forum is a private, not for profit organization which leads evidence-based, collaborative initiatives to improve the health of Louisiana citizens. The Quality Forum is the lead organization in the state for understanding federal requirements for Health Information Technology and Meaningful Use Standards.
- Louisiana Traffic Records Coordinating Committee (LA TRCC) supports the improvement of road safety through the collection, integration, and analysis of traffic safety data. Meeting on a quarterly basis, the LA TRCC brings different state agencies together in an effort to improve data collection and reporting of information

## **Environmental Analysis**

Geographical Area: Residents of rural zip codes in the state of Louisiana

Population Need: The E-RHIT Network has identified gaps in the system as it relates to communicating, sharing, and responding to patient data, patient outcomes and morbidity data. While the key elements necessary to create access for EMS Providers and receiving facilities to patient care reports are available, they are quite simply beyond the financial means of the individual providers.

Blocks & Levers:

- There is a disconnect between multiple patient data points in Louisiana. Patient data is available but there is no real-time connectivity between EMS, receiving facilities, and access to EHRs.
- The expansion of the E-RHIT Network efforts is allowed for strategic and data driven responses to this systemic disconnect detailed above.
- Approximately two-thirds of Louisiana EMS providers in Louisiana do collect patient data electronically and submit it to the statewide trauma network as a result of the efforts of the E-RHIT Network staff and members.

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): HIT/HIE

Background: The E-RHIT Network was formally established in September 2011 in response to a funding award by the Federal Office of Rural Health Policy. Informally, the Network Partners had been working together since 1995 toward increasing access to care, data collection, and quality improvement. Accomplishments of the E-RHIT Network, over the past four years, include but are not limited to:

- successfully developing, adopting, and incorporating into the state EMS / Trauma system a National EMS Information System (NEMSIS) compliant data dictionary;
- creating an EMS specific electronic health record template and making this template available to all EMS providers in the state while working with EMS providers to customize and incorporate a NEMSIS compliant template into their EMS Service;
- awarding 85 rugged laptop computers to eighteen Louisiana licensed EMS Services and ensuring that this hardware was incorporated into their standard operating protocols and procedures. Specifically, these computers are used in the ambulances, on scene and in route, to capture patient data. The data is then transmitted to and incorporated into LERN, which is the statewide trauma registry, as well as to the EMS providers system to be used for patient care reports, billing, and quality improvement activities;
- successfully facilitating the submission of data by EMS providers into LERN by training EMS professionals on this process. Prior to the formalization of the E-RHIT Network, only hospitals were submitting data into this registry; no EMS providers were submitting data. The submitted data is de-identified then analyzed to determine variations across communities in mortality and morbidity and used to inform training efforts; and
- identifying gaps in the system as it relates to communicating and sharing patient data, patient outcomes, and morbidity.

Strategic Objectives and Key Initiatives: Successfully developing, adopting, and incorporating into the state EMS / Trauma system a National EMS Information System (NEMSIS) compliant data dictionary; creating and making an EMS specific electronic health record template available to all EMS providers in the state; enabling EMS providers to customize and incorporate this NEMSIS compliant template into their EMS Service; successfully facilitating the submission of data by EMS providers into LERN; and identifying gaps in the system as it relates to communicating and sharing patient data, patient outcomes, and morbidity.

### **Challenges & Innovative Solutions**

At the receiving hospitals, there has been some resistance on the part of some hospital staff to utilize the available data. This reluctance may be due to the culture of the receiving facility where EMS and ER Nurses sometimes have differing opinions on processes. It may also be due to lack of time and/or resources; in a large-scale motor vehicle event or mass casualty event, the ER staff may simply not have time to access the web based system to review the data before the patient arrives. There are also times when computers are “down” either out of service or the network is out.

In the field and while in transport in the ambulance, the challenge is simply one of connectivity. Much of Louisiana and the majority of the project sites are

located in rural areas. Many of these rural areas do not have access to the internet. Paramedics can input data into the system while not connected to the internet, but the data cannot be transferred to a receiving facility until access to the internet can be established. This connectivity often does not happen until the transport is well underway.

The E-RHIT Network member discussions around data collection and analysis have focused primarily on two components; the challenges with timeliness and accuracy. While efforts to train end users on process to submit data timely and accurately continue, the members of the E-RHIT Network members recognize that there is some percentage of inaccurate data being submitted. To date, the Network members have not identified a way to determine what percent might be inaccurate and how to incorporate this potential inaccuracy into the analyzed data.

## **Network Continuation**

Value Proposition:

- To EMS Providers: access to funds to purchase hardware; access to EPCR system; access to training; access to networking opportunities; access to opportunities for QA and benchmarking.
- To Louisiana Rural Ambulance Alliance: addresses members' needs which is mission of the organization.
- To Statewide Emergency Response Network: assists with capacity to meet mission of collection of EMS transport data.
- To Traffic Records Coordinating Committee: assists with access to data and opportunity to analyze / cross walk Motor Vehicle Data with health outcome data
- To LaHIE (statewide HIE): assists with capacity to meet Mission

Network Revenue Stream: Through a collaborative relationship with the LA TRCC, additional funds in the amount of \$192,100 have been secured and will support Network activities over the next 12 months.

## **Project Officer**

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jberube@hrsa.gov



## MAINE

### Maine Rural Health Innovations Network (MRHIN)

Cary Medical Center

#### **Network Description**

Grant Number: D06RH28028

Organization Type: Hospital

Full Address: 163 Van Buren Road, Caribou, ME 04736

Website: Information not available

Year Formed: Information not available

Network Contact:

Leslie Anderson

Director

lrandolph@carymed.org

Members:

Hospitals

Mission:

Building upon trust and experience, the Maine Rural Health Innovations Network will advance the health and wellbeing of the people we serve through the use of best practices, transparency and advanced technology.

Vision:

To create the healthiest Maine population through collaboration and innovation.

Member Needs:

- Improvement in chronic disease management
- Improvement in work with limited resources through enhanced collaboration between partners
- A healthier population exists through leveraging existing community resources
- Improvement in fiscal viability of chronic disease management

Governance: The MRHIN is a collaborative network of ten hospitals in Northern and Eastern Maine. Each hospital has its own governance, including a Chief Executive Officer and a Board of Directors. Each hospital CEO is invited to participate in monthly MRHIN steering committee meetings. Additionally, each CEO has assigned a hospital designee as a steering committee member. All steering committee members participate in monthly MRHIN meetings.

The MRHIN Executive Director reports directly to the Chief Executive Officer at Cary Medical Center, the fiscal agent of the grant funding, and indirectly to all other hospital CEOs through this collaborative effort. The Executive Director is responsible for managing the day to day operations and business of the MRHIN. The hospital CEOs approve the ongoing work of the MRHIN through approval of the work plan, evaluation plan and the strategic plan. The Executive Director also provides written quarterly updates on efforts of the collaborative to each

hospital CEO and an annual presentation to the hospital CEOs and steering committee members.

In order for the MRHIN to function most effectively, the Steering Committee members are responsible for bringing each hospital's perspective into the decision-making process. Furthermore, the Steering Committee members are responsible for implementing the MRHIN work plan at each hospital and for reporting back on implementation challenges or obstacles. At points in the work plan, when grant funds are required to move a particular project forward, confirmation of approval of expenditures by the ten hospital CEOs is sought, with majority approval required for expenditure of funds.

## **Environmental Analysis**

**Geographical Area:** Residents of five counties in the northern and eastern sections of Maine

**Population Need:** The Maine Rural Health Innovations Network (MRHIN) is a collaboration of Northeastern health care partners who share common demographic challenges and solutions to serve a geographically isolated, low-income, highly geriatric population. MRHIN consists of ten hospitals that serve five counties in the northeast section of Maine: Calais Regional Hospital, Cary Medical Center, Downeast Community Hospital, Houlton Regional Hospital, Mayo Regional Hospital, Millinocket Regional Hospital, Mount Desert Island Hospital, Northern Maine Medical Center, Penobscot Valley Hospital and St Joseph's Hospital. MRHIN has been collaborating formally and informally since the 1990s to achieve the goal of improving and expanding access to health services for populations in the most rural and impoverished areas in our state. All of the members belong to the Maine Hospital Association and have networked at state-wide and regional initiatives to improve care. The purpose of this collaboration is to build on the history of partnership and develop additional innovative ways to coordinate and integrate health services across our network to improve quality, with a specific focus on some of the highest risk illnesses: the exacerbation of diabetes, congestive heart failure and chronic obstructive pulmonary disease.

**Blocks:**

- Decreased awareness of the challenges amongst partners
- Work force challenges/limitations
- Working across multiple IT/EMR platforms
- Engagement of direct care providers
- Competing priorities of partner hospitals
- Consumer healthcare delivery model

**Levers:**

- Shared vision by partners
- Ability to impact a large number of lives
- Experienced leadership team

- Collective content expertise
- Established collaboration with history of formal and informal partnerships
- Diversity of talent

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Population Health

Background: The Maine Rural Health Innovations Network (MRHIN) is a collaboration of Northeastern health care partners who share common demographic challenges and solutions to serve a geographically isolated, low-income, highly geriatric population. MRHIN consists of ten hospitals that serve five counties in the northern and eastern sections of Maine: Calais Regional Hospital, Cary Medical Center, Down East Community Hospital, Houlton Regional Hospital, Mayo Regional Hospital, Millinocket Regional Hospital, Mount Desert Island Hospital, Northern Maine Medical Center, Penobscot Valley Hospital and St Joseph's Hospital.

MRHIN has been collaborating formally and informally since the 1990s to achieve the goal of improving and expanding access to health services for populations in the most rural and impoverished areas in our state. All of the members belong to the Maine Hospital Association and have networked at both the state-wide level and regional level on initiatives to improve care. The purpose of this collaboration is to build on the history of partnership and develop additional innovative ways to coordinate and integrate health services across our network to improve quality, with a specific focus on some of the highest risk illnesses: the exacerbation of diabetes, congestive heart failure and chronic obstructive pulmonary disease.

Strategic Objectives and Key Initiatives:

- To integrate clinical care across the network for high risk patients with CHF and diabetes
- Building a virtual platform to coordinate and share services across the network that will expand access to and improve the quality of services for patients with chronic disease
- Integrate telehealth to improve access to care and prevent the exacerbation of chronic diseases for the highest risk populations

## **Challenges & Innovative Solutions**

Information not available.

## **Network Continuation**

### Value Proposition:

- Chronic diseases are effectively managed by Medical Providers
- Provider workforce has improved access to advanced education
- Best practices are aligned at partner hospitals
- Partnerships exist for improving access to care for patients with chronic disease
- Chronic diseases are effectively managed by patients & their families
- Community resources relationships are positive & impact patient outcomes
- Access to care is enhanced
- Collaboration between partners is effective and efficient, contributing to the health & well-being of community members
- Care is enhanced through shared resources
- Best practice models are aligned at partner hospitals

Network Revenue Stream: Information not available.

## **Project Officer**

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jberube@hrsa.gov

## MARYLAND

### Mountain Health Alliance

Western Maryland Area Health Education Center

#### **Network Description**

Grant Number: D06RH27794

Organization Type: Area Health Education Center

Full Address: 39 Baltimore St. Ste 201, Cumberland, MD 21502

Website: [http://www.ahecwest.org/content/mountain\\_health\\_alliance\\_mha](http://www.ahecwest.org/content/mountain_health_alliance_mha)

Year Formed: 2011

Network Contact:

Catie Wampole

Network Director

(301) 777-9150

[cwampole@ahcecwest.org](mailto:cwampole@ahcecwest.org)

Members:

FQHC, AHEC, hospital, clinic, private practitioners, health department, local health improvement coalition, non-profit community organization, higher education

Mission:

The Mountain Health Alliance is a tri-state Network dedicated to advancing a culture of health through collaboration and community engagement.

Vision:

The Mountain Health Alliance envisions that the Region will achieve a culture of health and wellness.

Member Needs:

Information not available.

**Governance:** While the Network meets monthly to discuss Network activities and assess progress toward Network goals, its seven-member Governing Board meets quarterly and addresses issues and/or policy concerns as they arise. Agencies that are members of the Mountain Health Alliance sign a Memorandum of Understanding outlining the Network's overarching goal and the role of the members. No financial obligation is assumed under this MOU.

#### **Environmental Analysis**

**Geographical Area:** Three state, five county Region that includes Allegany, Garrett, and the western-most area of Washington County, Maryland; Bedford County, Pennsylvania; and Mineral County, West Virginia

**Population Need:** Two assessments have been conducted regarding the need to establish additional dental clinics in the region. According to the findings, the first states there is no need to open a dental clinic in Allegany County, MD. The other found significant need for a dental clinic in Mineral County, WV. Other

needs assessments show a shortage of behavioral health specialists, most notably psychiatrists. These assessments also show that the wait time for behavioral health services throughout the Region is up to three months long.

**Blocks:**

- Levels of poverty contributing to poor health outcomes and challenges recruiting health professionals
- Differing funding streams and mechanisms of payment for services rendered across state lines
- Provider shortages and looming retirement of the current practitioners
- Lack of comprehensive oral health benefit as an essential health benefit

**Levers:**

- Bridges to Opportunity initiative; “Bridges” is a community-wide, comprehensive approach to addressing poverty based the ideas of Ruby Payne, Philip e. DeVol, and Terie Dreussi Smith
- AHEC West “grow your own”, rural clinical education opportunities, and continuing education programs for regional health professionals
- Possible Maryland Medicaid state dental benefit
- Community health workers increasing access to services, reducing misuse of emergency departments and/or avoidable readmissions, and reaching, educating, and supporting targeted populations

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Care Coordination, Oral Health, Population Health

Background: The Mountain Health Alliance (MHA) is a Network of public health care agencies, hospitals, and community organizations that works to broaden access to health care, especially for low income and/or uninsured, underserved adults in an isolated and rural region of Appalachia. Members of the Mountain Health Alliance are chiefly health care providers or community agencies involved in providing or assisting community members to find the health care they need. The purpose of the MHA is to create partnerships and agency collaboration that results in innovative approaches to finding health care solutions in a Region that lacks adequate practitioners and/or health care services. By banding together and working to grow access to care, members of the Mountain Health Alliance are acting in the best interests of both themselves and the population at large. In order to ensure that the MHA’s actions have an impact, the Network decided to focus on two areas of health care in which the Region overall has overwhelming need: Oral and behavioral health.

**Strategic Objectives and Key Initiatives:**

- Develop, strengthen, and sustain a mature rural network to address health, wellness, and workforce issues in the tri-state region.

- Enhance existing rural health workforce education pipeline and recruitment efforts to address health care workforce concerns in the tri-state region.
- Address identified health and wellness disparities for the underserved in the region.

### **Challenges & Innovative Solutions**

The network agreed to reduce the workforce education objective (objective 2) to increase direct services to the community. The network did so by hiring and training a second Community Health Worker. Barriers faced while addressing health care access and health disparities include lack of providers in the region and affordable solutions to emergency dental care. A unique compensation agreement was expanded and accepted by private practitioners in the region in addition to local health departments and FQHCs.

### **Network Continuation**

Value Proposition:

- Extensive network of providers and hospitals; recipients of services experience greatly reduced pain and suffering
- Network's two community health workers; target population can now gain access to community resources
- Emergency Department Referral program in hospitals; West Virginia University Potomac Valley Hospital in Keyser, WV, and Garrett Regional Medical Center in Oakland, MD in which the Emergency Department (ED) personnel fax patient information release forms (signed by the patient) for those presenting in the ED with oral pain to MHA's CHW for follow up. The CHW then contacts the patient directly, and proceeds to place them for treatment with a local dental provider, who treats MHA referrals at an hourly rate of \$150.
- Western Maryland Health System Behavioral Health referral; refers patients who do not exhibit psychosis or other serious, ongoing behavioral health issues, at discharge to the CHW. The CHW works with the behavioral health referrals to help them locate and utilize the community resources that will assist them in regaining and maintaining their independence.
- Continuing education trainings; created educational opportunities addressing integrating behavioral health into primary care, intraprofessional team-based care delivery, and cultural competency for area practitioners.

Network Revenue Stream: The Network created a revenue stream through the Community Health Worker training.

### **Project Officer**

Jayne Berube  
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 jberube@hrsa.gov

## MICHIGAN (2)

### MI-Connect Network

Alcona Citizens for Health, Inc

#### Network Description

Grant Number: D06RH21665

Organization Type: Information not available

Full Address: 177 N. Barlow Rd. Harrisville MI 48740

Website: <http://www.alconahealthcenters.org>

Year Formed: 2011

Network Contact:

Susan Kaderle

Network Director

(989) 569-6001 Ext 1730

[skaderle@alconahc.org](mailto:skaderle@alconahc.org)

Members:

FQHC, CMH organization, hospital, health department

Mission:

A collaborative resource center to expand access to high quality services for the at-risk residents in communities of Northern Michigan.

Vision:

Improve the health and well-being for the at-risk residents of Northern Michigan.

Member Needs:

- Combine medical and behavioral benefits into one payment pool
- Target complex patients for priority behavioral health care
- Proactive, onsite or near-site behavioral teams composed of in-house and/or contracted agencies and practitioners
- Match behavioral professional expertise to the need for treatment escalation inherent in stepped care
- Define, measure, and systematically pursue desired outcomes
- Apply evidence-based behavioral treatments
- Use cross-disciplinary care managers in assisting the most complicated and vulnerable
- Improve overall health status of students receiving in school preventative and restorative oral health care
- Integrate clinical care with public health interventions and environmental change strategies

Governance:

The MI-Connect Network currently has six active members governing the Network.



## Environmental Analysis

Geographical Area: 13 counties in Northern Michigan: Alcona, Alpena, Antrim, Arenac, Charlevoix, Cheboygan, Chippewa, Emmet, Iosco, Mackinac, Montmorency, Ogemaw, and Oscoda

Population Need: The major factor in the decision to pursue the grant opportunity for the MI-Connect Network was that the proposed service area clearly demonstrated serious unmet mental and oral health care needs in all thirteen counties. It is an area designated as health professional shortage areas (HPSA) for, mental health, primary care, and dental services as mentioned previously. In addition, the collaborative partners had all participated in regional needs assessments that had identified access to care, including primary care, oral and behavioral health care for at-risk populations as 2 of the top 3 priorities.

### Blocks:

- Limited resources at both the Network and partner levels. Multiple demands placed on all resources.
- Data systems are currently fragmented; partners are all on different systems at different stages. Data sharing is a challenge.
- Social Determinants of health; the target populations we serve are complex and multi-generational. How does the Network assist in breaking the cycle?
- Multiple demands placed on providers of care

### Levers:

- Technology infrastructure including telemedicine, technology knowledge/ development of regional and state wide HIE.
- The MI-CONNECT Network has a long-history of successful collaboration and sharing of resources.
- Strong Care Coordination model positions the Network to optimize the Triple Aim agenda in health care—improved quality of care, better health for the population, and lower per capita expenditures.
- The Network has developed Best Practice models in the areas of Integrated Behavioral Health and School-Based Oral Health that can be valuable resources for other Networks on a regional, state wide and national level.

## Grant Project Description

Project Year: 2014-2017

Focus Area(s): Behavioral Health, Integration, Oral Health, School-Based Care

Background: The goal of the MI-Connect Network is to increase access to quality health care in rural Northern Michigan through the development of an integrated regional network that utilizes a collaborative model. The focus of the current Rural Health Network Development funding is two-fold; the expansion of a currently established integrated behavioral health program into the Northwest

Lower and Southern Upper Peninsula of Michigan, and the establishment of a school-based oral health program throughout the entire 13 county Network region.

Strategic Objectives and Key Initiatives:

1. Integrate health care services and health care delivery to achieve efficiencies and improve the quality and delivery of rural health care specific to development and implementation of school-based oral health services and an integrated primary care/behavioral health model.
2. Collaborate to strengthen the health care delivery system through coordinated systems of care. Increase awareness of the need for additional behavioral health and oral health services within the MI-Connect Network service area.
3. Improve population health by implementing evidence based approaches to address health disparities in the areas of behavioral health and oral health.

### **Challenges & Innovative Solutions**

A critical challenge to the management and implementation of the project was the turf issue. Solutions used to address this issue were the guidelines as documented in the Memorandum of Agreement and MI-Connect By-laws to clarify roles and outline how decisions would be made. The MI-Connect Network used consensus decision making strategies whenever possible.

We experienced a great deal of leadership turnover which made it difficult to keep the Network momentum going. We were continually needing to bring new leadership up to date. Another barrier to achieving all the outcomes initially identified by the Network include limited resources to support the activities at both the Network and partner levels. Multiple demands are placed on all resources making it difficult to prioritize.

We were least successful in standardizing outcomes/ shared measures and QA/QI benchmarks. Data systems are currently fragmented; partners are all on different systems at different stages. Data sharing is a challenge. The Network MI-Connect Network Final Closeout Narrative 4 discussed utilizing Health Information Exchanges but trying to establish consistent processes for ongoing communication was difficult. It was also difficult to report out to the community. The Network was successful at educating staff and the community regarding the integrated model and health issues but not good at aggregating and reporting outcomes as a result of the program.

### **Network Continuation**

Value Proposition:

- Assistance with integration of behavioral health into primary care clinics
- Introducing preventative and restorative oral health services in elementary and secondary school settings

- Establish new relationships to improve the quality of comprehensive health care to regional residents of a largely poor, older and unhealthy population

Network Revenue Stream: The individual network organizations will continue to provide the behavioral health and oral health services as established through this collaboration. Although the formal structure of the network will go away, the services established will continue through the individual organizations revenue received for providing services. The majority of the BH and oral health services are billable. The individual organizations will provide the structural support for the supervision, billing and oversight of the activities.

**Project Officer**

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## MICHIGAN (2)

### Michigan Resuscitation Consortium (MiResCu)

Michigan Rural EMS

#### **Network Description**

Grant Number: D06RH21673

Organization Type: Emergency Medical Service

Full Address: P.O. Box 265, Caro, MI 48723

Website: <http://www.mirems.org/>

Year Formed: 2007

Network Contact:

Leslie Hall

Director

(989) 284-5345

[leslie@mirems.org](mailto:leslie@mirems.org)

Members:

Individual EMS providers, EMS agencies, community partners

Mission:

The mission of MiREMS is to provide support to Michigan rural EMS professionals and EMS agencies.

Vision:

The Michigan Rural EMS Network will increase the effectiveness of rural EMS delivery systems and thereby decrease the morbidity and mortality of patients.

Member Needs:

- Continuing education, including pediatric education
- Awareness of rural EMS needs
- Community awareness/support
- Staff recruitment and retention
- EMS Manager/supervisor roles

Governance: Michigan Rural EMS Network is a non-profit 501(c)(3) organization, governed by a set of bylaws and a Board of Directors. Board members have staggered terms, and a slate of officers is elected or appointed from among the Board of Directors annually. A full-time Executive Director manages daily operations under authority delegated by the Board of Directors.

#### **Environmental Analysis**

Geographical Area: Rural designated counties across Michigan

Need: Information not available.

Blocks:

- Limited number and engagement of members

- Limited MIREMS brand visibility or recognition by local rural EMS as a key resource
- Individual EMS agencies have limited resources and capacity due to low run volume and or part time/volunteer personnel structures

Levers:

- Strong driven leadership
- Vision and commitment by board members to rural EMS
- Opportunities for diversification of funding have been identified

## Grant Project Description

Project Year: 2014-2017

Focus Area(s): Population Health

Background: In 2008, two counties came together to form the Huron-Sanilac EMS network. Over the next three years, the EMS agencies in these counties worked together to address recruitment and retention issues in their counties. Due to the success of the two county initiative, leaders decided to investigate the potential of expanding efforts to become a state-wide initiative. This exploration resulted in development of the Michigan Rural EMS Network (MiREMS). MiREMS was incorporated in July 2011 and was approved as a 501c3 nonprofit status in September 2012. Through ongoing needs assessments and feedback from members, the Michigan Rural EMS Network developments programs and initiative to fulfill its mission and to meet the needs of rural EMS professionals and EMS agencies.

Strategic Objectives and Key Initiatives: The overall goal of this program is to develop a state, regional, and local network of communities that are implementing the Resuscitation Academy model. The long term outcome of this initiative will be the improvement of cardiac arrest survival rates in MiResCu communities by 10% or greater. Key initiatives include:

- Development of teams, HP-CPR training, and quality improvement
- Implement dispatch assisted HP-CPR
- Implement community initiatives
- Plan for MiResCu sustainability and business model

## Challenges & Innovative Solutions

1. Community Readiness: We have found that the readiness of individual MiResCu communities has varied greatly. Some communities had already formed a team before the MiResCu award, and had a solid understanding of the overall MiResCu model and program components. Other communities had very little knowledge about the MiResCu system change model. We assigned an Outreach Coordinator to work one-on-one with each community, and designed education and technical assistance specific to each individual community.

2. Difficulty finding paramedic Instructor Coordinators: The High-Performance CPR training program model included training regional paramedic instructor

coordinators, also certified as American Heart Association instructors, to provide training to healthcare providers. We found that there is a shortage of paramedic ICs in many of Michigan's rural communities. There are many more basic EMT instructors who are also certified American Heart Association CPR instructors. The curriculum was revised to accommodate two levels of trainers, both paramedic and EMT level. This allowed us to meet the needs of rural communities, while maintaining quality instruction standards. Communities also indicated that access to training supplies was a significant barrier. With carryover and no cost extension funds, we purchased training supplies and trailers to store and transport the supplies. We have identified sustainable and strategically located network teams to manage coordination of the training trailers.

3. Managing the part time nature of community personnel: We have found communication and follow through at the local level to be a significant challenge. Due to the largely volunteer nature of rural EMS, we have had difficulty making or maintaining contact with managers and community leaders. We have also found that there is a wide variety of skill levels regarding the use of technology. This has required a personalized approach to communication (i.e. email is not effective for all; some require phone calls.). We have also found delays in terms of decision making at the local level, because some EMS directors and project leaders do not have autonomous decision making authority. Many are required to take items, such as the Memorandum of Agreement, to their organization's board members for approval. We implemented the use of an online project management tool to improve communication and track progress. We provided training to all communities via online meetings, to ensure all had a good working knowledge of the tool.

## **Network Continuation**

Value Proposition:

- Memberships
- EMS innovative and best practices conference
- Technical assistance and consulting
- Networking and collaboration opportunities
- Access to equipment
- EMS system change initiative- Michigan Resuscitation Consortium (MiRESCU)
- Awareness of rural EMS needs
- Group purchasing opportunities
- Recruitment and retention toolkit
- Initial certification programs

Network Revenue Stream: Since 2008, various grants from the Health and Human Services Administration of the U.S. Department of Health and Human Services program have supported network development, program design, and project implementation. The network is currently in the process of developing a core operating budget that would cover base staff and operating expenses, and has made progress in developing self-sustaining programs through membership

fees and providing resources such as continuing education, technical assistance and consulting, and group purchasing.

**Project Officer**

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## MINNESOTA

### Northern Minnesota Network (NMN)

Sawtooth Mountain Clinic, Inc

#### Network Description

Grant Number: D06RH27790

Organization Type: FQHC

Full Address: 404 West Superior Street, Suite 227 Duluth, MN 55802

Website: <http://www.northernmnnetwork.org/>

Year Formed: 2004

Network Contact:

Sally Trnka

Director

218-722-1186

[sallyt@northernmnnetwork.org](mailto:sallyt@northernmnnetwork.org)

Members:

Five Federally Qualified Health Centers (FQHCs)

Mission:

The mission of the NMN is to assist members through improved HIT systems and support to help them provide comprehensive primary medical and dental services for low-income families, uninsured, underinsured, migrant and seasonal farm workers.

Vision:

Collaborating for care.

Member Needs:

- Project management
- Healthcare environment expertise
- Avenue for grant funds (i.e. network funding)
- Forward thinking with changes in the industry and opportunities to tackle challenges collectively
- Filtered communications regarding industry changes
- Continued relationship with FQHCs and networks regionally and nationally

Governance: The NMN established a formal structure as a health center-controlled network (HCCN) in 2004, by its first funded grant from HRSA. The operational structure includes articles of incorporation, bylaws, operational policies and procedures, and recognition from the Internal Revenue Service as a 510(c)(3) non-profit corporation. Each member is represented on the NMN's governing board by the member CEO/Executive Director. This Board member represents provider and clinical input during monthly Network board meetings. All members provide equal support (minus additional Board responsibilities) to the NMN.



## **Environmental Analysis**

Geographical Area: Low-income families, uninsured, underinsured, migrant and seasonal farm workers in need of primary medical and dental services in rural areas of Minnesota, Wisconsin, Illinois and eastern North Dakota

Population Need: The purpose of this NMN project was to strengthen the rural health care system, through expanded optimization and interoperability of health information technology (HIT) and the EHR system; supporting each NMN provider to fully adopt and integrate progressive meaningful use (MU) standards that enhance the continuum of care in rural communities. The project sought to enhance NMN members' capacity to measure and effectively report on quality of care and health outcomes, positioning member health centers for MU in a way that emphasizes use of health information technology, not simply adoption of a system.

### Blocks:

- Uncertainty surrounding legislation
- Lack of adequate funding
- Difficult to fully articulate value as safety-net providers
- Large volume of reporting requirements
- Staffing shortages

### Levers:

- Dedicated network Board with long-standing relationships and trust
- Strong policy focus on primary care
- History of IT collaboration
- Adaptability of Board and staff

## **Grant Project Description**

Project Year 2014-2017

Focus Area(s): HIT/HIE

Background: The Northern Minnesota Network (NMN) is a 501(c)(3) vertical, rural Health Center Controlled Network (HCCN) providing health information technology (HIT) systems, resources and support to safety net providers in rural areas in support of the community health care system. This Network has five formal member organizations, including three Section 330(e) Community Health Centers and two Section 330(g) Migrant Health Centers. These health centers provide care through 27 clinical sites in a service delivery area spanning over 19,000 square miles and twenty-three counties. The network also has formal relationships with three rural, critical access hospitals and four public health departments. While these relationships were initially developed a number of years ago, the growth and expansion of the health centers, and subsequently that of the network, has helped solidify stronger and more specific working relations with these hospitals and health departments.

### Strategic Objectives and Key Initiatives:

- Optimize utilization of the EHR system for all NMN members across 27 clinical sites through applications, including patient portals, computerized physician order entry (CPOE) and clinical decision support (CDS) systems to improve clinical performance and outcomes;
- Expand interoperability of the NMN's EHR system, including Continuity of Care Documentation, to advance health information exchange between providers, rural hospitals and the public health department,
- Standardize the ability to demonstrate MU of HIT systems to achieve MU Stages Two and Three criteria of the Medicare and Medicaid EHR Incentive Program requirements.
- Implement effective patient portal that enables increases patient engagement and self management.

### Challenges & Innovative Solutions

As with many other projects, engaging patients in patient portal utilization proved to be a significant challenge. The NMN continues to work with members, leadership, and their patients to enhance utilization of the patient portal. The NMN is also working with the HIE vendor to identify potential new opportunities for a "universal" patient portal. Another challenge was the health information exchange. Minnesota changed legislation for health information exchange opportunities early into the project which delayed selection of a meaningful health information exchange, after buying into a HIE that collapsed following the changes in legislation. Illinois still does not have a meaningful HIE that NMN clinics can connect to in that state.

### Network Continuation

#### Value Proposition:

- NMN has an outstanding track record of successfully apply for grants. All NMN members have benefitted significantly from the attainment of grants for more than ten years.
- NMN is recognized as a national-leader in EHR implementation and optimization.
- NMN is growing into a more comprehensive organization that can help support successful sustainability in times of immense change and insecurity.
- NMN provides leadership with EHR upgrades, general HIT project management, vendor relation support, strategic planning, and EHR optimization.

Network Revenue Stream: The network has been successful in creating revenue streams to sustain the network and expand services. The NMN currently receives funds through a partnership with two other HCCNs as a part of the Health Center Controlled Network Grant program. Based off current projections, additional grants need to be secured to support the ongoing work of the network and the member clinics. NMN members pay annual dues. Based off current

market trends, it is not anticipated that a dues increase will be necessary unless grants cannot cover the operating costs of the network at which point a dues increase will be explored.

**Project Officer**

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mmikre@hrsa.gov

## MISSOURI

### Effective Care Transitions for Rural Missouri

Health Care Coalition of Lafayette County

#### **Network Description**

Grant Number: D06RH27773

Organization Type: non-profit organization

Full Address: 825 S. Business Highway 13, Lexington, MO 64067

Website: [www.hccnetwork.org](http://www.hccnetwork.org)

Year Formed: 2006

Network Contact:

Amanda Arnold

Network Director

(660) 259-2440

[amanda@livewellcenters.org](mailto:amanda@livewellcenters.org)

Members:

FQHC, Rural health clinics, CAH, School districts, city and county government, social service agencies, ministerial alliances

Mission:

The Health Care Collaborative of Rural Missouri (HCC) has one central mission: Cultivate partnerships and deliver quality health care to strengthen rural communities. The mission includes actively advocating for everything from affordable health insurance to next generation technology to improve patient care.

Vision:

The program aligns with HCC's Mission, Vision, and Values in that it is a collaborative effort with partners, provides avenues for quality care in the designated areas of HCC, and strengthens rural communities by providing local services to underserved residents.

Member Needs:

As part of the community assessment process, HCC conducted a review of the Community Health Needs Assessments of local hospitals to determine if the data reflected in HCC's community assessment were consistent with other locally identified priorities. It is consistent. Thus, the ER Diversion program is poised to be valuable for all Network members and customers. These data indicate that more than 5,800 patient encounters occurred in the Emergency Rooms of member hospitals unnecessarily. Transferring these encounters to a medical health home will result in tremendous savings for the hospitals, increases for the clinics and other providers, and better quality care for the patients who also will realize a cost savings.

Governance: HCC has a 9-member governing body.

## Environmental Analysis

Geographical Area: Individuals in the three-county service area of Carroll, Lafayette and Saline counties.

Population Need: The original need was to improve the quality and safety of health care by improving care transitions from hospital (emergency department and inpatient) to the primary care setting as well as reduce hospital readmissions, improve coordination of services, help to facilitate enrollment in health insurance and establish primary care health homes for those who are not already enrolled in them.

### Blocks:

- Transportation
- Education
- Staffing
- Access to affordable health care
- Access to medications
- Quality of health care

### Levers:

- A MODOT 5310 grant to increase transportation
- Attending staff meetings at the hospitals
- Providing resource guides to staff
- Access to Federally Qualified Health Centers that are able to accept Medicaid and have a slide fee scale
- Access to our 340B Discount Drug Program.
- Care Coordination efforts between the hospital and the clinic.

## Grant Project Description

Project Year: 2014-2017

Focus Area(s): Integration, Oral Health

Background: Effective Care Transitions for Rural Missouri, will improve the quality and safety of health care by improving care transitions from hospital (emergency department and inpatient) to other settings; reducing hospital readmissions; improving coordination of services; facilitating enrollment in health insurance marketplace; and establishing primary care health homes for individuals who do not currently have one. The project is designed to assure that individuals are receiving care in the appropriate setting, at the appropriate time, at an appropriate cost. It is expected to result in the following outcomes: improved quality; reduced hospital readmissions; reduced use of hospital emergency department for primary care conditions.

### Strategic Objectives and Key Initiatives:

- By April 30, 2017, 90% of individuals seeking primary care in the hospital emergency department will be redirected to a primary care health home.

- By April 30, 2017, document a 25% decrease in non-emergent use of hospital emergency departments.
- By April 30, 2017, 35% of patients referred to HCC Live Well clinics as a health home will show improvement in clinical health outcomes.
- By April 30, 2017, health delivery system infrastructure is strengthened.

### **Challenges & Innovative Solutions**

HCC faced many barriers when implementing the Effective Care Transition program. Things such as technology, patient understanding, provider time, transportation, and financial resources were some of the major barriers that surfaced. HCC had many strategic planning sessions with the rural hospitals starting with the administrative team. HCC quickly realized that this group of individuals was not the group that needed to be educated on the priorities of the program. HCC realized they needed to be educating the staff that was working every day with the patients in which we were trying to decrease the over utilization of the emergency department.

### **Network Continuation**

Value Proposition: Network members recognize that patients' access care in a variety of ways, and through a variety of providers. This is a method that HCC Network has been using for many years with regard to programs and services. We have a proven track record of achieving higher outcomes with collaborative partners. Rural communities have learned to do more with less. The Network provides a platform where we can leverage expertise, funds and time to ensure that programs are developed with multiple partners' needs in mind. Because the Network is autonomous of any single provider, we work to develop the best program for the community based on needs, services and resources. HCC's Network members have been supportive of Network activities through leadership as well as financial participation. Each member pays annual dues to the Network as well as offers expertise through the program implementation process. HCC relies on Network partners and their staffs to help solve problems or trouble shoot issues additionally, HCC provides the Network member ongoing benefits such as additional training opportunities. With this project, HCC anticipates following the same pattern. In fact, Network partners have brought in their finance and program staffs to help plan, develop and implement this.

Network Revenue Stream: Yes, HCC has a diverse revenue cycle including fee for service programs, Medicare, Medicaid and third-party payor contracts as well as a growing network of private contributions.

### **Project Officer**

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 mcolburn@hrsa.gov

## MONTANA (2)

### Monida Healthcare Network

Barrett Hospital & Healthcare

#### Network Description

Grant Number: D06RH27763

Organization Type: Hospital

Full Address: 600 State Hwy 91 South, Dillon, MT 59725

Year Formed: 1996

Website: [www.monida.com](http://www.monida.com)

Network Contact:

Amber Rogers

Director of Clinical Services

(406) 829-2385

[arogers@monida.com](mailto:arogers@monida.com)

Members:

CAHS, PPS Hospital, physician members

Mission:

Successfully navigate the complex world of healthcare, building collaborative relationships between providers and hospitals, and pursuing shared strategic programs and services.

Vision:

As a leading member-driven organization, Monida Healthcare Network will engage its hospitals and providers to implement processes and programs that improve our communities' population health, control costs and improve healthcare quality.

Member Needs:

- Technical assistance with QRUR, MIPS, APM's
- Data validation
- PQRS measurement tools (registries that can share data with network for new contracting models)
- Space for shared learning at low cost

Governance: Monida Healthcare Network is governed by a 10-member board of directors consisting of 5 physician representatives (3 primary care and 2 specialists), 3 hospital representatives, 1 representative appointed by Community Medical Center (CMC), and 1 general representative. All board members serve 3-year terms and are elected by Monida physician members except for the CMC representative. Board members also serve on committees such as the Finance Committee and the Credentialing Committee.

#### Environmental Analysis

Geographical Area: Rural and frontier residents of Western Montana/Eastern Idaho

Population Need: The mission of Monida Healthcare Network is “Successfully navigate the complex world of healthcare, building collaborative relationships between providers and hospitals, and pursuing shared strategic programs and services.” In Montana, mental illness and substance use disorders are common. In 2014 Montana had the highest suicide rate in the United States for all age groups. In addition, more than 29% of our youth report symptoms consistent with depression. These high-risk factors are coupled with a lack of services for behavioral health treatment. A recent national survey ranked Montana 44th worst overall. The Network Development Grant assisted bringing 5 behavioral health specialists into our Network of Providers and increased the access of behavioral health services within our rural areas.

Blocks:

- Rate of Change (MIPS/ ACO/ CIN)
- Change of ownership of our largest hospital.
- Competition of Clinically Integrated Network (CIN) with Caravan.
- Lack of physician engagement.
- No method of aggregating or sharing data
- Providers still want data to be private

Levers:

- Increased ability of medical director to guide activities.
- Ability to leverage care coordinators in 4 of our 7 rural hospitals
- Integration of Behavioral Health poises us for dealing with the social determinates of health

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Behavioral Health, Integration

Background: The Monida Healthcare Network (Monida) is a mature, not-for-profit PHO (Physician-Hospital Organization) with headquarters in Missoula, Montana. It has been an important component of Western Montana’s/Eastern Idaho’s healthcare system since 1996. Monida is comprised of 8 federally designated rural or frontier Critical Access Hospitals (CAH), a Missoula urban tertiary referral hospital, over 450 physicians, and 8 other specialty surgery/procedure facilities and home health agencies.

Strategic Objectives and Key Initiatives: To improve accessibility to, and availability and acceptability of, behavioral health services by integrating diagnosis and treatment with primary care, including a strong data component and a billing/coding/contracting component.



## **Challenges & Innovative Solutions**

This network grant had 2 barriers. The first barrier was recruiting behavioral health staff to the network hospitals. It took significantly more time than expected to hire these positions. In the first year of the grant we had significant carry over dollars since the positions were unfilled. To combat this barrier, we used a recruiting firm that resulted in 2 hires that were not the right fit. In the end, successful hires were made by targeting behavioral health specialists that wanted to be in rural, outdoors-oriented location. The CAH were, in the end, their own best advocate- even though it took longer than expected.

The second barrier was that we were unsuccessful in creating a Quality Committee. In order to counter act this barrier the Medical Director, Stephen Tahta spent numerous hours in physician engagement, and newsletter discussing the need to move from volume to value and the benefits of network collaboration.

## **Network Continuation**

Value Proposition:

- Big Sky Credentialing has decreased the length of time it takes for the providers to get paid by the payers
- Monida Shared Staffing decreases the cost of per diem staff for our members
- Monida Billing and Coding services has assisted clients with achieving low rates of accounts receivable and maximize reimbursement.

Network Revenue Stream: Yes, Monida Healthcare Network has greatly expanded services to diversify revenue.

## **Project Officer**

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## MONTANA (2)

### Northcentral Montana HIT Alliance

Liberty Medical Center

#### **Network Description**

Grant Number: D06RH26827

Organization Type: Medical Center

Full Address: 1101 26<sup>th</sup> St. So. Great Falls, MT 59405

Website: <http://www.nmhacaretransitions.org/rural-care-transitions/rural-care-transitions.aspx>

Year Formed: 2003

Network Contact:

Cherry Loney

Director

(406) 731-8207

[cherryloney@benefis.org](mailto:cherryloney@benefis.org)

Members:

Critical access hospitals, rural hospitals and a tertiary hospital

Mission:

To collaboratively develop strategies, synergies, relationships, products and services, that will improve delivery, access and quality, while controlling the cost of not-for-profit healthcare in all Alliance-member communities.

Vision:

Through strong collaborative efforts we will enable safe and effective transitions for our north central Montana patients between all settings of care.

Member Needs:

- Optimal execution of transitions from one level of care to the next supported by improved handoff communication, timely patient follow-up with provider after discharge from acute care, enhanced patient/caregiver education, increased awareness across the region of resources available to patients, and improved physician-to-physician communication.
- Reduced preventable readmissions.

Governance: NMHA is governed by a board of directors comprised of CEOs of participating hospitals. Bylaws provide for general powers, number and term, resignations, removal, compensation, regular and special meetings, quorum, board actions, committees, officers, and conflicts of interest. Board officers include a chairperson, vice chairperson, president, secretary, and treasurer.

## Environmental Analysis

Geographical Area: Residents of New Hampshire's Coos and Northern/Central Grafton counties

Population Need: Throughout the region we had a history of poorly executed discharges, both from the tertiary facility back to rural facilities, and from inpatient care to home. Handoff communication was often incomplete and/or not available in a timely way for patients transitioning from one facility to another. Timely patient follow-up was inconsistent because patients were not clear on the follow up plan and/or had transportation barriers to keeping appointments. Patients and caregivers were not clear on the treatment plan and did not know how to effectively manage medications. They also lacked knowledge of red flags or signs the patient wasn't progressing as expected. And finally, rural facilities were concerned that patients referred to the tertiary facility for specialized care were never returned to the rural facility, even though once the patient was stable and improved, rural members had the resources to support ongoing patient needs such as physical therapy, occupational therapy, etc. This not only cost rural facilities valuable revenue but was also costly and inconvenient for patients and their families, which ultimately affected access.

Blocks:

- Disparate EHR's/Lack of HIE
- Lack of resources
- CEO turnover
- Distance and shared services

Levers:

- Member cooperation, collaboration, and commitment
- Both the network and the Care Transitions initiative provide value to all members
- Synergy with REACH
- Montana Telehealth Network
- Experienced program management and leadership

## Grant Project Description

Project Year: 2014-2017

Focus Area(s): Care Coordination

Background: NMHA is a regional rural health network established in 2003 as a mechanism for health care facilities within the region to collaboratively address, combat, and overcome the increasingly challenging environment for providing not-for-profit community health care. It is made up of 12 member organizations including 10 Critical Access Hospitals (CAH's), a Rural Hospital, and Benefis Health System, a tertiary care center. Two Indian Health Service (IHS) Hospitals are affiliate members. NMHA represents the entirety of acute care facilities in

the rural north central region of Montana and is governed by a board of directors comprised of the CEOs of each member facility.

#### Strategic Objectives and Key Initiatives:

- The expansion of an existing program designed to attract and retain pre-service primary care providers to this region in partnership with the University of New England School of Osteopathic Medicine and other educational institutions
- The development of a model for a regionally-based primary care extension program designed to strengthen the core capacity of the region's health care system by providing technical assistance and support to local primary care practice teams
- The development of a Interprofessional training curriculum for pre-service primary care students designed to prepare these providers with the knowledge and skills needed to care for an aging population perform them interdisciplinary team work

### **Challenges & Innovative Solutions**

Perhaps the biggest challenge was identifying an affordable, practical IT platform to transmit handoff communication in a timely way. Our solution was for Benefis to open their EHR to rural facility transition coach/discharge planners and providers, thus allowing access to relevant patient information. Alerting transition coaches/discharge planning staff in rural facilities of a pending transfer/referral from Benefis was somewhat challenging. Our solution was to use secure email and faxing in addition to the phone notification. This has helped ensure timely notification and in most cases, hastened the patient's transition to the rural facility or discharge home from Benefis.

Some patients needed assistance with supplies and durable medical equipment (DME) necessary for self-care. Our solution was to purchase a few that can be provided to patients who have no means to obtain them as well as to make them available for loan at each rural facility.

Full utilization of transition coaches in the rural facilities has been a bit of a struggle. We hired a dedicated rural transition planner at the tertiary center. She is part of the inpatient care team and works exclusively with rural patients. She helps them understand the benefits of transition coaching, which has resulted in more people consenting to the service. We reframed how we presented the benefits of a transition coach so that patients clearly understand how the service can help them.

And finally, there is certain level of CEO and staff turnover among member organizations. The network director reaches out to new CEOs to provide an overview of the program and ensure their questions are answered. Staff training is offered regularly so that new care transitions coaches in rural facilities have knowledge and background necessary to perform their duties. In addition, we facilitate peer networking by holding periodic televideo conferencing for coaches and their supervisors.

## Network Continuation

### Value Proposition:

- Care Transitions Communication Checklist
- Transition coaches in each rural facility and a dedicated rural transition coach based at Benefis.
- Secure email and access to Benefis EHR
- Patient/caregiver education and post-discharge support through *Live Well Binder* and North Central Montana Rural
- Health Care Transitions website focusing on *Hospital to Home* with online health information tools
- Patient access to durable medical supplies to support self-management
- Tools/technology to support physician-to-physician communication

Network Revenue Stream: Currently our main revenue source is membership dues which are a percentage of each member's overall net revenue. Funds are more than adequate to support network leadership as well as exploring needs and further service expansion. In addition, network funds will support costs to sustain the coordinator for North Central Montana Center for Rural Health Transitions once grant funding ends. Additionally, each individual member will continue to support their own in-house care transitions coach. The network also sponsors two annual conferences, one for governance/administrators and one for providers. These conferences have been offered for more than a decade and are a valuable learning and networking opportunity for regional governance as well as a great resource for provider CME. Membership dues, along with vendor sponsorships, help support conference costs.

## Project Officer

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# NEBRASKA

## Region 3 Behavioral Health Network

### Region 3 Behavioral Health Service

#### Network Description

Grant Number: D06RH27787

Organization Type: Behavioral/Mental Health Organization

Full Address: 4009 6th Avenue, Suite 65 PO Box 2555, Kearney, NE 68848

Year Formed: 1973

Website: [www.region3.net](http://www.region3.net)

Network Contact:

Warren Pennell

308-237-5113 ext. 227

[wpennell@region3.net](mailto:wpennell@region3.net)

Members:

Behavioral Health providers including hospitals providing behavioral health services

Mission:

To share patient information across the Nebraska Behavioral Health System in order to generate queries and reports to make informed decisions that foster better recovery and resiliency for individuals and their families who experience a behavioral health challenge.

Vision:

To optimize the behavioral health and wellness of individuals and their families who experience a behavioral health challenge using health information technology across a collaborative Region 3 Provider Network.

Member Needs:

- Centralized data system
- Increased planning for transitions of care
- Accessibility
- Collaboration improvements among network providers working on making referrals to various services
- Getting the word out to underserved segments of the population

Governance: Region 3 Behavioral Health Services is a political subdivision of the State of Nebraska governed by a Regional Governing Board consisting of elected officials from 22 counties in central and south-central Nebraska as required by Nebraska statute. The Governing Board oversees the behavioral health system within the 22 counties assisted by the input of the Behavioral Health Advisory Committee. The R3 Information Technology (R3IT) Workgroup served as the governing body for the grant project. It was comprised of a representative from each of the 15 Network Providers with the exception of two very small agencies without an IT department or staff. The R3IT Workgroup was responsible for the design, development and implementation of the network.

## **Environmental Analysis**

Geographical Area: Safety net population (those with no health insurance or underinsured) of children, youth, and adults, in an underserved rural area of 22 counties in central and south central Nebraska

Population Need: The strategic plan focused on the following: 1) Region 3 Network Providers do not have the infrastructure to quickly upload information to the DBH Centralized Data System; 2) Region 3 Network Providers submit patient data into the DBH data system manually or electronically; and 3) providers have no means of digitally accessing patient information. Later a fourth area was added to provide electronic health record software geared for remote client interaction versus a clinic based practice. The proposal was for a software much more conducive for Region 3's current practice.

Strengths: Deep experience, shared goals, strong leadership, problem solving ability

Weaknesses: Flexibility of funding, disparate systems, lack of interoperability, ability to report on aggregate data

Opportunities: New system, state input on new CDS, corrections reform

Threats: Performance-based funding with flawed data, priority overload, keeping up with all of the changes, ability to communicate electronically

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): HIT/HIE

Background: The Region 3 Provider Network delivers a wide array and intensity of behavioral health services to a population with chronic behavioral health and physical health conditions. The Region 3 Provider Network currently enters a limited amount of patient information into the DBH data system. They do not participate in a health information exchange, do not share a common electronic health record, and are in various stages of electronic health record adoption. Even though most network provider organizations have some form of electronic health record, they currently do not transfer patient information to DBH electronically.

Key network stakeholders, consisting of provider organizations' information technology staff and leadership, have worked together to develop strategies to assist the network in effectively addressing the above stated concerns. Many approaches such as secured messaging, interfacing, shared data, and the creation of a health information exchange have been explored to meet the ultimate goal of interoperability of all providers' network electronic health records.

### Strategic Objectives and Key Initiatives:

- Create a means of submitting patient information to the DBH CDS electronically through interoperable electronic records technology for Region 3 Network Provider organizations' disparate EHRs.
- Develop the organizational infrastructure necessary, including the equipment requirements and broadband connectivity needed, to submit patient information to the DBH CDS. (Interoperability between the Region 3 Provider Network and the Nebraska Division of Behavioral Health).
- Guarantee valid and accurate patient information digitally via DBH CDS queries and reports.

### Challenges & Innovative Solutions

The greatest barrier we encountered was the delays in the implementation of the CDS by DBH. Once the CDS went live in May 2016, there were barriers in the learning curve of CDS users and the automated systems within it. One barrier was the authorization system where the algorithms for some individual authorized services required redefinition and clarification. Due to the significant number of denials which then precipitated the need for appeals. Each update to the CDS created some unexpected barriers which had to be corrected by the CDS developers. Although most of these were minor, they did create frustration for data entry staff and billing personnel. The CDS has been live for 18 months and it is gradually becoming more effective. This effectiveness has been through the input from Region 3 Network Providers' staff who have made suggestions on making the CDS more user friendly.

The one barrier which did delay some of the Region 3 HRSA goals was that we could not move forward with the process for electronic data file transfers to the CDS until DBH and the database developer (H4 Technology) were ready to facilitate the process. Region 3's IT Manager did all of the preliminary work with providers' vendors so that when the CDS is ready for the electronic transfers it will be faster to implement.

### Network Continuation

**Value Proposition:** Access to database information across the array of behavioral health services for all levels of care, information for timely referrals and use of an electronic billing system.

**Network Revenue Stream:** The Region 3 Behavioral Services Rural Health Development initiative is to enable the Region 3 Provider Network members to connect to the Division of Behavioral Health's Central Data System. DBH will be responsible for the cost to maintain the CDS. In order for Network providers to remain in the Network and receive funding from DBH passed through Region 3, providers will contractually agree to timely input or upload data into the CDS. The goals of the grant do not include the development of any new product or new behavioral health service which would have its own



revenue and costs, therefore, there is no additional revenue or net income to forecast.

**Project Officer**

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## NEW HAMPSHIRE (2)

### Community Health Access Network (CHAN)

Community Health Access Network, Inc

#### **Network Description**

Grant Number: D06RH27768

Organizational Type: Member Organization

Full Address: 207a South Main Street, Newmarket, NH 03857

Website: [www.chan-nh.org](http://www.chan-nh.org)

Year Formed: 1995

Network Contact:

Kirsten Platte

Director

[kplatte@chan-nh.org](mailto:kplatte@chan-nh.org)

Members:

FQHCs

Mission:

CHAN's mission is to enable our member agencies to develop the program and resources necessary to assure access to efficient, effective quality health care for all clients in our communities, particularly the uninsured, Medicaid, and medically underserved populations.

Vision:

The organizational vision is to position CHAN as a model for functional integration, using current technology and a body of health information.

Member Needs:

- Determine/develop network capacity
- Support ongoing staff training needs
- Secure, reliable and efficient IT infrastructure
- Real time data
- Improvements in population health
- Position network as health center data aggregator
- Maintain current memberships
- Evaluate current partnerships
- Purposeful growth

Governance: Structured as a non-profit Limited Liability Corporation (LLC), the CAHN is governed by a Board of Directors consisting of Chief Executive Officers (CEOs) from member hospitals. Meeting monthly the Board operates according to By-Laws that identify the delegation of authority and define each party's role, responsibilities, and authorities. An Executive Committee consisting of the Board President, Vice President and Secretary/Treasurer facilitate agenda planning and operations for the Board. An Executive Director reports to the Board and implements all CAHN activities.

## Environmental Analysis

Geographical Area: Residents of nine counties from northern to southern New Hampshire and three counties in central Texas

Population Need: The health care environment in NH has significant population health and wellness challenges. NH ranks among the top states with respect to multiple indicators of health, although with significant, costly exceptions of excessive drinking and illicit drug use. In State fiscal years 2011 and 2012, over 58% of adult Medicaid enrollees who received services presented with a mental health and/or substance abuse disorder. In response to these challenges, a wide variety of stakeholders, including representatives from CHAN and its health center members, participated in a robust and stakeholder-driven process, resulting in the development of EMPOWERING THE GRANITE STATE: State Health System Innovation Plan Model Design Proposal. Included in the State Health System Innovation Plan is identification of eight core values to include:

- Increase access to care
- Build on existing strengths within the community
- Promote evidence-based interventions
- Motivate and engage the community
- Make all access points the “right” door for entry to care or services
- Focus on “health”, not just “health care”
- Include “adverse childhood experiences” and other social determinants of health
- Include all relevant stakeholders, including those with lived experience of targeted conditions

Blocks:

- Uncertainly resulting from recent political elections
- BOD-focuses on their own health center
- Shares staffing w/member center
- Technology-software (i.e. care management) very expensive
- Competition (overlap)

Levers:

- Payment Transformation Initiatives
- Triple Aim
- Data and Quality
- Integrated Delivery Networks (CMS 1115 waiver)
- PCMH
- MU

## Grant Project Description

Project Year: 2014-2017

Focus Area(s): Quality Improvement

Background: The Community Health Access Network (CHAN) is the only Health Center Controlled Network (HCCN) in New Hampshire. Established in 1995, CHAN has developed and supports an integrated clinical and administrative system infrastructure for its eleven Federally Qualified Health Center (FQHC) members which include three Healthcare for the Homeless Programs. Central to CHAN's focus has been the automation of the primary care health record. CHAN's systems include a fully integrated Electronic Health Record (EHR), GE Centricity, which supports over 150 providers. The EHR also has links to member reference labs and partner hospitals. The EHR is linked to the GE Centricity Practice Management (PM) system and shares a common reporting tool. The providers can also securely access the system remotely to support offsite care. CHAN also provides technical assistance and system services to local collaborators and consultation to peers at a national level.

#### Strategic Objectives and Key Initiatives:

- Expand access to and improve the quality of essential health care services by focusing on projects and/or network activities directly related to the evolving health care environment
  - Increase number of health centers participating in the Million Hearts initiative supporting improvement in performance and patient outcomes specific to quality measure NQF0018: Blood Pressure Control at rural FQHCs
  - Complete a Central Billing Feasibility Study and pilot
  - Identify areas for increased health center revenues and savings through consolidated financial services and strategic alliance/restructuring
- Achieve population health goals through the use of technology
  - Remap historical data to network's data warehouse
  - Expand network's data warehouse
  - Automate exchange of patient information between community partners to support continuity of care across the health care environment
  - Automate the process for patients and providers to communicate and share information

#### Challenges & Innovative Solutions

The Implementation of Million Hearts Program for improved HTN control at the centers did realize some barriers. Centers participate in any number of QI initiatives at a time, based on funder requirements, state and federal initiatives, and the needs of their specific populations. Health center capacity for QI initiatives can be limited, and efforts can be redirected for other priority activities, to include the current opioid crisis. Successful strategies included network 1) development of a HTN registry that brought efficiencies to Care Managers, which was made available to all participating health centers, 2) inclusion of HTN/Million Hearts on other QI meeting agendas, 3) face to face network participation at the health center to support center "re engagement".

Central Billing Feasibility Study and Pilot: Staff turnover at the Network level led to some timeline challenges. To address this, the network shored up its staffing, resulting in completion of RFP process, hiring of consultant, and forward progress. A strategy for health center engagement included a survey, giving centers a voice in the project. Health center project participants renamed the project "Selected Revenue Cycle Study", with centralized credentialing identified as the broadest need across centers. Phase II is under way with a Revenue Cycle Management Due Diligence committee developing a business plan to determine the best model to meet the centers' credentialing needs, but also ensure sustainability of this activity at the network level.

Expansion of CHAN Data Warehouse to include those participating rural center hosting their own EMR infrastructure continues to run into health center staffing capacity barriers. CHAN has moved forward with participation in a Management Services Organization with six NH health centers, supporting the data aggregation efforts for a successful shared savings contract with a NH Managed Care Organization, which has included realization of some shared savings and quality improvement dollars for the participating centers. This has helped to re-energize the interest of the rural centers in utilizing the central data warehouse, and piqued their interest again in MSO participation. Another strategy included network contracting for staff expertise to support the centers' data validation on their end, alleviating some of the staff burden at the center.

### **Network Continuation**

Value Proposition:

- Stable and flexible centralized infrastructure, including a fully integrated EHR, and shares a common reporting tool and robust data warehouse.
- Reporting infrastructure enables member agencies to engage in payment transformation activities.
- Formation of key partnerships with the NH Health Information Organization, as a member and community aggregator for information exchange within communities and with the Bi-State Primary Care Association to demonstrate health center value around cost savings and clinical outcomes.
- Technical Assistance to partner agencies, to include TA for Patient Centered Medical Home submission, Meaningful Use submission, Quality Improvement and more.

Network Revenue Stream: CHAN's funding source mix includes member dues, member shared systems fees, grants and other revenue. Member support in the form of member dues and shared systems fees has averaged between 49% - 53% of CHAN's budget from 2011 - 2015, with grant revenue historically supporting 43%-44% and the balance of the mix being "other" revenue which consists mainly of consultation/technical assistance.

**Project Officer**

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## NEW HAMPSHIRE (2)

### North Country Health Consortium (NCHC)

North Country Health Consortium

#### Network Description

Grant Number: D06RH28031

Organization Type: Member Organization

Full Address: 262 Cottage St., Ste. 230, Littleton NH 03561

Website: [www.nchcnh.org](http://www.nchcnh.org)

Year Formed: 1998

Network Contact:

Nancy Frank

Director

(603) 259 3700 ext. 223

[nfrank@nchcnh.org](mailto:nfrank@nchcnh.org)

Members:

Area Health Education Center, Federally Qualified Health Centers Critical Access Hospitals, Academic Institutions

Mission:

To lead innovative collaboration to improve the health status of the region.

Vision:

The North Country Health Consortium (NCHC) is a strong coalition that participates in identification of community need and change, and responds proactively. NCHC is committed to creating and sustaining a cohesive regional health care delivery network.

Member Needs:

- Increase knowledge about innovative team-based care models
- Opportunities to engage patients and families inside and outside the health care system
- Identify common focus to impact change
- Trained staff to provide guidance and technical assistance
- Improve efficiencies in IT; facilitate quality reporting
- Development of integrated care delivery systems
- Reduced administrative costs
- Provide broad perspective of health, including social determinants of health
- Achieve better health outcomes
- Enhance student's rural experiences
- Network relationships to establish regional clinical training programs
- Education and training both on-line and in-person
- Provide variety of educational modalities

Governance: The North Country Health Consortium (NCHC) is a membership organization. The Board of Directors (BOD) is elected by the membership at the

NCHC Annual Meeting held in November of each year. The organization's bylaws state that Board shall consist of not fewer than nine nor more than 21 directors. Each founding member of the organization shall be offered a seat on the board. A senior administrator from each member organization elected to the Board is identified as the official representative to the Board of Directors. The BOD meets monthly to hear project updates, review profit and loss statements, and provide strategic and administrative direction and input. The BOD employs a Chief Executive Officer (CEO) who reports to the Board. The CEO manages the day to day functions of the organization with the assistance of a Management Committee composed of the CEO, a Public Health Director, two Program Directors, and the Financial Director. The CEO also serves as the Project Director for the Northern New Hampshire Area Health Education Center.

### **Environmental Analysis**

**Geographical Area:** Residents of rural Northern and Central New Hampshire, including towns in Northern and Central Grafton County and all of Coos County

**Population Need:** The North Country population is faced with chronic shortages of health care providers- including personnel in every facet of healthcare delivery- especially providers who are willing to work at community health centers where the bulk of the primary care available to this population is provided. In comparison to New Hampshire state averages, the North Country population experiences higher rates of chronic illness, poorer health outcomes, is impoverished, has lower educational attainment, and experiences many other health disparities not visible in other parts of the state. Due to the rural geography, inherent barriers such as lack of transportation, unemployment, and lack of support services make it challenging to access needed health care and human services for the population.

#### **Blocks:**

- Residents of rural areas face unique challenges in maintaining and improving health. These include physical distances between people and resources and health issues that come with an older population. Rural residents also must cope with reduced access to care arising from less insurance coverage (due to unemployment or employment in small industries) and provider shortages.
- Little public transportation exists for those traveling into and out of the area or between communities. Moreover, because of the region's topography, average travel distances from most towns to available sources of health care available for low income families are 25 miles or more.
- Northern New Hampshire residents have higher incidences of chronic disease; have a higher incidence of premature death; have a higher percentage of residents that lack health insurance in comparison to the rest of NH; and are less likely to have a primary care provider.
- The NCHC Service Area population is faced with chronic shortages of health care providers, especially providers who are willing to work at



community health centers where the bulk of the primary care available to this population is provided.

Levers:

- The collaboration with the University of New England, College of Osteopathic Medicine (UNE) brings medical students who are interested in rural primary care medicine to the region to experience the North Country and rural medicine as students.
- NCHC is leading the network in facilitating practice transformation and the care coordination and communication to transform primary care into a more efficient and effective system for patients and providers. Trainings and technical assistance related to team-based care and quality improvement initiatives are provided to practices.
- CHWs are being trained to address the needs of the North Country residents. The CHWs will act as patient navigators to link residents to community services and help coordinate their care in the patient centered medical home model.
- A New Hampshire CHW coalition is also gaining momentum in the State of NH with NCHC and Southern New Hampshire AHEC leading the way. The CHW coalition is working with stakeholders from across the state of NH to educate the public about the CHW role and develop legislative policy to set standards for CHWs in the State of New Hampshire.

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Care Coordination, Workforce

Background: The North Country Health Consortium (NCHC) is a mature rural health network in rural Northern New Hampshire. Since 1998, NCHC has been improving the sustainability of the rural health and human service delivery system and improving access to health care for the residents of rural Northern New Hampshire. NCHC develops and implements initiatives that focus on the creation and sustainability of a cohesive regional health care delivery network. NCHC and its Board represent the majority of health and human service providers delivering services to the Northern New Hampshire rural population.

The North Country Rural Health Network Development Project (RHND) is designed to expand access to and improve the quality of essential health care services delivered in rural Northern New Hampshire. To achieve this goal, the North Country Health Consortium (NCHC) will improve access to quality primary health care services. The RHND project addresses the critical shortage of primary care providers in Northern New Hampshire. This program responds directly to the challenges of recruiting primary care providers to serve in rural settings, and the pending retirement of many existing providers in the local primary care workforce. The RHND project also addresses the relatively poor

health status of area residents, the relatively high proportion of older adults living in this area in comparison to elsewhere in New Hampshire, and the multiple challenges facing primary care practices as they respond to the requirements of the Affordable Care Act (ACA).

#### Strategic Objectives and Key Initiatives:

- Support the creation of a culture of health in Northern New Hampshire that is embraced by health care providers, health care systems and communities.
- Develop care coordination efforts that include health services and community support services by integrating clinical and nonclinical providers. Care coordination efforts will address “upstream” social determinants of health and build on local rural resources to help community members engage in their own health improvement.
- Workforce development that includes health services and community support services and integrates clinical and nonclinical providers.

#### Challenges & Innovative Solutions

Staffing was a barrier at the commencement of the grant period as recruitment of a fulltime project coordinator took longer than expected. Once fully staffed, the network was able to achieve all grant objectives.

#### Network Continuation

Value Proposition: Community Health Worker training program and facilitation of networking and learning collaborative, consulting: capacity and experience to respond to new opportunities, population and public health focus and integration through training, motivational interviewing, professional development/CME/CNE, healthcare workforce development services through preceptor and rural training contracts.

Network Revenue Stream: NCHC has successfully acquired a state grant to continue to build and expand opportunities to bring University of New England College of Osteopathic Medicine (UNE) students to northern NH for rural health immersions and rural clinical rotations. NCHC has also acquired additional funding to sustain the blended online and in-person Community Health Worker (CHW) training program created with this Rural Health Network Development (RHND) funding. Beyond the development of the CHW training program, NCHC has received state and federal funding to develop a CHW program to hire four CHWs to work with health systems and patients. The CHW staff have been trained via the blended training program.

#### Project Officer

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## NEW MEXICO (2)

### New Mexico Primary Care Training Consortium

Hidalgo Medical Services, Inc

#### **Network Description**

Grant Number: D06RH27774

Organization Type: FQHC

Full Address: 301 W College Avenue; Suite 16 Silver City, NM 88061

Website: [www.newmexicoresidencies.org](http://www.newmexicoresidencies.org)

Year Formed: 2012

Network Contact:

Charlie Alfero

Director

(575) 538-1618

[calfero@swchi.org](mailto:calfero@swchi.org)

Members:

AOA (Family Medicine) and DO Residency Programs, Hospitals (urban and rural), Medical Schools and Teaching Health Centers, FQHCs, Community Health Centers

Mission:

The New Mexico Primary Care Training Consortium improves the quality of essential health services by supporting existing and developing new training opportunities to increase primary care workforce in New Mexico.

Vision:

New Mexico is an innovative leader in training family medicine physicians and other primary care providers working in the most underserved populations in high quality integrated primary health care systems.

Member Needs:

Identification and prioritization of the Network member needs were identified using the Business Model Canvas Needs Assessment Structure and a meeting with Network Members to address Sustainability Planning. The needs and expectations across members are quality improvement; training assistance, faculty recruitment and development; student recruitment and retention; technical assistance; improvement and implementation of best practices in residency programs; advocacy; and time/resources.

Governance: The New Mexico Primary Care Training Consortium consists of the four New Mexico Family Medicine Residency Programs, the only Osteopathic School of Medicine, a former NM program director of a now-closed program, and others interested in residency training development and programming.

#### **Environmental Analysis**

Geographical Area: Residents of New Mexico

Population Need: The Consortium was informally developed because there is a need for more primary care physicians in New Mexico, and more specifically, in rural areas. Additionally, research has shown that New Mexico has the oldest physician workforce in the country, with over 50% of physicians in or approaching retirement. The state is only producing 24 physicians while we project the need to exceed well over 300 physicians per year. As a result of informal meetings taking place amongst the four family medicine residency program directors, it was mutually agreed upon to form a consortium of the four programs where they can focus on the quality of training received, and best practices would be pulled together from each program. The intent is to produce the quality of training, and in turn, increase the healthcare delivery system in New Mexico, naturally attracting other physicians to want to work in New Mexico and increase the interest of local students at the middle school, high school and college levels to want to pursue a career in healthcare.

Blocks:

- Medicare / Medicaid reimbursement affects hospitals and in turn the network
- Urban vs Rural
- New Mexico has a small population that covers a very large geography
- Financial Sustainability
- Competing Needs and Priorities
- Hospital CEO Turnover

Levers:

- Growing Membership
- Active Peer Network Committees
- National focus on value and quality of care
- Rural ACO Participation and Learning Opportunity
- New Mexico Medicaid interest in partnering with hospitals to explore rural opportunities that reduce overall costs

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Workforce

Background: Prior to 1996, there was only one academic medical center in New Mexico, at the University of New Mexico (UNM). In 1994, the New Mexico state legislature passed a number of primary care enhancing bills including funding to UNM for the development of 1+2 model residencies in Las Cruces, Roswell and Santa Fe. By 1996, all three were up and running under the auspices of UNM where the year one training of family physicians took place. The final 2 years of training were to take place in the home communities. In 1997, Congress passed legislation capping the number of residents nationally and at existing programs. This has caused a zero growth problem in New Mexico for primary care.

By 1998, the Las Cruces program decided to become an independent 3-year residency program at Memorial Medical Center. Over the last 16 years, these 4 programs met regularly at state American Association of Family Practice meetings, to discuss common training goals and opportunities. In 2010, Hidalgo Medical Services (HMS) in Silver City developed a 1+2 model and became the first non-hospital based, Community Health Center (CHC) based family medicine program in New Mexico. Unfortunately, shortly thereafter, the Roswell program lost its accreditation when there was a large turnover of physicians in the community, many of whom were preceptors or faculty for the Roswell program.

However, all five Program Directors and respective Program Coordinators continued to meet quarterly and ultimately decided to organize more formally. On behalf of the "network", the HMS – Center for Health Innovation applied for an ORHP Network Planning grant to better assist in the business planning of the Consortium. As a result, the New Mexico Primary Care Training Consortium (NMPCTC) was initiated, developed a facilitated strategic planning including reviewing other regional consortium funding and obtaining funding from the state legislature through the Medicaid program. Their association and collaboration has been greatly enhanced by the efforts of the Consortium, which began to formalize its structure in 2011 and incorporated early in 2013. The NMPCTC became a IRS 501(c)3 corporation and began working on the goals of the organization as described in this document.

Strategic Objectives and Key Initiative:

- Increasing residency opportunities and training slots, developing additional 1+2 rural residency programs and improving joint recruitment to increase the number of high-quality applicants with an interest in New Mexico rural practice
- To improve existing residency programs by reviewing and strengthening current resident curriculum, and creating a statewide quality standard for resident training

## **Challenges & Innovative Solutions**

A primary focus for the consortium was to create new training programs in rural areas of the state with the intent to increase the overall number of physicians training in New Mexico. Currently, graduate medical education funding is hospital-based, where hospitals are the only eligible entities to receive graduate medical education state and federal funding. In New Mexico, the University of New Mexico is the urban site in New Mexico that receives the majority of the state and federal funds for training. However, those funds are not being distributed to rural training sites nor are there any programs that are directly funneling residents out of the urban sites to work directly in rural areas. One strategy used to meet this challenge was propose that the state provide funding directly to federally qualified health care centers (FQHCs) so that training can also occur at such sites. Since the consortium was officially organized in 2015, the Network Program Director has initiated a State Plan Amendment (SPA) with the state to allow for FQHCs to be eligible for direct and indirect graduate

medical education funding, and in turn, to train residents. Research has shown that residents are most likely to stay in the communities in which they have trained, and the consortium believes if residents are trained in rural areas, they will most likely stay in such communities where the need is greatest. Recently, the Centers for Medicare and Medicaid Services (CMS) approved the New Mexico SPA, however, there are still some language amendments that need to be made to ensure FQHCs that have the capacity, accreditation, and interest in training residents, can do so.

### **Network Continuation**

Value Proposition:

- Residency Recruitment
- Roundtable knowledge-sharing
- Curriculum development
- Quality Improvement
- Technical Assistance: residency development/expansion and rural rotations
- Grant writing
- NMPCTC as a Sponsoring Institution

Network Revenue Stream: Yes; the Southwest Center for Health Innovation (New Mexico Primary Care Training Consortium) established residency development contracts (Sept.1, 2017 through August 31, 2019) with the Gerald Champion Regional Medical Center and Memorial Medical Center to provide Technical Assistance and support. Other contracts expected are with the Rehoboth McKinley Christian Hospital, and a dues structure for all Consortium members. Longer-term sustainability will be provided through the Sponsoring Institution model (expected upon accreditation approval from the Accreditation Council of Graduate Medical Education [ACGME]).

### **Project Officer**

Jayne Berube  
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jberube@hrsa.gov

## NEW MEXICO (2)

### New Mexico Rural Hospital Network

Nor-Lea General Hospital Inc

#### Network Description

Grant Number: D06RH27780

Organization Type: Hospital

Full Address: 7471 Pan American Fwy. NE, Albuquerque, NM 87109

Website: Information not available

Year Formed: 2013

Network Contact:

Stephen Stoddard

Director

505-346-0216

stephen.stoddard@nlgh.org

Members:

Hospitals

Mission:

The New Mexico Rural Hospital Network's mission is to support and sustain quality healthcare in our communities through collaboration.

Vision:

The New Mexico Rural Hospital Network will be the leader in quality rural healthcare through education, advocacy, sharing of best practices, and group leveraging.

Member Needs:

- Common voice to educate and advocate
- Best practice sharing
- Group Purchasing / Shared Programs
- Increase membership
- Continue to build on education and Peer to Peer
- Clinical evidence based
- Work with medical schools
- Incorporate
- Develop more in depth the Peer Network Committees
- Opportunities to work with other rural healthcare organizations (HealthInsight, SORH, NMHA)
- Sharing more data (financial, quality, etc.)
- 3rd Party Payor Contracting
- Develop a relationship with Indian Health Services

Governance:

- Contributions by the hospitals include time of the CEOs and other Leaders (CFOs, CNOs, Compliance Officers, Lab Directors, Quality Directors, etc.) to participate in Board and Peer Network Committee meetings. The hospitals also participate in the programs and

opportunities offered by the network and individual CEOs serve as Board Officers while other Leaders serve as committee Chairs for their Peer Network Committees.

## **Environmental Analysis**

Geographical Area: Residents of rural and frontier New Mexico

Population Need: The original need for the project was to help establish a healthy rural hospital network with dedicated leadership and staff that can address some of the common challenges of members in a collaborative way. The New Mexico Rural Hospital Network's mission is to support and sustain quality healthcare in our communities through collaboration.

Blocks:

- Medicare / Medicaid reimbursement affects hospitals and in turn the network
- Urban vs Rural
- New Mexico has a small population that covers a very large geography
- Financial Sustainability
- Competing Needs and Priorities
- Hospital CEO Turnover

Levers:

- Growing Membership
- Active Peer Network Committees
- National focus on value and quality of care
- Rural ACO Participation and Learning Opportunity
- New Mexico Medicaid interest in partnering with hospitals to explore rural opportunities that reduce overall costs

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): ACO

Background: The New Mexico Rural Hospital Network is a collaborative organization consisting of rural hospitals across the state of New Mexico.

Strategic Objectives and Key Initiatives:

- Continue implementation of residency program to increase primary care workforce in rural area
- Conduct marketing activities to increase public awareness of Network activities including health care workforce training and resident physician training in rural community
- Further development of educational opportunities for healthcare workforce in rural areas



- Increase quality of care for rural Nevadans through expansion of primary care residency program to rural community
- Conduct capacity building activities leading to a stronger, more cohesive organization

### **Challenges & Innovative Solutions**

One significant barrier we faced was with our goal to design and implement programs to increase the primary care workforce in rural areas when we initiated discussions with the top leaders at the University of New Mexico Health Sciences Center. The discussions went very well to work on starting physician residency rotations at our rural hospitals. The barrier we have faced and continue to face is to move from discussion and promises to actual implementation from UNM. To get around this barrier, we have found some success through developing a business partnership with a physician recruiting company that has helped some of our hospitals with their recruiting needs in primary care as well as some of our hospitals have been able to establish physician residency rotations from Texas Tech. University.

### **Network Continuation**

Value Proposition: NRACO Financial Consulting, Peer Network Committees, Group Purchasing Organization (GPO), Salary Survey, Quality New Mexico Learning Summit, NMHA's PARC Initiative and SNAC Grant,

Network Revenue Stream: Yes.

### **Project Officer**

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## NEVADA (2)

### Nevada Rural Health Network Humboldt General Hospital District

#### **Network Description**

Grant Number: D06RH27775

Organization Type: Hospital

Full Address: 118 East Haskell Street, Winnemucca, NV 89445

Website: <http://www.humboldthospital.org/>

Year Formed: 2008

Network Contact:

Elissa palmer

(702) 992-6888

Elissa.Palmer@unlv.edu

Members:

Hospital, University/College, Area Health Education Center (AHEC),  
Individual Physicians

Mission:

The mission of the Nevada Rural Health Network is to build, maintain and expand a partnership that blends together a Critical Access Hospital, frontier family medicine physicians, an accredited Graduate Medical Education program, a community-based educational outreach partner and other community partners to support a health workforce strategy addressing rural education, training, recruitment and retention.

Vision:

The vision of the Nevada Rural Health Network is the integration of community-based, rural specific, Graduate Medical Education and training situated in a frontier/rural setting, that connects community practitioners and local health conditions, and prepares appropriately trained physicians for diffusion to areas affected by geographic disparities in health workforce recruitment and retention.

Member Needs:

Increased access to education development opportunities for rural health care workforce and opportunity for rural residency opportunities.

Governance: A great strength of the Network is its continued shared consensus with regard to the decision-making process, communication, resolution of conflict, attendance and participation, all crucial to strategic planning. We were able to gather, consider, analyze, and prioritize environmental information in an organized and efficient fashion.

## **Environmental Analysis**

Geographical Area: Residents of rural and frontier Nevada

Population Need: Not only are Humboldt County and the surrounding areas (Lander and Pershing counties) isolated in their proximity to specialty and tertiary health care, but there is also a severe shortage of physicians and access to health care workforce trainings which is the impetus for this network. Humboldt General Hospital in Winnemucca serves approximately 18,014 rural and frontier residents from Humboldt, Lander and Pershing Counties. According to a query of the HPSA database, two service area counties are designated as Health Profession Shortage Areas (HPSA), Dental Health HPSAs and Medically Underserved areas; 100% of service area is designated Mental Health HPSAs

Blocks:

- Lack of time to develop and implement
- Distance and competing commitments inhibit ability for Network members to meet face to face as much as may be desired
- Turnover and staffing vacancies

Levers:

- Depth of resources, talent and knowledge amongst Network members to ensure issues are resolved and concepts are implemented
- Commitment of Network members to dedicate resources to achieve objectives, goals and vision
- Strength of coalition and dedication of Network members, staff and community to achieving objectives, goals, and vision

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Workforce

Background: Recognizing a need in rural Nevada and shared values that have consistently prioritized health workforce development, Humboldt General Hospital, a critical access hospital located in rural Winnemucca, Nevada, the University of Nevada School of Medicine (UNSOM) (Department of Family and Community Medicine-Las Vegas and the Nevada State Office of Rural Health), High Sierra Area Health Education Center and physicians in our rural community collaborated to address the critical shortage of physicians in rural and frontier communities; the need for improving access to quality healthcare; and the lack of health professional education programs based in rural and frontier areas.

Strategic Objectives and Key Initiatives: To continue, enhance and expand its initiative programs to conduct workforce development trainings and to implement a Family Medicine (primary care) Rural Training Program.

## **Challenges & Innovative Solutions**

During the course of this grant period, various members of the Network met in large and small group format more than 40 times even though Humboldt General Hospital, and the rural community physicians, are located in a rural community, 167 miles away from its AHEC partner and 554 miles away from its UNSOM Family Medicine partner. A great strength of the Network is its continued shared consensus with regard to the decision-making process, communication, resolution of conflict, attendance and participation, all crucial to strategic planning. We also utilize Tracking Activity Charts to record activities initiated by the Network. Data is gathered from multiple sources and recorded in this central tool. We have implemented a Dashboard as a tool to assess data collected on activities. Industry-created surveys for course attendees are used to assess effectiveness of Network educational activities and an online residency management program is used to monitor resident activities, duty hours, personnel tracking and evaluations.

The Network consulted with the American Academy of Family Practice - Residency Program Solutions to provide assistance with the development of a sustainability plan for the Rural Residency Track Training Program. It provided the Network with a report to achieve sustainable excellence by identifying specific revenue and suggestions on program structure to maximize funding sources including clinical service fees, federal support of graduate medical education (GME – both indirect and direct), hospital and medical school support. This consultation provided a fiscal and programmatic map to assure that no barriers will keep this network from being successful. Based upon this consultation, the network partners have a plan for ongoing assessment of sustainability of the residency through revenue generation and ongoing financial support by network members.

## **Network Continuation**

Value Proposition:

- Rural Residency Family Medicine Program
- Recruit Residents
- Public Awareness Activities

Network Revenue Stream: The NRHP Network has been successful in creating revenue streams to sustain the network and to expand the network's service offerings.

## **Project Officer**

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mmikre@hrsa.gov

## NEVADA (2)

### Nevada Rural Hospital Partners

Pershing General Hospital

#### Network Description

Grant Number: D06RH27785

Organization Type: Clinic, Hospital

Full Address: 4600 Kietzke Lane, Suite I-209 Reno, NV 89502

Website: <http://www.nrhp.org/>

Year Formed: 1987

Network Contact:

Holly Hansen

Nevada Rural Hospital Partners

(775) 827-4770

[holly@nrhp.org](mailto:holly@nrhp.org)

Members:

Clinic, Hospitals, Medical Centers

Mission:

To support the viability of member hospitals through shared services, resources, and advocacy by reducing costs, generating savings, enhancing quality, sharing resources and expanding the use of technology.

Vision:

NRHP is widely recognized as a successful network. Our members are exceptionally cohesive and share the belief that each member is stronger through united effort.

Member Needs:

- Programs and activities that shape and interpret the members' operating environment
- Programs and activities that support member financial viability
- Programs and activities that enhance the availability and quality of members' human resources
- Programs and activities that support an appropriate array of high quality services in member communities
- Programs and activities that support adequate facilities and technology in member facilities as well as the NRHP office

Governance: NRHP is made up of 13 CAH hospital providers, organized to include representation of all the hospitals and to ensure equal representation of each member.

#### Environmental Analysis

Geographical Area: Residents of Nevada's rural and frontier areas

Population Need: Nevada’s rural and frontier hospitals, emergency departments and hospital-based clinics stand alone as the only primary care providers in their communities. These communities may have small service populations, but they experience a higher prevalence of residents suffering from severe mental illness, and primary care providers are often ill-equipped to treat these patients who present in crisis. Without collaborative relationships (1) between rural primary care providers and behavioral health specialists who can support and educate them, and (2) between rural hospitals and clinics and Nevada’s state mental health agencies, it is impossible to integrate the disparate systems of care that exist in rural and frontier areas today.

**Analysis:**

NRHP as a network is the primary subcontractor for the Rural Hospital Flexibility Program (FLEX) program since 1999. Per the Nevada Rural Health Plan published by the Nevada Office of Rural Health all Critical Access Hospitals (CAHs) in Nevada must be Regular or Associate members of NRHP or NRHP Foundation and as such must participate in a number of NRHP programs and services

Increasing populations of Medicare and Medicaid reimbursed for at allowable cost, leaves rural hospitals with no capital to reinvest into the hospital. This provides unique challenges in maintaining, replacing, and acquiring equipment. On average, Nevada’s Medicare, Medicaid, and uninsured patients account for 67% of an acute care hospital’s patient load. Considering other government programs, this number grows to nearly 75% of a hospital’s cost structure that is being paid at or below cost, leaving Nevada’s critical access hospitals with few options but to look at shutting down services.

**Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Behavioral Health Intergration, Care Coordination, Quality Improvement, Telehealth

Background: The focus of this project is to achieve efficiencies and to improve quality of rural behavioral health services by integrating behavioral health into rural primary care settings and by collaborating to achieve population health goals through the use of technology. Nevada’s rural and frontier hospitals serve over 281,000 residents in an area spanning 96,000 square miles. Given the immense geographic dispersal of behavioral health patients, specialists, and primary care providers across Nevada, the adoption of telemedicine is essential. The state of Nevada is experiencing a tremendous behavioral health crisis, compounded by a shortage of psychiatrists and a severe budget shortfall. Using federal grant funds to stretch the scarce resources available in Nevada, we will be able to bridge this tremendous care gap, thus meeting the needs of a very vulnerable population.

### Strategic Objectives and Key Initiatives:

- To increase the rural and frontier primary care providers' knowledge of behavioral health issues.
- To increase the rural primary care providers' knowledge of local community resources available to meet the needs of behavioral health patients through support of the development of an inventory of local and state-wide services.
- To increase the utilization of currently available technology to provide consultation and treatment for behavioral health patients.
- To support the collection and utilization of program evaluation data, in order to gauge progress, make improvements and for strategic planning and sustainability purposes.

### Challenges & Innovative Solutions

Staffing turnovers at our partner agency (State of Nevada DHHS Division of Public and Behavioral Health (DPBH)), significant barriers to the development and implementation of shared clinical protocols, an extreme shortage of psychiatrists in particular and behavioral health providers overall, physician engagement was a barrier to the implementation of the telemedicine solution, Licensed Clinical Social Workers (LCSWs) cover the virtual waiting room for patient assessments during the hours of 8:00 AM – 12:00 PM and 1:00 PM – 5:00 PM, Monday through Friday, patient data can be exchanged between rural providers and state behavioral health facilities/clinics that share patients for continuity of care, and data collection tools and processes, along with turnover in individuals responsible for collecting data.

### Network Continuation

Value Proposition: The specific Products and Services provided through the NRHP Behavioral Health Integration. Program include:

- Consults for rural behavioral health patients via the VSee telemedicine platform, supported by funding (Award #D06RH2785), resulting in a recommendation for the patient (discharge to outpatient therapy or transfer to a higher level of care)
- Provider education - Behavioral Health in Primary Care Clinic, provided in partnership with Project Echo Nevada
- Legal advisement related to the involuntary legal hold of behavioral health patients by rural hospitals as the patient awaits transfer to an acute psychiatric facility

Network Revenue Stream: The NRHP Network has been successful in creating revenue streams to sustain the network and to expand the network's service offerings.

### Project Officer

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## NORTH CAROLINA

### Foothills Health Network

St. Luke's Hospital, Inc

#### **Network Description**

Grant Number: D06RH27791

Organization Type: Hospital

Full Address: St. Luke's Hospital 101 Hospital Drive Columbus, NC 28722

Website: <http://www.polkfitfreshandfriendly.org/fhn-partnership.html>

Year Formed: 2015

Network Contact:

Michele Trofatter

Director

[michele.trofatter@slhnc.org](mailto:michele.trofatter@slhnc.org)

Members:

Hospital, Clinic, Behavioral or Mental Health organization

Mission:

To improve the health of people living in Polk County and neighboring communities by increasing access to coordinated, quality care, and cultivating community engagement.

Vision:

As a network, we envision a healthy community with engaged citizens, community organizations, and collaborative healthcare partners.

Member Needs:

- Creating a vibrant system for communication of available resources
- Engaging local providers in the network
- Mapping the current referral patterns in Polk County

Governance: Our network is governed by the South Georgia Regional Management Team which includes a representative from each school district we serve, the district public health directors, local hospital administration and the director of each local Family Connection collaborative director in each county. The team meets monthly (the first Friday of each month) with the 4 collaborative directors and two times per year with the entire group. The collaborative directors take information back to each local monthly meeting to ensure the network stays connected and informed regarding rural health issues and progress of our 4 school systems in regard to implementation of the Rural Health Network Development initiative.

#### **Environmental Analysis**

Geographical Area: The uninsured elderly population and other medically indigent residents

Population Need: FHN has been very deliberate in creating a network for Polk County that includes not only health care providers (the traditional network



model), but also includes social service providers and the local wellness coalition. This complete community network model allows FHN to address not only chronic disease, access to care, and integrated care issues; it allows the network to address the individual, including social determinants of health such as transportation, housing, food insecurity, and other wellness needs. Creating an environment of health equity continues to be integral to the mission and vision of FHN.

The goals of FHN were created with input from all of its varied stakeholders. Objectives are aligned with these goals and have activities specifically associated with the objectives. Activities are assigned to workgroups and subcommittees of FHN. Reports to the full membership occur at monthly general membership meetings of FHN. Annually, the membership reviews and adjusts the strategic plan according to the accomplishments and necessary realignment of activities reported during the previous year.

Blocks:

- Physicians and office managers are not very engaged.
- County commissioners are not represented in discussions.
- Low community and provider awareness of the network.

Levers:

- Strong partnerships with SLH, PF3, BRCHS, TFC.
- Strong participation from local agencies.
- Collaborative efforts in community health assessment process.

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Care Coordination, Population Health

Background: The Foothills Health Network is a new collaborative conceptualized in early 2013 whose mission is to improve the health of people living in Polk County and neighboring communities by increasing access to coordinated, quality care, and cultivating community engagement. The network is also responsible for addressing unmet needs in the areas of behavioral health, chronic disease care and prevention, as well as increasing access to care, primarily serving the uninsured elderly population and other medically indigent residents.

The network is guided by three founding organizations consisting of St. Luke's Hospital (SLH), The Free Clinics (TFC), and Polk Wellness Center (PWC) who connect vertically with one another and whose leadership forms the steering committee for the network. These three organizations have a previous history of partnering in Polk County for the purposes of addressing unmet need in the community. The creation of Foothills Health Network has created an avenue for

increased formalization of these efforts, as well as the forum to engage community partners in support of the network's objectives.

#### Strategic Objectives and Key Initiatives:

- Integration of behavioral health screening and treatment with primary care through a depression screening program and integration of primary care with behavioral health through a chronic disease screening
- Improved quality and delivery of healthcare services through the utilization of evidence-based treatment for health issues most significant in Polk County- diabetes, cardio-pulmonary disease, and mental health
- Improved coordination of service through the implementation of an intensive clinical case management model, as well as coordinating access to medication assistance for patients and providers, including medication counseling and education and Medication Therapy Management
- Implementation and utilization of health information technology including interactive telemedicine for specialty consultation
- Health data sharing by electronic transmission of patient care summaries across multiple settings.

### **Challenges & Innovative Solutions**

Having a network in Polk County serves several purposes. First of all, in a rural county with a small number of primary care providers providing services, it is essential to collaborate whenever possible in order to leverage resources and achieve efficiencies. Furthermore, collaboration and coordination of the many agencies, headquartered both inside and outside the county, is important to ensure services aren't provided in silos. The network also identifies gaps in health care services available and works with existing partners and members, as well as approaching new ones to address identified needs for the community. The network uses its relationships with members and partners to help organizations work on strategies from a cooperative standpoint, rather than a competitive one, whenever possible with the network serving as a mediator. Without these important conversations and leveraged relationships, the low-income, uninsured patients' needs are often under-represented or not considered.

Challenges to collaboration in the network generally occur when organizations or agencies feel a competitive environment exists, their input is undervalued or unheard, or their engagement is unnecessary. Communication between FHN members, partner, and the steering committee is essential in minimizing the challenges. One important challenge to the network has been the change in leadership for BRCHS and SLH during 2016. With two new CEO's at the helm, the network and the steering committee have worked diligently to educate both about the purpose of the network and the role their organization plays in its success. Another challenge for FHN as it seeks to create financial stability is that

most of its partner organizations also seek grant funding and the network could be competing with its collaborative partners for regional or state funding in the future

## **Network Continuation**

Value Proposition:

- CASE MANAGEMENT- a full time case manager for Polk County residents to assist patients in obtaining primary care, behavioral health, or specialty care appointments.
- AFFORDABLE PRESCRIPTIONS – access to affordable prescription medications for residents of Polk County which can be picked up by the patient at St. Luke’s Hospital.
- DIABETES SELF MANAGEMENT EDUCATION-an individualized and comprehensive curriculum in which the person with diabetes learns how to manage all aspects of diabetes, from monitoring medications, diet and exercise to psychological and psychosocial stress.
- DIABETES PREVENTION PROGRAM - A CDC-recognized lifestyle change program is a structured program developed specifically to prevent Type 2 diabetes. It is designed for people who have prediabetes or are at risk for Type 2 diabetes, but who do not already have diabetes.
- HEAR2HELP- A collaborative effort with PF3 to provide two-way communication concerning health and wellness resources and CASE MANAGEMENT- a full time case manager for Polk County residents to assist patients in obtaining primary care, behavioral health, or specialty care appointments.
- COPE simulations- Cost of poverty experience provides first hand exercise to enhance awareness and empathy for people living in poverty.

Network Revenue Stream: The ability to begin projects in Polk County with “seed funding” from the network, grow them, and help them become either self-sustainable or incorporated into the budget of the supporting organization or agency has become very important in the overall sustainability for the network. Currently, the main activity of the network which is not self-sustaining is the Network Coordinator position. Sustainability for the network includes FHN’s ability to maintain current members and provide opportunities for new members to join, engaging in community-based activities which can become part of not only FHN’s strategic objectives, but the strategic objectives of FHN’s partners, and remaining responsive to community needs.

## **Project Officer**

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## NORTH DAKOTA

### ND Critical Access Hospital (CAH) Quality Network Northwood Deaconess Health Center

#### **Network Description**

Grant Number: D06RH27783

Organization Type: Health Center

Full Address:

UND Center for Rural Health, School of Medicine and Health Sciences,  
1201 11<sup>th</sup> Ave. SW, Minot ND, 58701

Website: <https://ruralhealth.und.edu/projects/cah-quality-network>

Year Formed: 2007

Network Contact:

Jody Ward

Director

[jody.ward@med.und.edu](mailto:jody.ward@med.und.edu)

Members:

All of ND CAHs (36) are active members of the Network.

Mission:

To support ongoing performance improvement of North Dakota's Critical Access Hospitals to improve the health of rural North Dakotans through collaboration, capacity building, and enhanced understanding.

Vision:

To empower rural hospitals to provide the best quality and safety for patients to achieve optimal outcomes.

Member Needs:

- CAHs deal with significant health workforce issues including supply of primary care physicians, nurse practitioners, physician assistants, nurses and other healthcare professionals.
- Having access to timely and correct information that is applicable to rural health settings, is a service of the Network and a highly identified need from members.
- Improved care coordination related to outpatient emergency department (ED) transfers; and enhancing data collection tools and methodology.
- A new ND rule issued by the ND Board of Pharmacy requires that a hospital must have a pharmacist review all medication orders prior to the first dose being administered to the patient. Currently 10 ND CAHs do not have 24/7 pharmacy coverage.
- Patient safety, medication reconciliation, patient falls, and quality guidelines for rural hospitals are topic areas of need for ND CAHs.

Governance: The Network Executive Committee was formed in April 2007 on a voluntary basis. Members, representing administration, quality improvement and nurse management are from nine different ND CAH's and represent North

Dakota's geographic regions. These executive committee members have agreed to serve either 1, 2, or 3-year terms. The purpose of the executive committee is to oversee the ND CAH Quality Network's activities. Monthly calls are held with one in-person meeting per year.

## **Environmental Analysis**

Geographical Area: All rural areas across North Dakota

Population Need:

- The identified need for ND CAHs was to develop an electronic repository for Emergency Department Transfer Communication data abstraction online. This allowed an electronic mode for hospitals to abstract real time data and improve their patient safety and processes. Additionally, not all ND CAHs had capability of 24/7 pharmacist review of first dose medications to patients. The grant provided education on this topic and purchase of electronic equipment for eleven ND CAHs to have telepharmacy capabilities.

Blocks:

- Limitation of human and financial resources in CAH
- Multiple responsibilities assigned to QI Coordinator in a rural facility-spread too thin
- CAHs support continuous development, focus on improving care in rural facilities. However, demand to do this exceeds the capacity in many cases to meet well intention and needed demands

Levers:

- Support provided to ND CAH Quality Network (Network) through the Center for Rural Health UND, Medicare Rural Hospital Flexibility Program
- Eight CAH experts (CEO, DON, QI Coordinator) serve the Network voluntarily every month and provide guidance
- History of strong collaboration between (Center for Rural Health UND, ND Hospital Association, ND Quality Improvement Organization, ND Department of Health, EMS Association and others)

## **Grant Project Description**

Project Year:2014-2017

Focus Area(s): HIT/HIE

Background: The North Dakota Critical Access Hospital Quality Network began in 2008 through the voluntary work of critical access hospitals throughout the state of North Dakota and funded by the ND Medicare Rural Hospital Flexibility Program (program administered through the UND Center for Rural Health (CRH). An executive committee of critical access hospital representatives serve as a

decision making body and provide leadership to the members and oversight of the coordinator's efforts. A stakeholder committee, represented by statewide partner organizations, provides feedback and a link to increase communication. Stakeholder partners include; ND Hospital Association, ND Department of Health (division of EMS & Trauma and Health Resources), ND Health Information Network, Quality Health Associates (state quality improvement organization), Blue Cross & Blue Shield of ND. The Network serves as a common place for North Dakota's critical access hospitals (CAHs) to share best practices, tools, and resources related to providing quality of care. The Network supports quality improvement activities of the Network members.

#### Strategic Objectives and Key Initiatives:

- The use of computerized provider order entry (CPOE) and telepharmacy to better facilitate pharmacist review of medication orders, within in 24 hours;
- Improving care coordination related to outpatient emergency department (ED) transfers;
- Enhancing data collection tools and methodology (e.g. pharmacy reviews and outpatient emergency department transfer communication)

#### **Challenges & Innovative Solutions**

We achieved our goals, developed new relationships with the ND Pharmacy Board, and others. No barriers identified.

#### **Network Continuation**

##### Value Proposition:

- Through the ND CAH Quality Network we are building local capacity within the CAHs to address QI
- Flexibility of RHND grant to allow us to address a specific piece of the ND legislation (Pharmacist First Dose Review)
- Regional CAH Meetings
- Assistance with CMS Conditions of Participation CAH survey
- Medicare Beneficiary Quality Improvement Program (MBQIP) Technical Assist; including EDTC and first dose verification of medication within 24 hours
- Networks webpage

Network Revenue Stream: The ND CAH Quality Network is supported for staff time through the Medicare Rural Hospital Flexibility grant program. The ND CAHs do not pay a membership for their participation. The Network is non-profit.

#### **Project Officer**

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## OHIO

### Integrating Professionals for Appalachian Children (IPAC)

Ohio University

#### **Network Description**

Grant Number: D06RH26831

Organization Type: University

Full Address: P.O. Box 826, Athens, OH 45701

Website: [www.ipacohio.org](http://www.ipacohio.org)

Year Formed: 2006

Network Contact:

Arian Smedley

Executive Director

[director@ipacohio.org](mailto:director@ipacohio.org)

Members:

Behavioral or Mental Health organization, Allied Health organization, Pre K-12 School, University/College, Area Health Education Center (AHEC), Social service organizations

Mission:

By leveraging our expertise and integrating our resources, IPAC will develop innovative, culturally-sensitive programs that address the critical and complex challenges impacting the health and mental health of children and families in the Appalachian region of southeastern Ohio.

Vision:

Ensure healthy development for all children living in Appalachia Ohio.

Member Needs: (1) early identification, assessment, and coordination of care for children with mental health concerns (2) onsite community interventions and workforce development; (3) improved care coordination (4) integrated services that combine existing resources and provide "one-stop shopping" for consumers; (5) strategic direct service programs that meet local needs; (6) streamlined billing and outcome tracking

Governance: Information not available.

#### **Environmental Analysis**

Geographical Area: High-risk pregnant women in an eight-county service area in southeast Ohio (Athens, Gallia, Hocking, Jackson, Meigs, Perry, Ross, Vinton); two additional populations in Athens and Meigs counties: (1) children who frequently use the emergency department for non-urgent care, and (2) children with histories of trauma and/or foster care placements

Population Need: Information not available.

#### Blocks:

- Communicating that the network is more than the sum of its individual parts: IPAC's work is often equated with the work of its individual agency partners, rather than something separate on its own right.
- Clarity and consensus among the board regarding its desired scope of authority: related to transparency, there remains variation among board members regarding the scope of decision-making desired by the board
- Loss of leadership and board turnover

#### Levers:

- Competent, committed staff
- Relationship with the medical school provides stable infrastructure
- Commitment and willingness of board members to engage
- Established history of collaboration and successful program development
- Diversity of skills and expertise on the board.

### **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Care Coordination

Background: Integrating Professionals for Appalachian Children (IPAC) is a rural health network, incorporated as a 501(c)3, that serves as a regional platform for advancing system-wide initiatives to ensure healthy development for all children living in Appalachia Ohio. By leveraging our expertise and integrating our resources, IPAC develops innovative, culturally-sensitive programs that address the critical and complex challenges impacting the health and mental health of our region's children and families. Efforts to strengthen interagency and community-university partnerships have facilitated initiatives designed to develop an integrated system of care, support professional development, assist with advocacy efforts, create opportunities for evaluation and research, and strengthen internal organizational capacity.

#### Strategic Objectives and Key Initiatives:

- Strengthening IPAC's brand through a multi-channel comprehensive communications plan targeting internal and external stakeholders based on historical data, a communication audit and an evaluation of how IPAC creates value for consumers of services, the community, and IPAC's participating agencies;
- designing & utilizing pay-for-performance contracts for IPAC's clinical Pathways Programs, current and proposed, to generate revenue when improved health outcomes are achieved
- diversifying and increasing revenue for IPAC through dues, conferences, fundraising and new business ventures; and by (D) investing in the development of the IPAC leadership and board of



directors to enable smart growth, as articulated in a comprehensive sustainability plan.

### **Challenges & Innovative Solutions**

Information not available.

### **Network Continuation**

Value Proposition:

- IPAC's value lies in its dual ability to assess local needs and adapt programs and initiatives to meet them. Below, we list the needs followed by the programs that address them [in brackets]: (1) *early identification, assessment, and coordination of care for children with mental health concerns* [Interdisciplinary Assessment Team]; (2) *on-site community interventions and workforce development* [Early Childhood Mental Health Consultation program in schools; local/regional conferences]; (3) *improved care coordination* [Family Navigator Program]; (4) *integrated services that provide one-stop shopping* [Integrated Behavioral Health & Primary Care]; (5) *strategic direct service programs that meet local needs* [Pathways programs for opiate-addicted mothers, smoking cessation, and ED over-utilization]; (6) *streamlined billing and outcome tracking* [contracting initiatives currently in progress]

Network Revenue Stream: Information not available.

### **Project Officer**

Jayne Berube  
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jberube@hrsa.gov

# OKLAHOMA

## Rural Health Network of Oklahoma

Little Dixie Community Action Agency

### Network Description

Grant Number: D06RH28029

Organization Type: Agency

Full Address: 209 North 4th Street, Hugo, Oklahoma 74743

Website: [www.RHNofOklahoma.org](http://www.RHNofOklahoma.org)

Year Formed: 2008

Network Contact:

Stacie Pace

Network Director

(580) 326-3351

[space@littledixie.org](mailto:space@littledixie.org)

Members:

Hospitals, clinics, community members, vendor members, home health agency, counseling center, ACO, long term care center, skilled nursing center, tribal nation clinic.

Mission:

Better Access, Better Healthcare-together

Vision:

To act as a convener and facilitator of change within the rural health care system in order to ultimately improve the health of rural Oklahomans.

Member Needs:

- Improve efficiencies and effectiveness of HR department
- Improve functionality of EHR platform
- Achieving goal of improved population behavioral health factors

Governance: Throughout the grant period, the governing Board, made up of representatives from the network, will meet four times a year and evaluate the program. The governing Board will assess the progress of the project, gauge whether there have been any problems, decide what can be done to solve the problems, if any, and then determine how project operations can be improved. This systematic, ongoing monitoring of measurable activities helps to ensure that the network is delivering high quality health care consistent with project goals and objectives. The board of directors consists of 2 hospital seats, 1 rural health clinic seat, 1 private clinic seat, 1 home health/behavior health center seat, 1 community seat, 1 tribal seat.

### Environmental Analysis

Geographical Area: Residents of Choctaw, Pushmataha, and McCurtain counties in Oklahoma

Population Need: Rural population in this region of Oklahoma is designated as a frontier area; isolated rural areas with a population of less than seven people per square mile. Access to health care is limited.

Blocks:

- Medicaid cuts
- Medicare cuts
- Funding for salaries
- Local Politics

Levers:

- Partnership with OSU
- State agencies recognizing the RHNOK as a vehicle to get programs to rural health care providers.
- IT needs of the health care providers
- Potential member interest
- Regional thinking
- RHN relationships in the community

### **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Telehealth

Background: The Rural Health Network of Oklahoma, Inc., (RHN) is a network of rural health providers and strategic partners. RHN works collaboratively to improve quality access to healthcare for people living in rural Oklahoma through a network of integrated services. As a rural health network, maximizing collaboration to ensure the best outcomes for both patient and provider is our priority.

RHN's purpose is to improve the health of rural Oklahoma by building a sustainable network of integrated services. This includes electronic health record (EHRs) and health information exchange (HIE) consulting, creating county health improvement organizations (CHIOs) and educating health care practitioners and the community about health care law, and chronic disease management, among other things.

Strategic Objectives and Key Initiatives:

- To strengthen the rural health care system to ultimately improve the health of Oklahomans living in Atoka, Choctaw, McCurtain, and Pushmataha Counties. This will be accomplished by enhancing health care quality, safety, access, and efficiency, as well as by improving the

availability and content of patient health information, through the promotion of technologies by the Rural Health Network of Oklahoma.

### **Challenges & Innovative Solutions**

Our advice for successful collaboration to achieve network goals is to work closely with your board of directors in order to make sure they are aware of any issues and successes the network may be having. They can help you in most cases. They have more of a buy in if they are aware of what is going on and are a part of the process.

The most significant barrier faced in achieving the goals and objectives was access to quality internet. This caused problems with the technologies of our members making it difficult to run the software efficiently. We were able to alleviate the problem by working with the internet providers in the area to get fiber connections for our members in Choctaw and Pushmataha Counties. Another barrier we faced was working with one of the doctors in Choctaw County that is the medical director for 3 hospitals in our network as well as several home health agencies in the area and the ambulance authority. He was not a fan of the network at the beginning of the grant and would not work with us. This caused some friction in working with our members that had affiliation with him. Once the FQHC's left the network (see explanation below) this doctor started listening to us and talking to us about needs he had. This doctor also runs a rural health clinic. He came on board after the first year as a member and was on the board of directors by the second year. He has been one of our biggest advocates and the most involved with the network. We had no unachieved objectives with this grant. Each obstacle was overcome.

### **Network Continuation**

Value Proposition:

- Health care HR service
- Health IT services and expertise
- Negotiation expertise with health care vendors
- Health care public relations expertise for promoting members' value
- Knowledge sharing and health care leadership development support
- Community coalition expertise for population health management

Network Revenue Stream: Yes, RHNOK will continue to sustain after the funding of this grant. RHNOK spun out of LDCAA, becoming a separate 501c3 and was awarded their first federal RHND grant in July of 2017. The network director will continue in place thanks to the partnership with Oklahoma State University. The activities will continue along with new activities that spun out of the needs identified during this grant.

### **Project Officer**

Marcia Colburn  
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mcolburn@hrsa.gov

## OREGON (2)

### Coast to Cascades Community Wellness Network Samaritan North Lincoln Hospital

#### **Network Description**

Grand Number: D06RH27789

Organization Type: Hospital

Full Address: 3043 NE 28th Street, Lincoln City, OR 97367

Website: <https://www.samhealth.org/about-samaritan/community-benefit-initiatives/community-health-initiatives/healthy-smiles-for-all>

Year Formed: 2009

Network Contact:

JoAnn Miller

Director

541-768-7330

[jomiller@samhealth.org](mailto:jomiller@samhealth.org)

Members:

Critical Access Hospital; Community Health Center; Free clinic; Health Departments; Hospitals; School Districts; Social Services Organization; Universities; Tribal Council; Affordable Care Organization; Rural Health; and a Healthcare System

Mission:

To provide leadership to enhance the health of communities through development and support for collaborative regional partnerships and community health programs in Benton, Lincoln and Linn Counties.

Vision:

To lead and sustain a system of partner agencies and organizations who are working together to provide integrated services and programs that promote individual and community health.

Member Needs:

- Expand low-income medical, dental and mental health services.
- Recruit more providers who will accept Medicare and Medicaid patients.
- Help the region's diverse communities to navigate the health care system.
- Champion community partnerships and initiatives that support basic human needs.
- Increase access to mental health care and education.
- Improve parenting education.
- Offer culturally appropriate community outreach and health education.
- Increase bilingual services and cross-cultural competence among medical and social service providers.
- Provide clearer communication and more compassionate care.
- Involve government and the community in making public health a priority.

- Increase drug, alcohol and tobacco cessation programs.
- Identify and address regional priorities that focus on the social determinants of health.
- Increase interagency collaboration.

Governance: The eight-member Steering Committee (a subset of CCCWN members) was established in 2014 to provide day-to-day support for regional health priorities and to provide overall direction for the Governing Board. The CCCWN Governing Board meets 2 twice a year and the Steering committee meets six times a year. The Governing Board and Steering Committee members serve as advisors and decision makers to the project and bring a wide range of expertise, skills and experience. Their responsibilities include guiding the ongoing functioning of the program as well as reviewing and approving the business and strategic plans and the reports for the project.

### **Environmental Analysis**

Geographical Area: All incorporated and unincorporated communities located in Lincoln, Benton, and Linn counties in Oregon.

Population Need: In 2009, Samaritan Lebanon Community Hospital saw an increase in the number of adults visiting the Emergency Department (ED) and Urgent Care (UC) sites for non-traumatic dental pain. The problems and needs to be solved were; a) Reducing Emergency Department (ED) and Urgent Care (UC) usage for non-traumatic dental pain in uninsured adults, b) Increasing access to dental services for oral health emergencies, and c) Educating the community around the importance of oral health.

#### Blocks:

- Inadequate systemic attention to the social determinants of health
- Infrastructural issues such as transportation, food distribution and housing quality
- The geographic isolation of some of the region's most vulnerable populations
- The difficulty of attracting, housing and retaining health care staff in underserved areas
- Racial/ethnic discrimination and bias in health care, housing and education
- Lack of cultural competence and linguistic diversity among regional health care workers

#### Levers:

- The following environmental factors are helping CCCWN to realize its vision:
- Ongoing state efforts to integrate physical, dental and behavioral health
- Expanded health care availability under the Affordable Care Act

- The increasing number and strength of partnerships between health care providers, state and local agencies, nonprofits, coalitions and other stakeholders
- The InterCommunity Health Network CCO Regional Planning Council's development of a regional delivery system that is firmly grounded in a philosophy of coordinated, patient-centered health care

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Oral Health

Background: The Coast to Cascades Community Wellness Network (CCCWN) addresses regional health priorities through implementation of collaborative, evidence-based approaches across our region. After four years focused on childhood obesity, the network designated oral health as the network's top priority in July 2013. The Healthy Smiles for All Initiative will improve the oral health of uninsured, underinsured, homeless and/or low-income residents in rural Lincoln and east Linn Counties.

Strategic Objectives and Key Initiatives:

- A comprehensive network strategic planning process and development of a strategic plan with a focus on oral health
- Integration of oral health care into 16 rural primary care, pediatric and OB/GYN clinics; and three community sites, two Women, Infants and Children offices; and four Head Start programs
- 3) annual delivery of comprehensive oral health education for health care providers utilizing Smiles for Life: A National Oral Health Curriculum for Primary Care Providers and the First Tooth program
- 4) annual review and adaptation of Initiative activities, based on evaluation data
- 5) a region-wide public oral health media campaign.

## **Challenges & Innovative Solutions**

- Barrier: Locating permanent dental care space for the Expanded Practice Dental Hygienists (EPDH) in each medical clinic.
- Solution: The clinic manager became a champion and identified a permanent exam room for the EPDH to practice in two of the three sites
- Barrier: Scheduling enough patients to make sure the EPDH did not have open appointments.
- Solution: We conducted a successful mass advertisement media campaign which dramatically increased the number of patients seen daily at the clinic for oral healthcare.
- Barrier: Getting appropriate referrals from the emergency department.

- Solution: We met with the Vice President of Patient Care to discuss and clarify the referral process and provide updated resource information to be distributed to patients.

### **Network Continuation**

Value Proposition: Conducting regular health needs assessments, creating community health improvement plans and community benefit plans, promoting and implementing community health improvement strategies, supporting local and regional health priorities, organize committees to develop and support community health projects

Network Revenue Stream: Yes. The CCCWN is now self-sustaining through financial and in-kind contributions of its members.

### **Project Officer**

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## OREGON (2)

### Northeast Oregon Network (NEON)

Northeast Oregon Network

#### **Network Description**

Grant Number: D06RH27782

Organization Type: Health collaborative

Full Address: 913 Main Avenue La Grande, OR 97850

Website: [www.neonoregon.org](http://www.neonoregon.org)

Year Formed: 2009

Network Contact:

Lisa Ladendorff

Director

(541) 624-5101

[lladendorff@neonoregon.org](mailto:lladendorff@neonoregon.org)

Members:

Hospital, Clinic, Behavioral or Mental Health organization, Pre K-12 School, University/College, Social service organizations, Economic Development

Mission:

Northeast Oregon Network increases access to and quality of integrated healthcare for Northeast Oregon residents by identifying system gaps, facilitating community-developed solutions, and advocating for health policy change.

Vision:

Improved health status for all residents of Northeastern Oregon.

Governance: NEON's Pathways Community Hub is governed and directed by a Board of Directors and a Leadership Team made up of members that represent various health and social services providers in the NEON region. The NEON Board includes a Program Manager from Head Start, the Executive Director of Northeast Oregon Economic Development District, an Administrator with Public Health, a CFO from a regional hospital and clinics, and a Professor at Eastern Oregon University. The Hub Leadership Team is comprised of ten members who represent primary care providers, a hospital, public health and mental health and prevention services, anti-poverty programs, and adult and child welfare services from the regions the Hub serves. Currently, under the Pathways Community Hub Project, NEON partners with ten regional organizations and has contracts with each partner to provide services to individual Community Members through the Pathways Hub. Leadership Team members have operational and strategic decision-making power over the hub and collaborate to continually improve the project.

#### **Environmental Analysis**

Geographical Area: Residents of Union, Baker and Wallowa counties in the Northeastern corner of Oregon

Population Need: The NEON area population is markedly poorer, less educated and less healthy than both the Oregon and national populations. Lack of technology access (including phone access), difficult and distanced geography, a sparsely populated frontier area, declining state and local economies, reductions in public and private resources, and a strong community biases against “government handouts” all combine to create a climate of great need and reluctance to accept “outside” help. Continual declines in the median wage, an uncertain state revenue situation, and the rapidly changing external environment, especially in health care, results in significant unmet community health needs. Given the high rates of adverse cardiac health outcomes, and high incidence rates of diabetes, the target population was adults with cardiac or diabetes diagnoses, or significant risk factors for such.

Blocks:

- Significant in region competition for our basic CHW training program.
- Lack of clear NEON branding and loyalty.
- Medicaid payer appears uninterested in contracting.
- Potential/likely repeal of the ACA and loss of Medicaid expansion.
- Lack of skilled and organized marketing and communications infrastructure.
- Growing competition from other regional networks.

Lever:

- The Hub is unique in our region and has growing partner interest.
- Recognized value in application assistance by multiple partners.
- Solid state and national reputation as a community based network among policy makers/networks.
- Growing need for CHW/other para professional continuing education.
- Strong strategic plan
- Solid fiscal systems and performance.

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Care Coordination

Background: The Pathways Community Hub is a program focusing on improving access to systems that support health, for members of the community experiencing barriers to health. The process by which members of the community are supported is through working directly with Community Health Workers (CHWs). Often, the root cause of poor health is due to circumstances outside of healthcare systems, but are actually linked to social determinants of health. CHWs assess the needs of a Community Member through conducting home visits, and working to build a relationship. Once barriers are identified, the CHW works with the Community Member to complete Pathways associated with those barriers. Some examples of Pathways include accessing transportation

services, or childcare services, so that a Community Member can visit their doctor, or enrolling a Community Member into an appropriate health education class. When a CHW and a Community Member complete pathways, NEON pays the associated organization strictly based on outcomes. This payment model is an innovative Alternative Payment Method (APM), which does not provide payment for the service alone, but rather only pays for achieving measurable outcomes.

#### Strategic Objectives and Key Initiatives:

- Increase access to care for uninsured residents by facilitating enrollment in health coverage through the Health Insurance Exchange Marketplace;
- Increase access to and impact of Care Coordination Services through the use of a standardized evidence based care coordination best practice that also includes addressing social determinant of health needs;
- Realign financial incentives for care coordination towards a payment for outcome model;
- Improve patient and population health outcomes for cardiac and diabetic indicators;
- Achieve ongoing non-grant sustainability of the Pathways Community Hub Program.

### **Challenges & Innovative Solutions**

In the early stages of the project, NEON encountered unexpected challenges helping our contracted health organizations incorporate community health workers into their practices and grow their enrollment to a level that would justify full-time health worker employment. The majority of organizations did not have prior experience with home-based community health work, and incorporating a different practice model into clinics took longer than NEON expected. To overcome this barrier, NEON worked closely with the Leadership Team to create policy solutions to facilitate clinic transitions and have tailored training for supervisors and community health workers to help them navigate challenges. In addition, NEON gathered best practices from clinics that successfully incorporated community health workers and disseminated them throughout the network and presented them in supervisor training programs and initial discussions with new partners. Finally, NEON was able to offer some startup funds to help smaller contracted organizations bridge the gap between hiring of community health workers and receiving outcome payments for work completed. These strategies have been successful, and while many of the organizations are not up to full capacity yet, enrollment is growing every month and experienced partners are finding that outcome payments fully fund their community health work programs. These early enrollment challenges set back the timeline of grant expenditures, and necessitated carryover requests each year, as enrollment and volume milestones were not met each year due to slow initial enrollment and low volume. As discussed briefly above, our second major barrier has been in relationship building and meaningful collaboration with our

Medicaid payer. Oregon has moved to a Coordinated Care Organization system, a local state version of an ACO that manages Medicaid payment and programs in a given geographical area. The NEON region has a particularly difficult CCO to work with, as it isn't really one organization, but rather a physical health payer that is private for profit and not located in the region, a mental health payer that is composed of a governing board of community mental health center directors, and a governance board composed of the prior two partners, five hospitals who have "paid to play", and several other community and ad hoc positions. The geographic region is very large, further complicating relationship building. The CCO, the Eastern Oregon Coordinated Care Organization (EOCCO), exists in name only, with no staffing. Staffing is instead provided by the physical health insurer and the mental health insurer. Often these two entities do not communicate with one another or work in a coordinated manner, with NEON staff often being told by field staff from one organization that they cannot access any resources from the other. While NEON has developed good working relationships with mid-level field and analytical staff, relationship access to the decision makers has been limited. Meanwhile, the physical health insurer is experiencing severe financial difficulties in its for-profit areas of business as it relates to the individual exchange market, and is under the supervision from the State Insurance Division. This situation makes it extremely difficult to have meaningful conversations about business cases and ongoing funding. In addition to direct challenges in communication about a potential payer relationship, challenges within EOCCO have made it difficult to request participant cost data that is generally available to other pathways hubs that have built persuasive return on investment analyses. Though NEON has made multiple data requests for cost of care data, and has worked on ROI models with a midlevel data analyst from the CCO, the CCO was unable to produce robust data for community members. NEON has finally been able to determine that the payer is unable to obtain the information, which was indirectly confirmed by the state. NEON has shifted strategies in this area as it has begun working with larger health systems in the area that have robust internal cost of care data. The contracted evaluator is now starting to access data from these health systems, and can start work on much more complete return on investment analyses. These analyses will form the basis of negotiations for third party payer contracts in the future, as they have for other pathways hubs.

## **Network Continuation**

### Value Proposition:

- Health Care Providers such as hospitals and primary care homes: Pathways Community Hub provides value by providing financial and programmatic support for integration of CHWs into practices, provides a means to address health related social needs of patients, provides population level measurement for and ROI for CHW work.
- Health and Human Service organizations: CHW Training Program provides value by helping existing work force retool, meetings state certification and billing requirements, provides local community of

practice, and provides onsite training for initial training and continuing education.

- Local State Department of Human Services, Insurance Agent and Justice System organizations: Health Insurance outreach and enrollment program provides value by helping staff meet their requirements for working with community members, helps extend their staffing by providing onsite service, help reduce recidivism.
- Local Health and Human Service Organizations: The NEON Consulting Program provides value by meeting the needs of local entities for program evaluation, grants writing and management, project management, community health assessments and executive coaching.

Network Revenue Stream: Creating revenue streams for the hub has been the largest challenge that NEON has faced over the grant period.

**Project Officer**

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## PENNSYLVANIA

### Keystone HIE (KeyHIE)

Geisinger Clinic

#### **Network Description**

Grant Number: D06RH27770

Organization Type: Clinic

Full Address: 100 N Academy Avenue Danville, PA 17822

Website: [www.keyhie.org](http://www.keyhie.org)

Year Formed: 2005

Network Contact:

Jim Younkin

Director

[jryounkin@geisinger.edu](mailto:jryounkin@geisinger.edu)

Members:

Hospitals, Physician Practices, Home Health Agencies, Long Term Care Facilities, Pharmacy, Emergency Medical Services (EMS)

Mission:

To enhance healthcare delivery through a collaborative platform that provides a timely and secure patient-focused exchange of meaningful health information.

Vision:

Connecting communities through the timely access of health information when it's needed, while improving healthcare outcomes and reducing re-admissions for the patients we serve.

Member Needs:

- Improve transitions of care to long-term and post-acute care (LTPACs)
- Reduce readmissions during transition of care
- Secure access to comprehensive patient data and self-management tools
- Health Information Exchange allowing patient data sharing nationwide
- Integration with state registries (cancer, immunization etc.)
- Data to coordinate hospital referrals, LTPAC admissions
- Exchange information with care team members, including primary care, emergency care, and discharges to home health
- Provide information to care team to support new Alternative Payment Models

Governance: KeyHIE has built a collaborative governance board to ensure the input of all stakeholders and a transparent decision-making process to expand and develop new and innovative tools to improve the secure exchange of healthcare information. This governance structure is accountable for defining the approach, methodology and execution of the project. The KeyHIE Governance Team meets quarterly in-person with monthly teleconference to discuss ongoing projects.

## **Environmental Analysis**

Geographical Area: Patients who receive long-term and post-acute services across a 31-county focus area in central and northern Pennsylvania

Population Need: Patients encounter multiple care settings depending on care requirements for chronic disease, short-term rehabilitation or management of an episodic incident. When care teams have a 360-degree view of patient care, the resulting coordinated care process for transitions of care impacts readmissions.

### Blocks:

- Vendors adhering to HIE standards
- Lack of direct vendor resource control
- Lack of technical resource recruiting
- Opt in/Opt out authorization models
- Rising vendor costs

### Levers:

- Enforcement of HIE standards with 17 EHR vendors
- Embedded vendor resources
- Exclusive service offerings
- Recruitment from local colleges
- Participant education on authorization options
- Negotiations on cost

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Care Coordination, HIT/HIE

Background: The program mission is to improve transitions of care to long-term and post-acute care (LTPACs) utilizing the KeyHIE exchange to create a Coordinated Care Process for transition of care impacting re-admissions. The focus will include three health information technology (HIT) connectivity solutions (KeyHIE Transform, MyKeyCare (MKC), and DIRECT secure messaging) provided by KeyHIE throughout a 33 county region in Pennsylvania. The solutions will improve the transmission of LTPAC patient care summaries across multiple electronic medical record applications (EMRs) and provide secure access to comprehensive patient data and self-health care management tools. The mission tasks include connecting, up to 25 LTPAC organizations throughout a 33 county area, to KeyHIE to utilize the solutions mentioned above to improve the transmission of LTPAC patient care summaries across multiple data collection settings. The result is secure access to comprehensive patient data and self-management tools to treat the patient effectively. The KeyHIE provider solution is centered on electronic communication to move patient records securely in a timely manner. The solution ultimately provides improved patient transition care

via patient record unification, patient record security, and transfer time reduction.

The Keystone Health Information Exchange (KeyHIE)® was established in 2005 and has now includes private practices, nursing homes, home health, and hospitals. KeyHIE incorporated in 2013 as a tax exempt, not-for-profit health information organization (HIO) under the Geisinger Foundation in Danville, Pennsylvania. Today there are 50 unique healthcare organizations participating as members in KeyHIE and serving nearly 4 million patients across central and northeastern Pennsylvania, including 20 hospitals, 250+ physician practices, 61 nursing homes and 28 home health locations.

KeyHIE operates as a loose collaboration aligned for the purpose of using health information technology (IT) to improve care coordination among its participants. KeyHIE is a fully operational, Pennsylvania-based health information exchange.

Strategic Objectives and Key Initiatives:

- To engage LTPAC providers to participate in a Health Information Exchange.
- To increase membership in the KeyHIE Health Information Exchange
- To provide LTPAC providers with technology solutions for transition of care.
- To measure the impact of improved transitions of care related to population health improvement.

### **Challenges & Innovative Solutions**

While progress continued to promote HIT and HIE adoption, rural providers have relatively few resources—legally, financially and labor-related—to support efforts to implement new HIT applications. Lacking technical expertise and capital for investment, many providers may find it difficult to sustain any motivation to learn about or pursue HIT. This situation may be especially true for the “stand-alone” providers typically found in rural settings.

A lack of LTPAC legal resources has produced a non-reactive response to signing the MOU and Keystone Participation Agreement (KPA). KeyHIE has provided several follow up teleconferences to review the bidding and non-bidding agreements.

The level of collaboration across the membership network has increased. New member participation in the annual KeyHIE user conference is the result of new digital connections that were made possible through the grant.

### **Network Continuation**

Value Proposition:

The health exchange provides integration into a certified health exchange through one of the following vehicles:

- Transform tool-converts MDS/OASIS into CCDs



- DIRECT messaging – used to securely email patient information
- Patient Portal access (MyKeyCare) for patients and family members to have access to their clinical information.
- Interface with LTPAC electronic medical record
- HIE delivers LTPAC information to Accountable Care Organizations (ACOs), Bundle Payments for Care Improvement (BPCI), and other Alternative Payment Models (APMs)

Network Revenue Stream: Network has been successful in creating revenue streams to sustain network and expand services provided by the network. Setup fees vary by type of implementation, levels of service and bed size. Annual subscription fees apply subsequent to go-live, and vary based on facility bed size and services selected.

**Project Officer**

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## SOUTH CAROLINA (2)

### Palmetto Care Connections (PCC)

Allendale County Hospital Nursing Home

#### **Network Description**

Grant Number: P10RH23477

Organization Type: Nursing home

Full Address: 1880 Main Highway Bamberg, SC 29003

Website: [www.palmettocareconnections.org](http://www.palmettocareconnections.org)

Year Formed: 2013

Network Contact:

Kathy Schwarting

Director

[kathys@g3consults.com](mailto:kathys@g3consults.com)

Members:

Hospitals, mental health centers, alcohol & drug abuse centers, federally qualified health centers, rural health clinics, academic health centers, health systems, AHEC, schools

Mission:

Facilitate health care access across South Carolina through the utilization of innovative technology to promote the provision of qualified medical professionals of various disciplines.

Vision:

Improving the Health of South Carolina through telemedicine.

Member Needs: Palmetto Care Connections formed a Needs Assessment Committee that was tasked with developing a process by which to assist rural communities in defining their telehealth needs. To begin this process, health data from the region is reviewed in an attempt to define the gaps in service. This committee then developed a Health Needs Assessment Checklist to be used to assess unmet community health needs, determine connectivity issues, gauge technical support and ultimately develop a telehealth plan. This project was a deliverable tasked to PCC in the 2015 Statewide Telehealth Strategic Plan. Through this deliverable, a thorough needs assessment process was designed.

Governance: Board of Directors

#### **Environmental Analysis**

Geographic Area: Residents of Abbeville County, Allendale County, Edgefield County, and Fairfield County in South Carolina

Population Need: The original need for the project totally revolved around increasing access to care in rural/underserved communities. The Project Director for the RHND grant had spent the last 16 years working in a rural hospital, building a rural health network and recruiting providers to the rural communities. Telehealth was viewed as a tool to infuse services into these rural

communities which had a very difficult time recruiting primary care physicians, let alone specialty providers. Many patients in these rural communities had little to no means of transportation to get out of their communities and travel to the health systems located in urban areas. The Project Director had worked closely with the SCORH over the years and shared a passion for working in the rural communities. In looking at telehealth as part of the solution to the access issues, it was determined that there was a little telehealth being provided in SC through two successful programs: telestroke provided by MUSC and telepsych provided by the SC Department of Mental Health. Although both programs proved to be successful in SC, no one agency or organization was working to get these needed services into the rural communities, thus Palmetto Care Connections was founded.

Blocks:

- Confusion about the definition of telehealth vs. telemedicine
- Other outside service providers
- Confusion in marketplace about mission and roles of Palmetto Care Connections
- Process of state allocation of funds
- Reimbursement gaps

Levers:

- Being the leader for PSPN/broadband
- Coordinating the annual telehealth summit
- Advisory Council Member participation from other healthcare organizations
- Monthly Education/Communications committee to support telehealth education

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Telehealth

Background: Palmetto Care Connections (PCC) is the telehealth network for South Carolina that offers telehealth support services and membership opportunities to healthcare providers. In 2010, a state level Telehealth Workgroup initiated the development of a statewide Telehealth Network called Palmetto Care Connections (PCC). The primary focus of PCC is to coordinate existing Telehealth/Telemedicine activities, expand successful models such as the South Carolina Department of Mental Health TelePsych and The Medical University of South Carolina's REACH or TeleStroke program. It is to develop new Telehealth/Telemedicine applications, assist providers in navigating through the steps of implementing Telemedicine, advocate for reimbursement by all payors and serve as a resource or clearinghouse of Telehealth information for South Carolinians.

## Strategic Objectives and Key Initiatives:

### Objective 1: Strengthen and expand existing network

Outcome 1.1 Create a five year strategic plan by the end of year one.

Outcome 1.2 Create protocols and procedures for project expansion sites by the end of year two.

Outcome 1.3 Create culturally competent provider and education training by the end of year one.

Outcome 1.4 90% of urban specialists who undergo training will demonstrate an improvement in cultural competency knowledge.

### Objective 2: Improve patient outcomes

Outcome 2.1 Create a continuum of care linking 4 rural clinics, 4 CAHs, USC, and MUSC.

Outcome 2.2 Increase access to care as demonstrated by providing 30 consults in year one, 50 in year two, and 75 in year three.

Outcome 2.3 150 patients will be enrolled in the home monitoring program by end of Year 3 and exhibit measurable improvement after one year on enrollment.

Outcome 2.4 Provide 75% patients with patient education and demonstrate an improvement in knowledge by 50% percent of participants.

## Challenges & Innovative Solutions

**Telehealth reimbursement:** Currently there are a little over half of the states in our nation that have successfully been able to implement parity for the purpose of expanding telehealth services. Parity means that telehealth services can be reimbursed at the same as if provided face to face. If states have not accomplished parity, then telehealth providers must work one on one with individual payers which is a long, tedious and difficult process. PCC has worked over the last few years with health systems, health care providers and leaders in telehealth to obtain parity through our legislative process but to date has not been successful in achieving parity. This continues to be a major barrier that we work through every legislative cycle. In lieu of parity, PCC has worked with its partners to approach individual payers and encourage them to reimburse for telehealth services. Currently many of the larger payers such as BCBS, United Healthcare and Medicaid reimburse for these services. There have also been issues with payers defining the definition of the "origination site" meaning where the patient is located. For example, school based telehealth is an up and growing trend and has exploded in South Carolina whereby Medicaid reimburses for these services but however SCBCBS does not currently consider a school as an origination site thus will not reimburse for school based telehealth. Again PCC continues to work with its partners to address these issues.

**Hospital closures/Failing small, rural hospitals/Administrative turnover:** The plight for many small and rural hospitals is pretty bleak. In the last five years, SC has seen the closure of two rural hospitals, both of which were located in the service area for this grant. SC now only has 4 CAHs and two of them are struggling to stay open. Our grant was intended to work with 4 of the five CAHs in South Carolina. It is very difficult for these hospitals to implement new

programs such as telehealth Remote Patient Monitoring programs when they are worried about meeting their payroll needs every pay period. Since the awarding of the RHND grant, we have experienced CEO turnovers. Actually, none of the CEOs that served as partners to PCC for this grant are in their positions any longer. Turnover makes it very difficult to implement new programs. RPM also did not work in the CAHs because these hospitals are reimbursed for their costs, so it does not benefit them to work to improve readmission rates which is one of the biggest benefits for RPM.

### **Network Continuation**

Value Proposition:

- Raise Awareness, of the benefits of telehealth, particularly in the rural healthcare environment, and raise awareness of Palmetto Care Connections and their services available to help fulfill this need;
- Provide Assistance, for broadband access to rural healthcare providers to obtain federal subsidy for broadband needed to utilize telehealth services;
- Encourage Evaluation, of the benefits and assistance available to rural healthcare providers for integrating telehealth technology;
- Provide Education, by building rapport with interested providers and providing them the information they need to

Network Revenue Stream: PCC has been very successful in developing a business plan and creating revenue streams that will sustain its activities

### **Project Officer**

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## SOUTH CAROLINA (2)

### Upper Midlands Rural Health Network

Upper Midlands Rural Health Network

#### **Network Description**

Grant Number: D06RH26842

Organization Type: Member Organization

Full Address: P.O. Box 1537 Chester, SC 29706

Website: [www.umrhn.org](http://www.umrhn.org)

Year Formed: 2004

Network Contact:

Karen Nichols

Network Director

803-377-8026

[knichols@umrhn.org](mailto:knichols@umrhn.org)

Members:

Public health district, FQHC, community mental health center, hospitals, clinic, pre K-12 School, university/college, Area Health Education Center (AHEC)

Mission:

To improve health in Chester and Fairfield counties through a collaboration of a diverse group focused on access to care, health promotion and education.

Vision:

To strengthen health accessibility, quality, and education for the citizens of the UMRHN region so that citizens enjoy improved quality of life

Member Needs:

- Dental services available to refer low income adults
- Mental health services available to patients
- Diabetes education to support PCMH model for rural practices
- Public health assistance to identify and manage health outcomes that will support revisions in both practice process and patient outcomes

Governance: The members of the Upper Midlands Rural Health Network are the governing body and are therefore vested with the entire management of the business and affairs of the Network. The Executive Committee consists of the Chair, Vice Chair, and the Secretary/Treasurer. Officers serve a 2-year term, provided, however, the officers may be elected to a subsequent term not to exceed a total of 4 years.

#### **Environmental Analysis**

Geographical Area: Chester and Fairfield Counties in north-central South Carolina

#### Population Need:

- The prevalence of diabetes in Chester County is 11.7% and Fairfield County is 13.1%, compared to the state prevalence of 9.6% and the national prevalence of 8.1%. This project supported the Network to expand access to, coordinate, and improve the quality of essential health care services in rural Fairfield and Chester (and later, Lancaster) Counties.

#### Blocks:

- Don't have a quorum at all meetings
- Need key people from hospitals at table
- Not every organization has the same objectives, and that makes working together tough sometimes

#### Levers:

- Communication is good
- Robust committee structure
- Good attendance and participation
- The members are cooperative with each other
- Good Director

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Care Coordination

Background: Established in 2004, UMRHN is a 501(c)(3) organization dedicated to improving access to health care and securing healthcare safety nets in Chester and Fairfield counties, in north central South Carolina.

Currently, UMRHN is implementing a Care Transitions Intervention© program focusing on diabetes education and coaching. This evidence-based program, developed by Dr. Eric A. Coleman, MD, MPH, is a self-management model in which the patient is taught skills to better manage their complex diabetes care needs.

The primary goals of this project were: 1) To strengthen the Network and its effectiveness in improving the system of health care in Chester and Fairfield counties; 2) To improve coordination between local providers; 3) To improve the self-management skills of patients with complex diabetes care needs in Chester and Fairfield counties; and 4) To improve access to diabetes education and coaching.

#### Strategic Objectives and Key Initiatives:

- Strengthen Network infrastructure, branding and financial stability
- Expand and sustain Network trainings and programs offered in Chester, Fairfield, and Lancaster Counties
- Engage in Network program planning efforts that promote appropriate utilization of health care services in the three counties

- Promote electronic health information exchange and telehealth initiatives
- Develop oral health programming for uninsured adults in our region

### **Challenges & Innovative Solutions**

Barrier: CTI® is new concept for the medical community and patients

Strategy/enhancement: Continuous education regarding the program and benefits for wider acceptance; incorporation into medical school curriculum/residencies

Barrier: Low number of eligible patients participating in CTI® program

Strategy/enhancement: Continuous improvement of the “pitch” used with patients to make them feel more comfortable; involvement of the caregiver to help demonstrate/explain the benefit

Barrier: Turnover rate of trained TCs resulting in job vacancies

Strategy/enhancement: The supervisor also attended training, which can help with onboarding and orienting new staff

### **Network Continuation**

Value Proposition:

- Opportunities to collaborate and interact with fellow members to accomplish Network goals.
- Opportunities to serve on committees and accomplish specific tasks that correspond with the committee’s charge.
- Providing public service information on health-related topics and gaining exposure for the agency that contributed the material.
- Exposure through the listing on UMRHN website.
- The use of the Coleman model of Care Transitions Intervention© prevents avoidable readmissions, saves the hospitals money, and helps the patient have better long-term outcomes.
- Assistance with HIT initiatives ensures the members stay in compliance and helps defray the costs of keeping up with ever-changing technology.

Network Revenue Stream: Yes, we have two new contractual arrangements to assist our Network members with start-up projects. One will provide an average of \$27,000 per year for three years and the other will provide an average of \$15,000 per year for four years. We have also started participating with our local foundations to engage new donors to support the school nurse workshop, our longest-running program.

### **Project Officer**

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## SOUTH DAKOTA

### One Connect Emergency

Pioneer Memorial Hospital And Health Services

#### Network Description

Grant Number: D06RH27786

Organization Type: Hospital

Full Address:

University of North Dakota

School of Medicine & Health Sciences, Suite E231

1301 N. Columbia Road, Stop 9037

Grand Forks, ND 58202-9037

Website: <http://www.sanfordhealth.org/promo/one-connect>

Year Formed: 2011

Network Contact:

Anne Christiansen

605.326.5161

315 N Washington St., Viborg, SD 57070

Anne.Christiansen@SanfordHealth.org

Members:

Hospital, Clinic, Long-term care, Behavioral or Mental Health organization, Emergency Services organization, Home Health organization

Mission:

To support rural and underserved communities by providing 24hr emergency services.

Vision:

To provide connected care everywhere.

Member Needs:

- Access to emergency physicians and specialists
- Continuum of care between facilities
- Streamlined transfer process
- RN documentation assistance
- Access to rural medical direction in EMS trucks

Governance: All network partners understand the importance strong governance in the sustainability of the tele-emergency Network and have participated in a governance structure that was maintained throughout the project period. The governance structure was rapidly implemented to allow all the members to begin work on project objectives, share experiences and challenges, propose solutions, and make decisions. The governance board included a mix of individuals as well as Network partner representatives.

## **Environmental Analysis**

**Geographical Area:** All community members who receive health care in the 27-county service area, including four states—North Dakota, South Dakota, Minnesota, and Iowa

**Population Need:** The Emergency Access Network was designed on the concept that rural and underserved communities and residents have above average need for emergency care but limited access to immediate, 24-hour care. Current research on emergency care indicates that high-quality care is critical in the early hours of an emergency event. Rural hospitals are not often staffed with 24-hour physician coverage; in some hospitals, coverage is provided only by nursing staff and midlevel providers. Additionally, emergency trained physicians are in urban centers; rural physicians are trained in family medicine and have less experience with high risk, low volume events.

### **Blocks:**

- Financial hardships of potential network sites
- Limited capacity with Pediatric & Orthopedic specialty care
- Lessons learned for appropriate EMS equipment
- Lacking business development due to high turnover

### **Levers:**

- Open communication across the Network
- Physician champions
- Connectivity reliability
- Coordinated care collaboration

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Telehealth

**Background:** Since 2011, Pioneer Memorial Hospital & Health Services has been awarded ORHP funding to establish a telemedicine emergency network named One Connect Emergency. Utilizing sophisticated video links, telehealth equipment, and dedicated physician time to provide remote, 24-hour access to emergency physicians. When needed, the critical access hospital activates the service by pushing a button to connect to a remote emergency physician to “enter” the rural emergency department through two-way interactive audio/video technology. Through the assistance of technology and the rural professionals, the remote physician will be able to assist with evaluation and treatment plan for the patient, at a level requested by the end-user physician or staff. This mature, ever-growing Network has now grown to 29 sites since inception.

#### Strategic Objectives / Key Initiatives:

- To achieve efficiencies in provision of care for rural communities within an existing network of partners
- to expand access to essential health care services, not otherwise available to patients with urgent conditions, through addition of new sites and increased level of service at existing sites
- to strengthen the rural health care system through interactive telehealth services, specialist consultation and electronic transmission of patient care summaries across multiple settings.

#### **Challenges & Innovative Solutions**

Sustainability was and will be the largest challenge facing the Network. As described in the sustainability section of the report, various models and methods continue to be explored by project leaders. This, however, did not affect the network's ability to complete the program activities and meet the program goals.

One of the barriers faced by the Network is access to specialty care. While the Network has strong relationship with Sanford Health providers, not all specialists have capacity or interest in telemedicine services. The Network succeeded with implementing telestroke program, mainly due to the physician champions as well as the regional stroke coordinators. Another barrier faced by the Network is expansion of sites. While the Network did meet the goals for expansion into two sites which included Watford City in North Dakota and Bemidji in Minnesota. The Network is very limited to the potential sites to join the Network. Many rural critical access hospitals across the country are facing financial burdens and taking on an additional monthly cost for access to tele-emergency is not fiscally possible to some.

#### **Network Continuation**

##### Value Proposition:

- Access to board- certified ER physicians for treatment and stabilization
- Streamlined transfer process
- Assistance with RN documentation
- Access to neurologists within minutes to assist with an acute stroke
- Access to burn surgeons and neonatology specialists
- Quarterly educational webinars with CME's
- EMS pilot project- offering a hands-free visual to medical control providers

Network Revenue Stream: Yes.

#### **Project Officer**

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## TEXAS

### Texas Rural Accountable Care Organization (TRACO)

Matagorda Regional Medical Center Foundation

#### Network Description

Grant Number: D06RH27777

Organization Type: Non-Profit corporation equally owned by nine hospitals.

Full Address: 104 7<sup>th</sup> Street, Bay City, TX 77414

Website: Information not available

Year Formed: 1994

Network Director:

Tara Dilley

Director

(361) 772-1547

tipoutreach@yahoo.com

Members:

Rural hospitals in 9 Texas counties

Mission:

To integrate health care locally and regionally for purposes of responding to the growth of managed care in a way that preserves local control and maintains the independence of the member institutions

Vision:

To assist rural providers in transforming the healthcare delivery system from cost-based reimbursement and fee-for-service (pay for volume) to care management and population health with improved quality (pay for value)

Member Needs: Most rural providers do not have the volume of patients and supporting data in one market to demonstrate value with empirical evidence, or have a business case that would support the necessary technology to do so. By aggregating providers and beneficiaries in the region in an ACO, TRACO will be able to provide those analytics for all of its members.

Governance: Board of directors who are the appointed representatives from each of the Member/owner hospitals

#### Environmental Analysis

Geographical Area: Residents of nine counties in southeast Texas, primarily situated along the Texas Gulf of Mexico between Houston and Corpus Christi

Analysis: In 2012, SETHS contracted with the Rural Community Health Institute at the Texas A&M Health Science Center to research the viability of the SETHS members to create and own a clinical data warehouse to support healthcare transformation, which included the assessment of the IT infrastructure and capabilities of the SETHS' member hospitals and current SETHS IT initiatives. "A

Careful analysis of the status of existing strategic decision support in rural hospitals and SETHS member hospitals yields significant gaps in 8 categories: 1.) reimbursement reform, 2.) service duplication, 3.) hospital value-based purchasing, 4.) increased demand for quality/performance-based reporting, 5.) increased need for analytics, 6.) increased patient involvement and collaboration, and 8.) transparency to the patient.” (SETHS Clinical Data Warehouse Business Plan, Jan 2013)

Population Need: In general the region’s residents are poorer, less educated, and more dependent on publicly financed health care services than other Texans and Americans. They are also less likely to live with the security of health insurance. Health insurance participation in the region is significantly worse than in Texas – which as a state has one of the highest percentages of citizens without health insurance in the US. The Network estimates that 30% of the region’s citizens do not have health insurance. A combination of demographic patterns, hard economic realities and persistent health manpower shortages challenge the regional rural hospitals and rural and public health clinics.

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): ACO, HIT/HIE

Background: Southeast Texas Health System (SETHS), the Network, is a Texas nonprofit corporation equally owned by 9 independent 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 member/owners are primarily rural and in the Texas gulf coast region between Houston, Austin, San Antonio and Corpus Christi. SETHS’ business model, much like a rural utility cooperative, is the foundation of which SETHS products and services are delivered. The primary purpose of this project is to support the formation, implementation and sustainability of an Accountable Care Organization (ACO) with a fourth aim of creating sustainable financial viability for the participating safety net providers.

Strategic Objectives and Key Initiatives:

- To support the formation, implementation and sustainability of a rural-focused Accountable Care Organization (ACO)
- To expand and enhance existing network programs—a Diabetes Self-Management Training program (DSMT), a Health Information Exchange (HIE) and a payor/managed care contracting program—to serve as the foundations of the ACO

## **Challenges & Innovative Solutions**

Navigating through the ACO requirements from a rural perspective is the intent of this grant.

The biggest and most important challenge is that healthcare transformation activities, specifically ACOs, are designed for providers with a high volume of patients. TRACO represents low patient volume providers. The metrics and methods normally used to achieve improved quality and lower cost will have to be adjusted for the TRACO participants. To address this challenge, TRACO will continuously monitor the data, assess the evidence and adjust both the metrics and the methodologies to create an appropriate and sustainable solution.

Cost and time to create and support an ACO is also a big challenge. The TRACO providers will leverage SETHS' existing programs—disease management, managed care contracting, and Texas Rural Accountable Care Organization (TRACO) Matagorda Regional Medical Center Foundation technology infrastructure—by spending new dollars to enhance the programs instead of creating new ones. TRACO will also save time and money by using SETHS' existing administration and governance, leveraging their collaborative history.

Finally, the most critical challenge is to assure that the technology infrastructure can deliver the data needed to achieve the ACO (and Medicare's) goal of better health, better care and lower cost. This challenge is not exclusive to rural providers, however the rural provider's access to experienced technology staff is. The Network is addressing this problem by the development of a shared Chief Technology/Information Officer.

## **Network Continuation**

**Value Proposition:** By nature, the Network 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 make their decisions; where Members contribute equally to and democratically control the capital of the organization. Benefits to Members are in proportion to their use with the cooperative and Members support other activities approved by the membership. Historically, SETHS develops a product or service confirming the effort with board action. Projects may be initially supported by grant funds (which are used for infrastructure and not sustainability) and 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" to ensure sustainability on the Network. Specific projects managed by SETHS, are overseen by a workgroup and/or committee which would include any stakeholders not represented by the SETHS board. The SETHS board, who takes the financial risk, has final authority.

Network Revenue Stream: Information not available.

## **Project Officer**

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## VERMONT

### Behavioral Health Network of Vermont d.b.a. Vermont Care Network

Behavioral Health Network of Vermont d.b.a. Vermont Care Network

#### Network Description

Grant Number: D06RH27764

Organization Type: Behavioral or Mental Health organization

Full Address: 37 Elm Street, Montpelier, VT

Website: [www.bhnavt.org](http://www.bhnavt.org)

Year Formed: 1994

Network Contact:

Simone Rueschemeyer

Director

(802) 262-6124

[simone@vermontcarepartners.org](mailto:simone@vermontcarepartners.org)

Members:

Long-term care, Behavioral or Mental Health organizations

Mission:

VCN integrates the full continuum of health, wellness and social services enabling Vermonters to lead full and satisfying lives. By providing care beyond health care and through enhanced services, collaboration and integration, we achieve improved value, health outcomes and life satisfaction.

Vision:

For all Vermonters to lead healthy and satisfying lives.

Member Needs: The needs of the members are focused on efficiency, improving health outcomes, and participation in health delivery and payment reform. Ultimately, they need services that can be provided to enable financial viability, sustaining the agencies so that they can provide high quality community based care. From this process we developed our strategic objectives and matched our services to the needs of our members.

Governance: The network board consists of 16 members all of whom are the Executive Directors/CEOs of the member agencies. There is a four-member Executive Committee with a Board President, Vice-President, Treasurer and Secretary. All 16 agencies have been extremely involved in the project and work together with the Executive Director to guide and implement the activities of the network. The Executive Director reports to the Board President.

## Environmental Analysis

Geographical Area: Statewide, covering all 14 counties in Vermont.

Population Need: At the time of the writing of the RHND application, there was a strong national effort to advance healthcare quality and reduce costs. Support for the installation and use of electronic health records, use of data registries for population management, and health information exchange technology to provide client specific information at various places of care had been the focus of effort for the past several years. In Vermont, this was no exception for primary and specialty medical services. What was missing, however, was the inclusion of mental health, developmental disability and substance use information from the community mental health agencies and specialized service providers.

The system was not functioning within the same environment it was even four years prior. Payment reform models were being piloted, care delivery models were changing and accountable care organizations were being developed. All of this was dramatically impacting the mental health and developmental disability provider community. They were being scrutinized and mandated to report data of all types to various entities. It was essential to develop a specialized data repository and a process for practice improvement. All of this data was required for continued funding, for improvement in care delivery through best practice work and enhanced care coordination and for demonstrating value to ACOs and others.

Blocks:

- Cost of IT infrastructure
- Sustainability of repository
- Limited Medicaid funding/underfunded system/understanding
- Medically oriented health reform process led by ACO and State and new Administration
- Challenge in demonstration of value of network on other parts of the delivery system (i.e. education/corrections)
- Standardization of tools and assessments is hard.

Levers:

- The All Payer Model calls for a plan for inclusion in 2020
- Integration is a focal point of health reform (opportunity to push the social model)
- Network is committed to understanding trust cost of system
- Network is interested in creating efficiencies and coming together in a different manner
- Network understands the social determinants of health and embeds that work in its delivery system

## Grant Project Description

Project Year: 2014-2017

Focus Area(s): HIT/HIE



Background: Vermont Care Network (VCN) is a statewide network of 16 non-profit community-based agencies that specialize in mental health, substance use disorders and developmental disabilities. Two years ago, VCN established a partnership with the Vermont Council of Developmental and Mental Health Services (the Council) under the umbrella name of Vermont Care Partners (VCP). The mission of VCP is to provide statewide leadership for an integrated, high quality system of comprehensive services and supports. VCN is seen as the business and innovation arm of the partnership and the Council is seen as the trade association and policy arm. Together the two organizations work on behalf of the same 16 agencies.

#### Strategic Objectives and Key Initiatives:

- Ensure high quality clinical data for population health and quality/outcome reporting
- Aggregate data for individual agency and network-wide analysis and reporting through the adoption of a unified database system
- Utilize the network to work with ACOs to improve health outcomes and decrease cost with the primary objective being the development of common protocols and the advancement of patient engagement
- Allow for electronic transmission of patient care summaries across multiple settings to inform and enhance care across the continuum.

#### **Challenges & Innovative Solutions:**

Our largest barriers to achieving our goals and objectives were: a constantly changing health care reform process, changes in the political environment, a delay of the funding for the data repository itself, an inability of the current agency electronic health platforms to provide CCDs and ADTs, an inability to access all payer claims data, and 42CFRPart2.

While the work of the data repository is not yet complete, the project has been very successful and we are 90% of the way to completion. There are more than 5,000,000 service records for over 50,000 unique individuals in the repository. The work was slowed down by the delayed DVHA funding but the work was not abandoned. As for the EHR vendor's inability to create the interfaces necessary for the repository, we resolved that by designing an alternate data extraction process. This was time consuming and costly but has proven successful. One of our goals for the repository was also to resolve the issues of 42CFRPart2 so that we could tie the repository to the Vermont Health Information Exchange and/or at least begin to share more data electronically with care delivery partners. Key players and stakeholders of health care reform in Vermont have yet to resolve this barrier. We will continue to work with the State, the ACO and others to achieve electronic data sharing to enable a truly integrated delivery system.

Our work in payment reform was abruptly ended due to a change in administration in Vermont but that work has begun again with involvement from VCN, the Vermont Council as well as the network agencies.

## **Network Continuation**

### Value Proposition:

- Health delivery reform leadership
- Payment reform leadership
- Development of methodology for assessing quality across the network and a process for quality improvement and peer learning.
- Identification and streamlining of outcomes
- Education and training
- IT services and expertise
- Public relations and value demonstration
- Contract and grant negotiation
- Change management consultation
- Provider network development and new business

Network Revenue Stream: The network is supported by yearly member dues, conference income and grants. Each year the network expands its services based on previous year's successes. Dues are assessed each year and agreed upon based on previous year's accomplishments as well as future need. VCN is in the process of marketing its Center of Excellence work to other non-profits in the hopes of building this into a product line that can assist in diversifying revenue streams even more. In addition, the VCN Executive Director and Quality Director have begun to market a strategic planning service to earn additional revenue that can support the network's services.

### **Project Officer**

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## VIRGINIA

### Giles County Health Network (G-NET)

Giles Free Clinic

#### **Network Description**

Grant Number: D06RH27771

Organization Type: Clinic

Full Address: 219 Buchanan Street, Pearisburg, VA 24134

Website: [www.chcnrv.org](http://www.chcnrv.org)

Year Formed: 2011

Network Contact:

Leah Wechtaluk McFarren

Network Director

(540) 921-3502

[gnetdir@CHCNRV.org](mailto:gnetdir@CHCNRV.org)

Members:

Hospital, Clinic, Behavioral or Mental Health organization, Pre K-12 School, Social service organizations, Agency on Aging; Medicaid Transportation; Health Department

Mission:

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.

Vision:

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.

Member Needs: The top barriers to health care consumption were affordability, and a lack of dental providers. The top rated unmet health care need identified was for dental care. All member organizations of G-NET serve individuals who are in need of, but cannot access, dental care—both preventive care and treatment.

Governance: G-NET is comprised of ten separate 501(c)(3) organizations, each of which plays a role in the governance of the network and the success of the network's programming. Each organization contributes to G-SMILE by providing expertise through Steering Committee membership, and providing assistance with public education and outreach to the target population, oral health patient referrals to the new dental unit at the Giles Free Clinic, and community-wide program awareness initiatives. The Steering Committee (one leader from each of the ten organizations, typically the Chief Executive) meets bi-monthly on the second Friday of the month, from 8:30-10:30 am. Meetings are held in a

conference room of the local critical access hospital. Agendas are provided in advance, and written Minutes are kept and approved. The Steering Committee operates according to consensus rule with elected Chair running meetings.

## **Environmental Analysis**

Geographical Area: Adults, children, and families who have poor or limited access to health care services due to low income and lack of health insurance.

Population Need:

- Giles County exhibits high indicators of poverty, uninsurance and child abuse—all much higher than statewide averages. Local data demonstrate that dental access is a top unmet health need of the County's residents. A serious dental provider shortage is slated to worsen as the few current dentists in the area approach retirement.
- 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 in the local Giles Free Clinic. 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. As a value-add, the Network will provide all member organizations with annual Appalachian Cultural Competency trainings, to ensure a highly satisfied and engaged patient population.

Blocks:

- Cultural acceptance of poor oral health/missing teeth as inevitable.
- Virginia Medicaid does not cover adult dental services (with a few exceptions).
- Sliding scale fee may still be too high for many low-income patients.
- Target population has high fear of going to the dentist.
- The dental unit may be overrun with patients and have a long wait time for appointments.
- Shifts in community norms around oral health may take years of strategic and coordinated effort.

Levers:

- Highly engaged and invested G-NET Steering Committee as collaborators in G-SMILE.
- High need for oral health services should result in high usage of the new dental operatories, and therefore high impact on health of the target population.
- New Health Center designation of Giles Free Clinic results in affordable sliding fee scale for oral health services.
- Target population known to respond to financial incentives to change behavior (e.g., go to dentist).
- The Giles Free Clinic building is expandable to add a dental unit.
- G-REACH is available for transportation to/from dentist.

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Oral Health

Background: The people of Giles County have benefited greatly from a long-standing partnership between local health care providers and the Office of Rural Health Policy (ORHP) of the US Health Resources and Services Administration (HRSA). In May 2011, the Giles Free Clinic was awarded a HRSA-ORHP Rural Health Network Development Grant. This Network Development Grant facilitated the formalization of the Giles County Health Network, G-NET. G-NET is a vertical health network consisting of a variety of types of organizations serving the people of the County, all with the common vision of a healthier community. On the heels of the launching of G-NET, in May 2012 HRSA-ORHP awarded a three-year Rural Health Outreach Grant to the Giles Free Clinic. That grant supported the development and delivery of a non-emergency medical transportation program for low income, uninsured residents of the County—a priority of G-NET. This medical transportation program, named G-REACH, was a product of the early strategic planning of the Network, which identified medical transportation as the number one barrier to health care access in Giles County. In September 2014, a second ORHP Network Development grant was obtained, to expand the scope of G-NET and establish a community-based oral health care initiative, appropriately named G-SMILE. The full energy of G-NET is behind the successful development and sustainability of G-SMILE. The Steering Committee of G-NET is grateful for the financial support and technical assistance provided by HRSA-ORHP, and is committed to responsible and efficient planning and programming on behalf of the underserved of Giles County, Virginia.

Strategic Objectives and Key Initiatives:

- 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 in a local charity dental clinic. 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. The Network will provide all member organizations with annual Appalachian Cultural Competency trainings, to ensure a highly satisfied and engaged patient population.

## **Challenges & Innovative Solutions**

Information not available.

## Network Continuation

Value Proposition:

- **For the Community:** G-SMILE involves the community in educating all Giles County residents on oral health, and provides a locally-based dental clinic that is accessible both financially and geographically.
- **For Underserved Residents:** G-SMILE's dental clinic charges according to a sliding scale and features the integration of oral health and primary care, which provides health benefits that go beyond oral health.
- **For G-NET Members:** G-SMILE solves logistical problems for network organizations that previously had nowhere to refer individuals in need of accessible oral health care. G-SMILE greatly expands access to affordable dental care for patients and clients served by all Network member organizations. Ultimately, the health status of the entire County is expected to improve, which is valued by all Network members.

Network Revenue Stream: Yes, the sustainability strategies outlined in our Sustainability Plan have been implemented and are having the desired effect. The anticipated revenue stream from patient nominal fees and third-party payment for dental services is trending in the right direction, with revenues increasing every month. The dental clinic is on solid financial footing, and serving more and more people. We currently have a one-month wait for first non-emergency appointments. This is good news in terms of sustainability, indicating that the demand is high. Our array of oral health care services offered has not expanded (since we have always provided comprehensive prevention, treatment, and restorative services) but our community outreach is expanding. We hope to begin providing in-school examination and prevention services next year at all local elementary schools. G-SMILE is as strong as ever, thanks to our partnership with HRSA and the technical assistance that was provided as part of launching this new rural health network.

### Project Officer

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## WASHINGTON (4)

### Children's Village Trustees Yakima Valley Farm Workers Clinic

#### **Network Description**

Grant Number: D06RH26829

Organization Type: Clinic

Full Address: 518 West 1st Avenue, Toppenish, WA 98948

Website: <http://www.yakimachildreenvillage.org/>

Year Formed: 1993

Network Contact:

Linda Sellsted

Project Director

509-574-3207

LindaS@yvfwc.org

Members:

Hospital, Clinic, Behavioral or Mental Health organization, Foundation

Mission:

Crossing the bridge together... connecting children with special needs and their families to supportive services.

Vision:

Children and youth with special health care needs and their families will have access to a family centered and integrated system of services.

Member Needs:

The U.S. Department of Health and Human Services defines CSHCN as "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

Governance:

Children's Village is a mature network that has integrated its administrative, clinical, and financial systems of care since 1997.

#### **Environmental Analysis**

Geographical Area: Children with special health care needs (CSCHN) and their families in central Washington

Population Need: Information not available.

Blocks:

- Lack of vision, data-driven strategic/business plan
- No interoperability
- Decreased integration (families, staff)
- Low profit margin

- Lack of coordination with community-based services
- Access barriers (workforce, technology, cultural)

Levers:

- Mission-driven collaboration (families, staff, providers, community partners, Trustees)
- Philanthropic support (fundraising, grant writing)
- Culturally appropriate, evidence-based, innovative services
- Health professions training
- Family-centered facility

### **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Behavioral Health, Care Coordination

Background: The Children’s Village Network (Children’s Village) provides care for children with special health care needs (CSHCN) and their families in central Washington. The U.S. Department of Health and Human Services defines CSHCN as “those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.” In 2014, Children’s Village, the regional neurodevelopmental center in central Washington, served 4,938 CSHCN.

Children’s Village has shared administrative, clinical, and financial systems of care since 1997. Members are co-located in a 37,745 square foot clinic, jointly fund administrative staff, exchange clinical data in patient care summaries and interprofessional care team conferences, and jointly fund operating expenses. In addition to individual Network member providers and staff, the following shared Children’s Village staff run the Network: 1.0 FTE Director, 1.0 FTE Fiscal Coordinator, 8.0 FTE Schedulers, 1.5 FTE Childcare Aides (for siblings of CSHCN), and 2.7 FTE Housekeepers. Because Children’s Village is not a non-profit corporation, each Network member agency follows its own personnel and financial policies and procedures for its operations and budget at Children’s Village.

Strategic Objectives and Key Initiatives: Provide Health Home care coordination for up to 240 rural CSHCN families; ensure rural CSHCN needs are represented in the Central Washington Health Partners (CWHP) Accountable Care Organization (ACO); provide interprofessional care team training to at least 18 allied health professions students; provide universal developmental screening training to at least 24 health homes and childcares; provide early intervention consultation to at least 39 childcares and early learning centers; and interface the Seattle Children’s Health Information Exchange (HIE) with the CWHP ACO HIE.

### **Challenges & Innovative Solutions**



In addition to intrapersonal/individual, interpersonal, organizational/institutional, and community factors, there are public policy factors associated with the unmet health needs of CSHCN, including limited funding and benefit gaps.

## **Network Continuation**

Value Proposition:

- Developing a Family Voices structure will improve family integration
- Developing scope of services will improve the vision, reduce workforce barriers, reduce workforce shortages, and improve workforce training
- Providing care coordination will improve coordination with community-based services, reduce cultural barriers, and improve social determinants of health
- Providing continuity of care will reduce technology barriers, improve interoperability, improve staff integration, and improve health information exchange
- Providing quality care will improve data-driven strategic and business planning
- Developing a business structure will improve governance
- Recruiting strategic partners will reduce community partner competition
- Maximizing revenue will improve the profit margin and family, public, and private revenue

Network Revenue Stream: As the Affordable Care Act evolved, monetary resources were less than previously projected.

## **Project Officer**

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## WASHINGTON (4)

### Critical Access Hospital Network (CAHN)

Critical Access Hospital Network

#### **Network Description**

Grant Number: D06RH26829

Organization Type: Hospital, Clinic

Full Address: 714 West Pine Street, Newport, WA 99156

Website: Information not available.

Year Formed: 2002

Network Contact:

Jac Davies

Executive Director

509-998-8290

[jacjdavies@comcast.net](mailto:jacjdavies@comcast.net)

Members:

Hospital, Clinic

Mission:

To share resources and collectively support rural health systems to develop integrated models of care.

Vision:

The CAHN collectively contracts for and supports cost effective high quality population health services in rural communities through the development of individual community capacity and innovative partnerships.

Member Needs: Because there are other sources for these services, there is no need for the CAHN itself to develop additional capacity. Instead, the value that the CAHN can bring is through supporting collaboration and coordination among its members, focusing on creating a framework and resources that enable members to work together to identify common needs, identify and implement cost effective means of meeting those needs, promote consistency, reduce costs and improve health outcomes across the region.

Governance: Information not available.

#### **Environmental Analysis**

Geographical Area: Residents of eastern Washington

Population Need: High quality primary care should be the fully available in rural areas where it is easily accessible to rural residents and can coordinate with local community resources. Management of chronic conditions in a patient's local rural community can provide more support for the patient, leading to better control of the chronic condition and fewer adverse health outcomes. More complex care that is delivered in urban/metropolitan tertiary centers can be transitioned to the rural facilities for coordinated follow up care such as

rehabilitation and care management. To effectively implement population health initiatives for rural communities that integrate high quality primary care services with complex care delivered outside of the area, it is critical for rural providers to operate successfully within a value-based purchasing environment.

Blocks:

- Different sizes, resources and capabilities of network members can make it difficult to find common ground
- Competing demands for time and resources from other initiatives (e.g. ACOs)
- Different patient populations and payer mix between hospitals drive different strategies for success
- Uncertainty in changes to payment models make planning difficult

Levers:

- Most members are located in a common referral region, which creates some common ground
- Strong interest among members in working together
- Changes in payment models and other health system transformation efforts create new opportunities to work together
- WA state development of Accountable Communities of Health creates new requirements and opportunities for collaboration

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Behavioral Health, Integration

Background: The Critical Access Hospital Network (CAHN) is a nonprofit, multi-county network of Critical Access Hospitals in eastern Washington, formed for the purposes of sharing resources, promoting operational efficiencies, and improving health care services for member hospitals and the rural communities they serve. Initially organized in 2002 the CAHN has grown in size and scope with support from Health Resources Services Administration's Office of Rural Health Policy and Rural Network Grant Program, the Washington State Flex Program, and its CAH member organizations.

Strategic Objectives and Key Initiatives: (1) Improve the quality and delivery of both behavioral and primary care health services in four rural counties in eastern Washington, (2) strengthen the rural health care system by establishing local public-private partnership organizations in four rural counties in eastern Washington and (3) expand impact with shared best practices and results.

## Challenges & Innovative Solutions

While there are limitations related to scalability in rural health system development, there are also advantages that come with smaller communities. Smaller systems can be nimbler in making the kind of change necessary to succeed in the new health care environment. Novel delivery arrangements may be pursued more easily among stakeholders who know and trust one another and who have a collective interest in improving community well-being. The transition to high performance rural health systems will require a change in the balance and configuration of essential services, greater integration within and across service sectors, attention to population health, and shared governance and management structures. The CAHN needs to provide key resources and create an infrastructure that will support this transition in eastern Washington.

## Network Continuation

Value Proposition:

- Platform for communication and information sharing - Supports information and resource sharing between CAHN members. The distributed nature of the CAHN membership as well as the physical distance between member sites makes it difficult for individual staff to obtain information and develop a peer support network. The CAHN platform for communication and information sharing includes a website and videoconference system that provide mechanisms to promote and facilitate communication between members, not only helping individuals get access to information that can help them with challenges at their own facility but also serving to identify common challenges across all facilities that could be addressed by group action such as joint negotiation for purchased services.
- Framework for collective action - A formal, structured committee framework supports information and resource sharing, peer networking, and joint negotiation for purchased services or value-based contracts. By focusing on specific goals that are shared across CAHN members, the committees will be able to make measurable progress and provide concrete benefits for each member.
- Measurement system for tracking progress -- Establishing and facilitating use of a common quality metric tool, designed for rural health systems, will allow members to collect, track and trend data unique to their specific environment. This service will also help members evaluate current performance every month, set targets for improvement and learn from each other and from benchmark hospitals and clinics.

Network Revenue Stream:

- Members have identified and implemented a common behavioral health services solution.

- Board members are willing to pay dues that fully support organization operations.

**Project Officer**

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## WASHINGTON (4)

### Medical Information Network North Sound (MIN-NS)

Skagit County Public Hospital District 2

#### **Network Description**

Grant Number: D06RH26828

Organization Type: Hospital

Full Address: 325 Pine Street Mt. Vernon, WA 98273

Website: [www.min-ns.org](http://www.min-ns.org)

Year Formed: 2008

Network Contact:

Murray Laidley

360-982-2415

[murrayl@min-ns.org](mailto:murrayl@min-ns.org)

Members:

Hospital, Clinic, Labs, Jail, Long Term Care, Skilled Nursing Facilities,  
Department of Defense

Mission:

MIN-NS will identify and implement cost-effective information and related technology solutions; implement and provide ongoing support of a regional electronic health record; enable participating providers to optimize practice efficiency through workflow redesign; create sustainable economies of scale; and demonstrate improvements in quality of care and health of our communities

Vision:

The care experience of our patients and the health of our communities are vastly improved through the integration of patient information across the care continuum.

Effective medical and clinical decision support requires access to patient data, available to all sites of care. With the addition of claims information a complete view of the patient is gained, enabling population health management and care coordination.

Patients receive the best possible care, close to home. Their care team has access to medical information at any site of care within the network.

Member Needs: Longitudinal record of care for a patient, community record of care, population health management solution, OneHealthPort CDR Project, HCA Transformation Demonstration Delivery System Reform Incentive Project

Governance: The MIN-NS board operates today with two directors from Island Hospital, two directors from Skagit Regional Health and one director from Skagit County Public Health. The MIN-NS Board of Directors meet twelve or more times per year to provide collective guidance and direction to the Executive Director. The Finance Committee comprised of the CFO Board members meet with the Executive Director monthly to review budget and proforma.

Going forward MIN-NS plans to adjust Class A Board membership to those aligned with the strategy of network expansion, recruiting Class A Board members from the Strategic Accounts, and will significantly expand Class B membership from the community.

## **Environmental Analysis**

Geographical Area: Patients seeking care in the North Sound area of Washington State

Population Need:

The Goal is to improve the rural health care system in the service area.

- Expand Within MIN-NS Service Area:
  - MIN-NS is aggressively approaching Key Strategic Accounts for Network participation in the five-county service area defined in the Articles and Founder MOU. An expanded network provides economies of scale to the participants and supports the objective of rural network expansion. A cost-sharing model will reduce the cost of services to all network participants and here the price of MIN-NS services.
- Position MIN-NS as an Innovator of the Medicaid Transformation Project Toolkit:
  - The Washington State Health Care Authority, (HCA) has solicited proposals from firms interested in participating on a project to help HCA successfully carry out the terms of a Section 1115 Medicaid Transformation Project demonstration (Demonstration) with the federal Centers for Medicare and Medicaid Services (CMS).
  - The Demonstration aims to transform the state's Medicaid delivery system through regional, collaborative efforts led by Accountable Communities of Health (ACH) and new, supportive services to address relevant social determinants of health.
- Each ACH will serve as the administrative lead for its region to coordinate and oversee regional projects identified in this toolkit. ACHs are regionally situated, multi-sector organizations and, as such, are the vehicle to foster relationships between providers that are necessary to achieve the envisioned Medicaid system transformation. It is critical to understand that ACHs are comprised of groups of leaders from a variety of sectors. Together, these sectors will partner to design and implement the transformation projects within this toolkit.
- MIN-NS is uniquely positioned to partner with the North Sound Accountable Community of Health (NSACH) because MIN-NS' Five-county service area is the same as the NSACH area. MIN-NS Operates an HIE and Community Record of Care which is the foundational solution for required projects in the Medicaid Transformation Project Toolkit.

Blocks:

- Lack of regional scale and scope, available data not adequately comprehensive

- Lack of support by Skagit Regional Health communicated to our entire network
- Lack of Board support for regional and larger deals
- Concern over the native capabilities of the new EMR's (Epic and Meditech)
- Fear of HIPAA Breach, Especially at Skagit County, Skagit County Jail, Skagit County Public Health
- Lack of Direct Secure Messaging directly integrated into the HIE for incoming and outgoing referral communication
- Need for a populated provider directory
- Pricing needs to be more economical to integrate and push data to MIN-NS

#### Levers:

- Regain founder support through sustainability evaluation
- Expand the board to include community stakeholders that support the mission
- Document the ongoing value to the hospitals and community through sustainability evaluation
- Provide education
- Complete DSM implementation, populate provider directory
- Establish viable small practice pricing under the sustainability evaluation

## Grant Project Description

Project Year: 2014-2017

Focus Area(s): HIT/HIE

Background: Medical Information Network – North Sound (MIN-NS) Health Information Exchange (HIE) brings health information from disparate systems together into a unified view; for better individual care and population health management capability. Since MIN-NS' inception in 2008, our founding members have held the vision of a unified regional health information delivery system. They recognize that information about their own patients is fragmented and stored in many locations and systems. They created MIN-NS to resolve this problem and bring that information together to form a more complete record of their patients' care.

Our first HIE integration was between the separate Meditech EMR installations at Island and Skagit Valley Hospitals. From this humble but ambitious beginning, MIN-NS has expanded to include other EMR systems at our founders' ambulatory clinics, as well as integrating the EMR at Whidbey General Hospital and Clinics. The HIE has further grown to include other specialty clinics, home health agencies and long term care facilities, physical therapy clinics, as well as ancillary laboratory and imaging service providers.

In addition to EMR integration to the HIE, MIN-NS provides added value through complementary services, such as Direct Secure Messaging, Telehealth, Custom



Forms, Analytics and Reporting, as well as secure network services and consulting. The emerging need for Population Health Analytics is driving the next wave of development activity at MIN-NS. Early in the development of MIN-NS we recognized the need for a data warehouse. Applying analytic tools and algorithms to the current clinical data contained in the HIE is essential for proactive care management and coordination.

MIN-NS is the innovative enabler for our participants to achieve the Triple Aim. We apply the technology solutions to make healthcare organization's strategies successful, especially community and rural healthcare organizations.

Strategic Objectives and Key Initiatives:

- Add Telehealth: Integrated secure video conference with HIE Screen-Share to existing HIE infrastructure. Enable Provider to Provider and Provider to Patient Telehealth sessions.
- Enrich Direct Secure Messaging and Provider Directory for subscriber and non-subscriber participants.
- Expand the MIN-NS HIE Network to connect more rural health care providers across 3 counties to state and national HIE systems.

### **Challenges & Innovative Solution:**

MIN-NS services provide greater perceived value to the small, independent stakeholders and less value to the largest participant, Skagit Regional Health. Contributing to the senior management perception of poor ROI to the hospitals is that some benefits are realized at the site where patient care is delivered or where money has been paid to the hospitals directly. Examples of the latter are Meaningful Use reimbursements, USAC reimbursements, avoidance of FAX exchanges, provision of HCA mandated programs and OneHealthPort, better patient coordination, and attribution for the ACN programs for which MIN-NS provided infrastructure and services to the hospitals at MIN-NS expense. Dollars or value of these types of programs do not show up as revenue on the MIN-NS Profit and Loss statement. Consequently, the founding hospitals are not prepared to fund the network on their own and new funding must be obtained. The funding of the Accountable Communities of Health has not proceeded to the point where they are beginning to fund integration projects.

### **Network Continuation**

Value Proposition:

- Clinical records for shared patients
- Care coordination
- Reporting countable transitions of care
- Identity management and analysis
- Attribution analysis
- AFM, Fidalgo, IIM
- EDIE, Syndromic Surveillance, Immunizations, CDRNetwork

Network Revenue Stream: The network achieved significant expansion through the addition of several new members. However, income from these sources has not proved sufficient to achieve sustainability at the current cost levels.

**Project Officer**

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## WASHINGTON (4)

### Washington Rural Health Collaborative

Washington Rural Health Collaborative

#### **Network Description**

Grant Number: DO6RH27795

Organization Type: Member Organization

Full Address: PO Box 1034, 114 W Maple Street, McCleary, Washington 98557

Website: [www.wwrhcc.org](http://www.wwrhcc.org)

Year Formed: 2003

Network Contact:

Holly Greenwood

Executive Director

(360)726-2487

[holly@washingtonruralhealth.org](mailto:holly@washingtonruralhealth.org)

Members:

Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs) and rural clinics owned by member CAHs.

Mission:

Collaborating to stimulate innovation and agile partnerships that improve rural health care quality, efficiency, and sustainability.

Vision:

To be recognized as a significant network of partners in supporting member hospitals in achieving service excellence through collaboration and innovation.

Member Needs:

- Readiness for transition to value (infrastructure and culture)
- Joint contracting and purchasing
- Enhanced ability to collect and analyze data to improve quality
- Training and education (compliance, quality, Medicare Bootcamp)

Governance: The WRHC Board of Directors is made up of the highest-ranking officer of each of the member organizations and the Chief Medical Officer. The Board elects its leadership annually and meets monthly – usually in a face-to-face format with virtual meeting support for those members who cannot attend in person.

#### **Environmental Analysis**

Geographical Area: Rural counties in west, south, central, and northwest Washington State.

Population Need: The Collaborative operates in Washington, a Medicaid-expansion state. The State is an early adopter market for many value-based strategies, including the its announcement of its goal to move 80% of state – financed healthcare into a fully integrated Managed Care System by 2020. With

both CMS and Washington State detailing specific targets for transitioning to value-based payment (VBP) and private payers clearly expressing their intent to accelerate their own transitions, the key drivers of change for our Collaborative and our individual members was the transition to value.

On average, 65.5% of our member's operating revenues are from Medicare and Medicaid. The range is 40.5 to 89.7%. The Collaborative has re-positioned resources to support the challenges for its members to make the changes needed to be successful with value-based contracting.

#### Strengths

- Dedicated and committed staff
- Purchasing power/joint contracting
- Staff education and training
- Sharing of best practices and performance templates
- Creative problem solving
- Committed board and committee members
- Strong financial stability

#### Weaknesses

- Limited staff with competing priorities
- Data analysis and evaluation
- Inconsistent participation by some member hospitals
- Turnover in key hospital positions (CEO, CFO, CNO, QI)
- Shared tools and resources
- Readiness of hospitals to assume value-based contracts

#### Opportunities

- Washington State Innovation Grant
- Partnerships with other collaborative organizations like the Western Healthcare Alliance and Washington Hospital Services
- Expansion of Joint Contracting and Shared Services
- Coordination of services within collaborative setting

#### Threats

- Rising costs and falling reimbursement for hospitals
- Accountable Communities of Health and unclear roles within them
- Insurance market changes happen faster than hospitals can change
- Loss of CAH funding

### **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): HIT/HIE, Quality Improvement, UBC Development, negotiation and management

Background: The Washington Rural Health Collaborative is an existing, mature, and robust network consisting of 13 Critical Access Hospitals (CAH), all separately governed and serving the rural areas of Washington State. The Collaborative enjoys stable and competent leadership, a well-defined mission, and a formalized organizational structure. Most importantly, it has a demonstrated history of delivering value to its members and the rural communities they serve. The Collaborative's strength has always been its ability to unite the member hospitals to achieve much more as a group than the individual members could ever hope to achieve separately.

The Collaborative, formed in 2003, started with eight Critical Access Hospitals located predominately along the Olympic Peninsula in western Washington. At formation, the Collaborative was named the Western Washington Rural Health Care Collaborative. In early 2014, the Collaborative changed its name to the Washington Rural Health Collaborative in recognition of its expanding membership.

The Collaborative's activities support members in improving health care delivery and quality in their own communities by bringing leadership and managers from member hospitals together for support, development, and professional growth. It also promotes efficiencies among its members through benchmarking, grants, contracts, and shared services.

#### Strategic Objectives and Key Initiatives:

- Improve the ability of member hospitals to collect and analyze data to improve quality
- Drive down the cost of care delivered in Collaborative hospitals
- Assure member hospitals are prepared to participate in Value-Based Care
- Key initiatives:
  - Expanded our partnerships and formed a new ACO
  - Initiated a Collaborative-wide Performance Improvement Project to reduce unnecessary hospitalizations and redundant clinical testing by improving transfer communication between hospitals, EDs, and Primary Care Clinics affiliated with the hospitals.
  - Implemented a web-based tool to promote benchmarking of financial and quality measures among hospital members.
  - In 2017, the Collaborative will implement a clinic benchmarking system for those Clinics in the readiness phase for value-based contracting. The system, a companion to the hospital benchmarking system will support comparison of key clinical, financial, and operational measures within the Collaborative as well as across the country.

#### **Challenges & Innovative Solutions**

All four RHND Grant goals were met along with most of their objectives. The objectives partially met were dependent on access to claims data to identify the costs of care and to measure improvement through grant-funded initiatives. The five ACO-member hospitals learned to use feedback based on claims data from

the ACO - all but one are early in the process of analyzing the data for improvement. One hospital through an acquired clinic had access to historical claims data and is modeling its use for workflow re-design and process improvement.

The hospitals that are participating in the readiness cohort for VBC did not receive claims data before the end of the grant. We adapted the QHi benchmark database by adding the value-based contracting (VBC) measures common to the agreements in negotiation to the database to simulate the process of gathering, reporting, and receiving feedback on clinical data.

Provider engagement was a challenge throughout the project. The Physician Leadership Group had an average participation level of 34% in the last year of the grant. The providers in rural clinics are challenged to see their expected patient loads. For the most part these providers are employed by the hospital and have productivity goals tied to their salaries. Time spent in meetings does not contribute to those productivity goals, making it a costly commitment for the provider. However, there are engaged providers who are committed to the success of their clinics and its hospital. We have relied on their participation and the leadership of the WRHC CMO to meet the challenge of provider participation.

### **Network Analysis**

Value Proposition: Joint contracting/purchasing; performance improvement program coordination, infrastructure, and support; training and education (compliance, quality, Medicare Bootcamp)

Network Revenue Stream: Yes. Since its inception, the Collaborative operating expenses have been supported by member dues with specific initiatives supported by grant funds such as FLEX Funding received for a variety of short-term activities such as the Medicare Bootcamp provided in 2015 for all Washington CAHs. Over the next 3 years, the Collaborative will transition from a dues-supported organization to multiple sources of revenue to sustain the organization. The Collaborative is diversifying its revenue streams to include member dues, fees-for-services, as well as grants and donations.

### **Project Officer**

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## Rural Wisconsin Health Cooperative (RWHC)

Rural Wisconsin Health Cooperative (RWHC)

### Network Description

Grant Number: D06RH27788

Organization Type: Not-for-profit Hospitals and CAH

Full Address: 880 Independence Lane PO Box 490 Sauk City, WI 53583

Website: <http://www.rwhc.com/>

Year Formed: 1979

Network Contact:

Louis Wenzlow

Director of IT

(608) 643-2343

[lwenzlow@rwhc.com](mailto:lwenzlow@rwhc.com)

Members:

Not-for-profit Hospitals and CAH

Mission:

The network's mission is to promote and implement Telehealth best practices to provide quality behavioral health services to underserved Wisconsin consumers.

Vision:

Improve patient access and outcomes by expanding behavioral health services to underserved rural areas of Wisconsin.

Member Needs: Information not available.

Governance: RWHC as a whole is governed by a Board of its 40-member hospital CEOs. The RWHC Behavioral Telehealth Program is governed by a committee of the participant hospital representatives. The hospitals on the committee are represented by CEOs, COOs, CNOs, various hospital/clinic department directors, and one behavioral health clinician.

### Environmental Analysis

Geographical Area: Underserved populations of Wisconsin

Population Need: The primary need the project was designed to address was the lack of behavioral health service availability in underserved rural areas of Wisconsin, which is a major problem due to the behavioral health workforce shortage that exists in most of Wisconsin and the nation as a whole.

Blocks:

- Low reimbursement for behavioral health services
- No WI parity laws and not all WI payers reimburse for telehealth

- Behavioral health practitioner shortages limit availability and increase costs
- Complexity of credentialing requirements
- Complexity of behavioral health service provision

Levers:

- High need/demand for behavioral health services
- RWHC's Director of Health Plan Contracts is positioned to help with reimbursement
- Network approach can leverage multi-facility practitioner supply
- RWHC's Credentialing Service will mitigate credentialing block
- Network approach allows for shared learning/protocols to mitigate complexity for new participants

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): Behavioral Health, Integration, HIT/HIE

Background: The Rural Wisconsin Health Cooperative (RWHC) is working to develop a Behavioral Telehealth Network in order to address the behavioral health workforce shortage and provide much needed behavioral health services to underserved populations of Wisconsin. Established in 1979, RWHC is a mature network of thirty-nine Wisconsin rural hospitals that have organized to improve rural Wisconsin healthcare access and outcomes. RWHC serves its members and other rural hospitals with an array of collaborative services intended to reduce the cost and improve the quality of patient care, including clinical quality measure submission, credentialing, patient satisfaction surveys, peer roundtables, leadership and nurse mentoring, and various technology services.

Strategic Objectives and Key Initiatives: To drive improvements in patient access to behavioral health services, facilitate the collaborative development of related Telehealth protocols, improve staff satisfaction, improve patient outcomes, and reduce costs by sharing staff and infrastructure across the network.

## **Challenges & Innovative Solutions**

Lack of availability of behavioral telehealth clinicians, Complexity associated with credentialing of behavioral telehealth practitioners, Challenges associated with behavioral telehealth service reimbursement (WI is not a telehealth parity state), Potential challenges associated with patient, physician, and staff acceptance of telehealth service delivery, Potential challenges associated with telehealth technology implementation, Challenges associated with implementing new workflows relating to both behavioral health and telehealth.



## **Network Continuation**

Value Proposition: Information not available.

Network Revenue Stream: The network is preparing for sustainability beyond the grant period by incorporating a network fee into the behavioral health practitioner fee. Based on current commitments, including by the facilities that have requested to participate in the program's expansion phase, this will generate roughly \$20,000 in revenue toward network expenses for the first post-grant-period year (our 5th Program Year), with revenue increasing as service volume increases. The \$20,000 will not cover all of the network expenses (primarily network staff for ongoing project management and expansion). However, the RWHC Executive Director and Board have prioritized this initiative and will subsidize the program over time, until the above and other potential revenue streams increase. Other anticipated revenue streams include future state and federal grants that are likely to become available to support continued expansion of the program to new facilities and potentially new telehealth modalities.

## **Project Officer**

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## WISCONSIN (2)

### Safetyweb Network

ABC for Rural Health, Inc

#### **Network Description**

Grant Number: D06RH26830

Organization Type: Hospital, Clinic, Public Health Agency and a non-profit, public interest law firm

Full Address: 100 Polk City Plaza, Ste. 180, Balsam Lake, WI 54810

Website: [www.safetyweb.org/](http://www.safetyweb.org/)

Year Formed: 2009

Network Contact:

Mike Rust

Director

715-485-8525

[miker@co.polk.wi.us](mailto:miker@co.polk.wi.us)

Members:

Hospital, Clinic, Public Health Agency and a non-profit, public interest law firm

Mission:

The Safetyweb Network seeks to increase access to and retention of health care coverage and benefits among the uninsured and underinsured residents of Polk County and among Network patients.

Vision:

Through training, technical support and technology innovation, the Safetyweb Network will become a long term, formal, sustainable, integrated and active network that will provide patients in Polk County, Wisconsin with the most precisely optimized current and future health care coverage of any U. S. county.

Member Needs:

- More efficient health benefits screening system
- Readily available expert training & continuing education
- Readily available case consultation services
- Rapid referral of complex cases
- Decision support tools
- Technical support
- Case management tools

Governance: The network is governed by the SafetyWeb Management Committee, which is composed of one executive-level representative from each network member organization.

## **Environmental Analysis**

Geographical Area: Uninsured and underinsured residents of Polk County, Wisconsin

Population Need: This project was prompted by a persistent lack of access to health care coverage and health care benefits among residents of Polk County, Wisconsin, despite the introduction of Health Benefits Counseling in Polk County operations and among the county's three Critical Access Hospitals (CAH). One indicator of the specific problem to be addressed was the rate of Uncompensated Care at local hospitals and the rate of self-pay patients at the Polk County Behavioral Health Department. The three CAH's provided nearly \$8 million in uncompensated care (charity care and bad debt) to over 14,388 individuals in 2012 – altogether about 3.2% of total patient revenue. Additionally, ABC for Rural Health's recent Mental Health Audit Project had revealed that the Polk County Behavioral Health Department payer mix showed that fully 60% of its patients were self-pay; far above what was anticipated. This Network Development project sought to bring new technology solutions and an updated Health Benefits Counseling process to bear on this problem to provide increased access to legal services for patients and increased third party payments for providers. Overall, the project would bring direct legal services into contact with clients much more quickly improve provider workflows through specific technology upgrades

### Blocks:

- Integration of new activities into work flows
- Development and deployment of new technology
- Staff time and resources
- Lack of experience with Case Meetings
- Long history using an old model of Health Benefits Counseling services
- SafetyWeb does not yet have a fully shared vision of a self-sustaining future
- SafetyWeb does not have a formal governing or corporate structure

### Levers:

- Extensive history of collaborative practice
- Decision support tools & Technical support
- Emerging potential for commercialization of MCP
- Accepted use of Video Conferencing
- 501(r) rules
- Inclusion of county HBC programming and Behavioral Health

## **Grant Project Description**

Project Year: 2014-2017

Focus Area(s): HIT/HIE

Background: The Safetyweb Project seeks to increase access to health care coverage and benefits among the uninsured and underinsured population of Polk County, Wisconsin, and surrounding area by developing and formalizing a network of the Health Benefits Counseling programs at three Critical Access Hospitals, the Polk County Health Department, and ABC for Rural Health. The program will field test an electronic patient benefits screener developed by Contractor My Coverage Plan (MCP) and ascertain how best this instrument can be integrated into provider work flows. Additionally, the program seeks to improve the efficiency and reach of provider-based benefits counseling programs through the introduction of formal networking operations, knowledge and practice selfassessments, and training to identify knowledge and practice levels appropriate to MCP integration.

The Safetyweb Network began in 2009 as Chronic Care Plus of Polk County, a “virtual” free clinic designed to respond to community-expressed need to enable health care access for a growing population of chronically ill, uninsured, low income adults; many of whom were being housed in temporary shelters and half-way houses. Network Benefits Counselors met by telephone to distribute applicant patients to the most appropriate CAH for integrated, free primary care and health benefits counseling services.

Strategic Objectives and Key Initiatives: Increase access to and retention of health care coverage among health care treatment seekers and patients among network providers.

### **Challenges & Innovative Solutions**

Technology: The development of the SafetyWeb Network has been tied to the development of our patented electronic patient health coverage screener program into a workable, marketable software program. This would not only serve the interests of the Network partners, but it would also provide an ongoing income. Initially, we worked with software engineering firms, but this contracting approach failed. The software engineers were unable to reach an end user-level understanding of the overlapping and inter-related layers for health care coverage eligibility. We overcame this barrier by hiring a full team of three in-house software programmers. In turn, those programmers were able to train a small team of our attorneys and advocates to produce health care coverage algorithms. This enabled us to maintain a working connection between content and technology. While the development of the “My Coverage Plan” tool remained an unachieved objective during the grant period, we are using the no-cost extension period to bring the tool (now called “Advocus”) to production level. As of this submission, we are presenting demonstrations to health care providers as potential customers. We also developed another technology approach to augment health benefits screening work with Network partners: Video Conference Case Meetings. These case meetings have proven to be an effective tool to bring the full arc of health benefits counseling legal services to patients in a more timely and effective manner. Finally, we have also successfully employed technology for training and continuing education purposes

through the development of “quick-hitter” video case tips and training videos that are accessible through our HealthWatch Wisconsin website.

## **Network Continuation**

### Value Proposition:

- Safetyweb supports the effective integration of advanced health benefits counseling services that reduce medical debt for patients, increase third party revenues, and reduce the need for and incidence of charity care and bad debt.
- Safetyweb provides partners with expert training and continuing education that keeps partner staff up-to-date on changes in health care coverage systems, frees partners from the need to maintain full in-house training knowledge and expertise, and assures that managers and departments can be confident about staff changes and transitions.
- Safetyweb provides partners with rapid access to case consultation, collaboration, and referrals that connect patients almost seamlessly with expert legal support to manage complicated challenges without tying up partner staff time and resources or forcing patients to give up or seek private legal counsel
- Safetyweb assists with coverage issues for patients’ families and for patient coverage needs beyond immediate situations; increasing the value of this service for patients
- Safetyweb provides partners with decision support tools - such as a case database - that improve partner staff’s ability to track individual situations, follow up on and assist as needed with coverage strategies, and facilitate future interactions.
- Safetyweb can provide OMC and other medical centers with 501(r) compliance tools that will satisfy compliance requirements and also improve service consistency
- Safetyweb can provide partners with My Coverage Plan; a patient health benefits coverage screener that will assist in the benefits screening process, improve service consistency, and reduce staff time.
- Safetyweb can provide OMC and other medical centers with professional charity care review that will assure that all third-party sources coverage have been exhausted, save charity care dollars, and reduce bad debt
- Safetyweb can provide Polk Behavioral Health with professional intake benefits review services that will assure timely billing and maximum reliance on private insurance plans as well as Medicaid, and will also guard against public and private violations of mental health parity.
- Safetyweb can provide the Polk County Health Department with expert health benefits counseling services and/or staff transition support that can assure a consistent and expert health benefits counseling service while reducing the need for the county to try to manage transitions and trainings in-house.

Network Revenue Stream: Current plans call for phasing in contracts for service during this No Cost Extension period. These contracts for service with health care providers represent the initial revenue streams that will both sustain the network and help it to expand. Each revenue stream created during the Network Development Grant period represents a variation of health benefits counseling services offered directly, remotely, or via technology:

- Direct Health Benefits Counseling contract placement services with Wisconsin counties and Federal Financial Participation
- Telecommunications: remote HBC services using video conferenced Case Meetings in conjunction with local provider advocate and patient financial services staff Final Narrative Report HRSA Rural Health Network Development Program Grant Number D06RH26830 ABC for Rural Health 4
- Electronic: with the support of the Development Grant, we were able to develop our patented Health Care Coverage Screener, now called Advocus, to the point where we are now providing product demonstrations two – three times each month for prospective customers. These demos include not just an initial patient health coverage screener in conjunction with a dedicated database, but we are also developing client-specific algorithms for hospital 501(r) screenings (charity care) and developing Ability to Pay screeners for state contracted mental health and AODA providers.

**Project Officer**

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