Grantee SOURCEBOOK

Rural Health Network Planning Development Program

2019

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

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Rural Health Network Development Planning Program

Background of the Rural Health Network Development Planning Program

The purpose of the Rural Health Network Development Planning Program (Network Planning Program) is to assist in the development of an integrated health care network for consortia that do not have a history of formal collaboration. Health care networks can be an effective strategy to help smaller rural health care providers and health care service organizations better align resources and strategies, achieve economies of scale and efficiency, and address challenges more effectively as a group than as single providers. This program brings together key parts of a rural health care delivery system, particularly to establish and improve local capacity and coordination of care.

The Network Planning program promotes the planning and development of health care networks to: (i) achieve efficiencies; (ii) expand access to, coordinate, and improve the quality of essential health care services; and (iii) strengthen the rural health care system. The program supports one year of planning with the primary goal of helping networks create a foundation for their infrastructure and focus member efforts to address important regional or local community health needs.

(FY)19 Rural Health Network Development Planning Grantees – Programmatic Focus Areas

Collaboration is a key factor in addressing the challenges and disparities in rural health care planning, delivery, access, and outcomes. Disproportional chronic disease rates, a higher incidence of mental health problems and substance abuse, hospital closures, limited broad band, and health care provider shortages are among the issues facing rural communities. With funding provided by the (FY)19 Network Planning Program, twenty-five grantees in sixteen states addressed these challenges by bringing together a broad range of partners to form rural health networks. Recognizing the importance of leveraging their combined resources, more than eighty percent of these grantees placed a primary (five grantees) or secondary (fifteen grantees) focus on strengthening their network organization/infrastructure development with the intend of formalizing their collaboration by identifying leadership and decision-making structures and establishing policies and procedures.

In addition to the network infrastructure development, Network Planning grantees drew on their combined expertise and resources to focus on a number of health care issues. Eleven of the twenty-five (FY)19 Network Planning grantees worked on plans to improve behavioral health/mental health services through varying approaches. Three of the networks with a primary emphasis on network organizational/infrastructure development focused their programmatic work on behavioral health. Five additional grantees had a primary focus on behavioral health, with three addressing school-based mental health. Another three included substance abuse as another high priority area for the (FY)19 grantees.

Creating efficiencies in the delivery of health care was another important effort for these rural health networks.

- Twelve expended some of their resources on increasing efficiencies and/or the integration of health services.
- Eight explored the feasibility of increasing efficiencies through the use of telehealth, and one other developed a plan for designing a transportation system to address the problem of revenue lost through missed medical appointments.
- Nine more explored methods for coordinating the care of patients with behavioral health issues and/or chronic diseases, one of which examined options for the reimbursement of care coordination services. Another is developed a plan for coordinating palliative care services.

Recognizing the need to expand health care providers in their rural communities, seven grantees consider avenues for workforce development, primarily of behavioral health/mental health professionals but also primary care physicians and nurses and Community Health Workers.

Understanding the complexity of health and the need to promote health, nine of the (FY)19 grantees took a broad approach by looking at population health and taking the social determinants of health into consideration in their planning efforts.

Contents of the (FY)19 Rural Health Network Development Planning Grantee Source Book

In addition to the programmatic focus areas of the Network Planning grantees, this Source Book provides the grantees' description of their efforts to formalize their networks, the programmatic work they have undertaken, and their plans for sustaining their network beyond the Network Planning grant cycle. The geographic areas served by the network, a listing of network partners, and the primary contact person for the network also are provided.

2019 Rural Health Network Development Planning Grantees

Focus Areas

State	Grantee	Network Name	Primary Focus Area	Other Focus Areas
AZ	Arizona Community Health Workers Association, Inc.	Arizona Rural CHW Workforce Development Network	Workforce Development	
AR	1st Choice Healthcare, Inc	Northeast Arkansas Opioid Coalition	Substance Abuse/Addiction - Opioid	
AR	University of Arkansas Winthrop Rockefeller Institute	Rural Health Association of Arkansas	Network Organizational/ Infrastructure Development	• Health Education • Hospital Closure/Alleviating Loss of Services • Increase Health System Efficiencies • Workforce Development
AR	White River Health System	Arkansas Community Health Network	Network Organizational/ Infrastructure Development	• Behavioral Health • Increase Health System Efficiencies • Substance Abuse/Addiction – Other than Opioid • Telehealth
CO	Memorial Regional Hospital	Branches of Hope	Behavioral Health	• Care Coordination • Increase Health System Efficiencies • Network Organizational/ Infrastructure Development • Telehealth
CO	Mountain Family Health Centers	Western Mountain Regional Health Alliance	Population Health/ Social Determinants of Health	• Behavioral Health • Increase Health System Efficiencies • Integrated Health Services • Network Organizational/ Infrastructure Development

State	Grantee	Network Name	Primary Focus Area	Other Focus Areas
CO	Southeast Mental Health Services	Southeast Colorado - Workforce Innovation Network (SECO-WIN)	Behavioral Health	• Integrated Health Services • School Based Health Services • Telehealth • Workforce Development
FL	St. Johns River Rural Health Network	Putnam County Care Connect (PC3)	Increase Health System Efficiencies	• Behavioral Health • Care Coordination • Network Organizational/ Infrastructure Development • Telehealth
GA	Glascock County Board of Education	Tri-County School Health Network	School Based Health Services	• Behavioral Health • Health Education • Increase Health System Efficiencies • Network Organizational/ Infrastructure Development
IL	Arukah Institute of Healing, Inc.	C5-Rural: Collaborative, Complementary, Conventional, & Community-Based Care for Rural Populations	Behavioral Health	• Care Coordination • Integrated Health Services • Mental Illness/Mental Health • Population Health/Social Determinants of Health
IA	Avera Health	Emmet County Behavioral Health Network	Mental Illness/Mental Health	• Behavioral Health • Health Education • School-Based Health Services • Telehealth
KY	Livingston Hospital and Healthcare Services, Inc.	Livingston Crittenden Lyon (CLC) Health Alliance	Behavioral Health	• Telehealth

State	Grantee	Network Name	Primary Focus Area	Other Focus Areas
MI	Central Michigan District Health Department	Central Michigan Regional Rural Health Network	Integrated Health Services	• Behavioral Health • Network Organizational/ Infrastructure Development • Population Health/Social Determinants of Health • Workforce Development
MI	Huron County	Thumb Community Health Partnership	Increase Health System Efficiencies	• Care Coordination • Integrated Health Service • Network Organizational/ Infrastructure Development • Population Health/ Social Determinants of Health
MO	Taney County	Ozarks Wellness Network (OWN it)	Population Health/ Social Determinants of Health	• Network Organizational/ Infrastructure Development
MO	West Central Missouri Community Action Agency	Health & Wellness Network	Transportation	• Increase Health System Efficiencies • Network Organizational/ Infrastructure Development • Population Health/ Social Determinants of Health
NE	South Heartland District Health Department	Rural Behavioral Health Network	Behavioral Health	• Network Organizational/ Infrastructure Development • Workforce Development

State	Grantee	Network Name	Primary Focus Area	Other Focus Areas
NY	Council on Addiction Recovery Services, Inc. (CAReS)	Appalachia Recovery Network	Network Organizational/ Infrastructure Development	• Behavioral Health • Mental Illness/Mental Health Services • Substance Abuse/Addiction – Opioid • Substance Abuse/Addiction – Other than Opioid
NC	Granville-Vance District Health Department	Integrated Care Planning Network (ICPN)	Integrated Health Services	• Behavioral Health • Network Organizational/ Infrastructure Development • Telehealth
OH	Hopewell Health Centers	Partnership to Achieve Compliance and Savings (PACS)	Reimbursement for Health Services	• Care Coordination • Chronic Disease Management – Diabetes & Other • Population Health/ Social Determinants of Health
OK	Rural Health Network of Oklahoma	Oklahoma Primary Healthcare Extension System (OPHES)	Network Organizational/ Infrastructure Development	• Behavioral Health • Integrated Health Services • Workforce Development
SD	Coteau des Prairies Hospital	Sisseton Area Health Network (SAHN)	Care Coordination	• Network Organizational/ Infrastructure Development • Population Health/Social Determinants of Health • Substance Abuse/Addiction – Opioid & Other

State	Grantee	Network Name	Primary Focus Area	Other Focus Areas
WA	Adams County Public Hospital District No.2	Grand Columbia Health Alliance	Increase Health System Efficiencies	• Care Coordination • Chronic Disease Management – Other than Diabetes • Population Health/ Social Determinants of Health • Workforce Development
WA	Columbia County	Southeast Washington Health Partnership	Network Organizational/ Infrastructure Development	• Care Coordination • Telehealth
WA	Family Health Centers	Okanogan Palliative Care Initiative	Palliative Care	• Care Coordination • Chronic Disease Management – Other than Diabetes • Integrated Health Services • Network Organizational/ Infrastructure Development

Arizona

Arizona Community Health Workers Association, Inc
Arizona Rural CHW Workforce Development Network

P10RH33036

Project Focus Areas: Workforce Development

Network Statement

While many Americans have access to quality health care, others face barriers, such as a lack of insurance or inability to afford the health care that they need. Arizona consistently ranks at the bottom when it comes to the provision of health care services in rural areas and the health and wellness of its rural residents. We believe that by establishing a strong Community Health Worker (CHW) workforce, we can help support Arizona in addressing access to and quality of care for some of our most vulnerable citizens, the rural poor. For this reason, we created the Rural Arizona CHW Workforce Development Network in 2018. Members currently represent health centers, tribal health departments, county health departments, and nonprofit organizations and academic institutions from all four corners of our state.

We need your help, however. If you want to understand the important role that CHWs play in supporting the health of individuals and communities, and how CHWs can be utilized within your organization, contact us. Your voice matters. Help us build a model that supports the capacity and practice of CHWs in rural Arizona. Together, we can assure that all Arizonans receive the health care services they need.

Network Development

The purpose of The Arizona Rural CHW Workforce Development Network is to assess needs, address gaps, and increase the effectiveness of CHWs. CHW services in care coordination and integration of primary care and behavioral health care are critical to health care transformation and value-based reimbursement in rural Arizona. Network members have been working in identifying needs and gaps that we have as a network. We have worked together to develop a network statement, an organizational assessment, and an external environmental scan. Through this process we have been able to identify areas where we can work together to improve as a network. We have come to understand where we see each other in our roles in the network and also have also learned that some members are at different levels of involvement in the network. However, this was a perfect time for us to reflect and share with our network members the feedback we received and plan on how we will continue strengthening our involvement in the development of our network.

Programmatic Development

Together as a network we developed a concept and strategies to enhance and strengthen the CHW workforce in Arizona. During our network activities, our state was impacted by COVID-19, thus making our network realize that we needed to respond to the new needs that we were identifying in our communities. The Project Director and Network Director began to work on a strategy to address the overwhelming need for behavioral health support among the CHW workforce. We adapted our vision and made significant changes in order to continue services and support for the CHW/CHR/Promotoras workforce in Arizona communities. A Mental Health Webinar series in English and Spanish was developed and directed toward the CHW workforce to support, train, and prepare them for workforce re-entry and ensure that they were physically and mentally strong.

AzCHOW (Arizona CHW Association) staff, in collaboration with the Arizona Rural CHW Workforce Development Network members, are now playing a leading role in addressing the mental health impact that COVID-19 brought to our communities. We are also reaching out to other organizations to support the continuing need for these mental health webinars that have reached CHWs/CHRs/Promotores. In addition to the weekly mental health webinars, we have reached out to program clients, identifying needs/challenges, and connecting them to appropriate resources.

Sustainability

Network continuation beyond the planning grant is about more than just funding. Network members must have a sense of ownership and commitment to continue to work together to disseminate and apply the training compendium development, as well as to promote sponsorship for needed CHW training around the state. Support will be needed from Arizona Department of Health Services, from local community colleges that support CHW training curricula, and from the clinics, hospitals and community-based organizations that employ and train CHWs. Support from health pans and insurers will be sought. We have applied for funding through the Rural Health Network Development grant, and we are also seeking funding from Arizona private health foundations that are investing in rural health, such as the Legacy Foundation, the Vitalyst Foundation and local community foundations.

Region Covered by Network Services

County/State	County/State
Apache County, AZ	Pima County, AZ
Coconino County, AZ	Santa Cruz County, AZ
Cochise County, AZ	Yuma County, AZ
Mohave County, AZ	Maricopa County, AZ
Navajo County, AZ	

Network Partners

Organization	Location	Organization Type
Arizona Community Health Workers Association	Douglas, AZ	Non-Profit
Chiricahua Community Health Centers, Inc.	Douglas, AZ	Federally Qualified Health Center (FQHC)
North County Health Care	Flagstaff, AZ	Federally Qualified Health Center (FQHC)
Cochise Health and Social Services	Bisbee, AZ	Public Health
Yuma County Health Department	Yuma, AZ	Public Health
Navajo Nation Department of Health	Kayenta, AZ	Tribal Nation
Hualapai Health-Education and Wellness	Peach Springs, AZ	Tribal Nation
Southeast Arizona Area Health Education Center	Nogales, AZ	Area Health Education Center
Campesinos Sin Fronteras	Somerton, AZ	Non-Profit
University of Arizona Prevention Research Center	Tucson, AZ	College/University
Arizona Department of Health Services	Phoenix, AZ	Public Health
Northern Arizona University	Flagstaff, AZ	College University
Arizona Complete Health	Tucson, AZ	Health Plan

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Project Focus Areas: Substance Abuse/Addition-Opioid

Network Statement

The opioid crisis has reached national epidemic proportions and is responsible of over one hundred deaths every single day. Rural areas like Northeast Arkansas are not immune to this epidemic. High opioid prescribing rates and lack of access to substance abuse treatment make Northeast Arkansas counties some of the most at-risk communities. Our counties are faced with the growing problem of abuse, addiction, and overdose of legal prescription pain medication, as well as illegal opioid drugs such as heroin and fentanyl. As with most communities across the United States, Northeast Arkansas has not embraced an integrated, coordinated strategy to address the opioid crisis.

With the vision of collaboratively addressing this issue, four key providers joined forces to increase access and treatment for residents in Lawrence, Sharp, Clay, Greene, Randolph, and Fulton counties. These four Founding Members have since added over 60 additional individuals as Advisory Members. Collectively, they have formed the Northeast Arkansas Opioid Coalition (NAOC) to spearhead regional prevention, recovery, and treatment efforts to effectively reduce the impact of the opioid epidemic on our most vulnerable citizens. Through the combined efforts of all these organizations, communities, and individuals, the Northeast Arkansas Opioid Coalition can ultimately reverse the course of the opioid epidemic and achieve an improved quality of life for all our citizens.

Network Development

Members of Northeast Arkansas Opioid Coalition (NAOC) include 1st Choice Healthcare, Inc., Mid-South Health Systems, Piggott Community Hospital, and Arkansas Methodist Medical Center. The network's mission is to collaboratively evaluate and address the opioid epidemic in Northeast Arkansas. This mission builds a foundation for NAOC's vision of facilitating the creation of comprehensive prevention, treatment, and recovery services for OUD/SUD in our region. To formalize the network, NAOC developed governing rules that define the membership process for both Founding and Advisory members and gives equal representation to the four Founding Members. NAOC also saw value in having a diverse group of network members throughout the counties served. The network was broadened with a wide array of Advisory Members to include medical clinics, the recovery community, social service organizations, mental health centers, law enforcement, judges, public health, and faith-based entities. Each Advisory Member signed a membership application committing to the network and including an agreement to the coalition's Governing Rules. Additionally, during this planning cycle, Founding Members adopted a Vision and Mission statement that not only builds a foundation for the network but also describes NAOC's role in our 6-county region. Finally, NAOC's Founding Members developed three core values that set the stage for collaboration among diverse entities. NAOC has grown to over 60 organizational and individual members committed to addressing the opioid epidemic in our region.

Network development for NAOC has faced several challenges during the planning cycle. These challenges include varying needs of the wide geographical area we serve and coordination of schedules among members. NAOC serves a large 6-county rural region that covers 3,700 square miles. Each county's need for Opioid Use Disorder/Substance Use Disorder (OUD/SUD) services vary. To better understand the diverse needs required "boots on the ground" and communication with those affected by the opioid epidemic. To help address this issue, NAOC hosted community

meetings in each county it serves. The first meetings were successful as shown by a diverse group of organizations and individuals committing to the network. In April 2020, the network had plans for the second round of community meetings to help further promote the mission and vision of NAOC. These meetings are now on hold due to COVID-19. Moving forward we plan to hold additional community meetings in each county served, and the network director will facilitate communication flow for advisory members in each county to help assure network sustainability. All four of NAOC's Founding Members are chief officers in their respective entities, so balancing time for the network is challenging. All four Founding Members attended quarterly board meetings and participated in network development activities over the past year. Other needs of the network have required communication through email, telephone calls, and other platforms such as Zoom. To better facilitate collaboration, the Founding Members have designated key staff who are more accessible and actively participate in the network as well.

NAOC innovations include actively participating in other community coalitions in our region. Collaborating and networking with similar groups helps bring attention to our mission and sets the stage for future partnership. Currently, our network director participates in three other coalitions that focus on prevention of OUD/SUD. Networking with those agencies that can provide up to date data related to SUD/OUD will also help add value to the network. During the past year NAOC received support from the Arkansas Department of Health, Arkansas Drug Director's office, and community action agencies with data related to OUD/SUD in our region.

Programmatic Development

NAOC is an emerging network that is still in the planning phase. Our efforts this past year have set the stage for an effective strategic plan to address collaboratively OUD/SUD in our 6-county region. After formalizing the structure of the network and broadening our membership, our next step focused on gathering data of existing opioid resources in the region. A survey was created and sent to all members of the network. This tool was used to show services offered related to education, prevention, treatment, and recovery for opioid use/misuse. In addition, the network director and a key staff member compiled information from credible sources to complete the inventory. Following the completion of the service inventory, a gap analysis was performed to find any shortfalls of services in our region. As a result of these activities, data showed that in each county there were one or more gaps in services in relation to prevention, treatment, and recovery. This gap analysis was used as a foundational element to set the stage for our strategic plan. The information was then brought to the Founding Members to discuss what treatment strategies we could do as a network. Founding Members are now in the last stages of developing a strategic plan. This data also supported our process in building a website for the community. Our site www.naocolition.com is used as a clearinghouse for information about opioid issues and resources affecting the 6-county coalition and the various communities we serve.

As NAOC moves closer to network implementation there are many initiatives being discussed on how to address the opioid epidemic in our region. Programmatic development will need support from both in-kind resources and external funding. Utilizing internal resources, the network envisions implementing and supporting regional prevention services by partnering with community action agencies to help build anti-drug youth coalitions and taking part in community events that improve health literacy and reduce the stigma of OUD/SUD. Other prevention initiatives include supporting take-back programs in the state that promote the safe disposal of medications. Treatment initiatives include increasing the number of professionals trained to screen for OUD/SUD and improving access to care for those that need services. NAOC plans to develop regional referral agreements that help streamline transfers for OUD/SUD treatment and for alternative treatments such as pain management. NAOC is also seeking local, state, and federal funding to support recovery initiatives that include implementing a Peer Recovery Support Specialist program. This program is designed to help those suffering from SUD/OUD navigate to the proper services. To further improve access to recovery, NAOC plans to integrate telehealth services through our Peer Recovery Support Specialist for those individuals presenting to our clinics and hospitals needing immediate attention. NAOC Founding Members have a robust history of collaboration and all are committed to addressing OUD/SUD in the communities they serve. As NAOC nears the completion and formalization of our strategic plan, there has been some hesitancy in embarking on new endeavors in SUD/OUD prevention, treatment, and recovery services.

Currently, three of the four Founding Members offer little to no direct OUD/SUD services. To help overcome this programmatic challenge, core concepts of the Sustainable Network Model to include adding value and leveraging have been utilized. This has helped improve the cohesiveness of the network by demonstrating that learning from each other and taking chances can add value to the network. Currently there are talks to obtain Peer Recovery Support Specialists to aid in navigating care for OUD/SUD patients who present to our respective entities.

Sustainability

Collectively, all Founding Members have voiced commitment to continue network efforts past the planning year. One key strength that solidifies the structure of NAOC is that the four Founding Members have had a long and productive relationship and have collaborated in some capacity for years. The network is fortunate to have resources within their respective agencies and can offer many of the services projected within our strategic plan, although the level of services we provide will depend on external funding. To maximize the use of in-kind resources, there will be great value in utilizing the Sustainable Network Model for future endeavors. NAOC will stay vigilant to the community's need and pursue any federal, state, or foundation grant funds that align with the coalition's mission, vision, and core values. NAOC is actively seeking funding through HRSA for the Rural Communities Opioid Response Program-Implementation (RCORP-Implementation) (HRSA-20-031). Finally, NAOC will continue to cultivate existing relationships with its Advisory Members and continue to grow our membership with those individuals sharing the same priorities of addressing the opioid epidemic in our region.

Region Covered by Network Services

County/State	County/State
Clay County, AR	Lawrence County, AR
Fulton County, AR	Randolph County, AR
Greene County, AR	Sharp County, AR

Network Partners

Organization	Location	Organization Type
1st Choice Healthcare, Inc.	Corning, AR	Federally Qualified Health Center (FQHC)
Mid-South Health Systems	Jonesboro, AR	Behavioral Health
Arkansas Methodist Medical Center	Paragould, AR	Hospital
Piggott Community Hospital	Piggott, AR	Critical Access Hospital (CAH)

Grantee Contact Information

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Arkansas

University of Arkansas Winthrop Rockefeller Institute
Rural Health Association of Arkansas

P10RH33056

Project Focus Areas: Network Organization/Infrastructure Development

Other Focus Areas: Health Education
Hospital Closure/Alleviating Loss of Services
Increase Health System Efficiencies
Workforce Development

Network Statement

The health of Arkansans should not be determined by where they live. Unfortunately, more than 1.1 million of our citizens are at greater risk simply because they live in smaller communities that are remote from larger population centers. People living in rural communities tend to have less access to high quality, affordable health care services. Barriers include lack of transportation, income, insurance, or availability of local providers or facilities. Rural residents tend to be older, poorer, and suffer from a broader range of health disparities, compared with city-dwellers. Rural health stakeholders comprise many groups and interests, including hospitals, clinics, multi-disciplinary providers, educational & workforce institutions, business & industry, transportation, governmental leaders, funders, insurers, safety-net programs, and a diverse range of consumers, to name a few.

The purpose of the Rural Health Association of Arkansas (RHAA) is to create a neutral, coordinating, and unifying entity and voice of advocacy for improved health and health care access for ALL rural Arkansans. Our goal is not to replace or duplicate any existing programs or initiatives, but to support and complement all related efforts. We hope to be an effective network of bridge builders, with an accessible and functional infrastructure, to provide a venue for the broadest range of rural health advocates to voice and navigate concerns, to help consolidate and amplify their messages, and to pursue mutually beneficial solutions. We seek to inspire healthier rural communities across Arkansas, through communication, collaboration, education, advocacy and improved access to information, resources, best practices, and policies. What began years ago as a small informal network of like-minded rural advocates has now expanded to a broad-based statewide coalition that is ready to launch a formal association through which ALL rural health stakeholders, from every corner of Arkansas, can have a seat at the table. We will serve as a rallying point for those efforts to coalesce into a united voice promoting and building a more accessible and equitable system of health care for our neighbors who happen to live in the more rural areas of our beautiful state. We are excited to link arms with other interested parties to create a healthier future for all Arkansans.

Network Development

The strength and progress of our network lies in our core leadership group. As the Founding Board and Advisory Committee, they have established strong working relationships and the ability to work as a team that will serve the new RHAA organization well. The trust and respect this core group have built for one another and their shared commitments and clarity of value around the network itself has created a strong foundation from which to work. If that “heart” and mindset can be modeled for new members and reflected in the activities and programs that are developed as the network grows and moves forward, then the network will be a strong and productive one. We hope to become an effective network of bridge builders, with an accessible and functional infrastructure, to provide a venue for the broadest range of rural health advocates to voice and navigate concerns, to help consolidate and amplify their messages, and to pursue mutually beneficial solutions. We seek to inspire healthier rural communities

across Arkansas through communication, collaboration, education, advocacy and improved access to information, resources, best practices, and policies.

The most significant challenge we have faced is the COVID-19 pandemic, which has shut down and overshadowed all other plans. However, we continue to hold virtual meetings as needed to continue forward progress. Other top challenges, as we see them, will be effective recruitment and engagement of new members and diversification of funding sources to ensure long-term sustainability. Up until now, our network has been supported largely by grants and in-kind or volunteer contributions. A major goal for this next year is to develop a robust financial plan and begin seeking diverse financial support, including grants, sponsorships, and minimal membership dues.

Although not an extreme innovation, one thing that has helped propel our movement forward, outside of the passion of our core leadership group, has been third-party facilitation and consultancy. Especially in our informal building stages, it was beneficial to have meetings at a neutral space, with no perception of competition. Having facilitators from outside the medical field lead structured discussions allowed a short cut to openness and honesty within the network, building on the shared passion for improving health outcomes of rural Arkansans. Working with non-industry facilitators and outside experts also helps our network leaders develop and hold each other accountable to deadlines and progress goals.

Programmatic Development

Progress made to date in our programmatic development effort is first reflected in successfully developing and establishing the new Rural Health Association of Arkansas (RHAA and securing official 501c3 Non-profit status for our new organization. Officers were elected and the founding board members named. Our first programmatic project for the newly founded RHAA was the creation and launching of our new website, including the posting of a list of state and national rural health resources that might be useful to current and future network members, including COVID-19 resources, see www.RHAArkansas.org

Again, our biggest challenge has been the Coronavirus pandemic. However, our founding board and officers and workgroups continue to meet, plan, strategize and move forward with plans for marketing, membership recruitment, staffing, communications, and standard operations like mailing and banking. Once we are able to get an operational infrastructure in place, then we can more effectively move forward with program development.

Mirroring some of the benefits of having non-industry partners helping to organize the network itself, having a neutral meeting space and discussion leaders for large network meetings has given our core leadership a large amount of data and information. While putting that data to use has been on hold for the reasons above, having a large list of issues supplied directly from our network members will be a strong place from which to develop future programming.

Sustainability

Adequately developing resources, such as diversified funding streams and dedicated staff, will be necessary to establish and sustain network activities, and this will require planning. It is most important now for our network to recognize what is currently possible, identify what we would like to be possible, and then put steps in place to bridge the gap between the two. There is a very positive drive to do as much as possible for our members to help improve the rural health landscape in Arkansas.

A no-cost extension from this HRSA grant, combined with a second Blue & You grant, will provide us with funding for the next year to support a contract extension for our consultant, Ryan Kelly, who will serve as an interim administrator to help our new RHAA become solidly established. During the coming year, we will finalize and implement a strategic plan to address infrastructure, outreach, recruitment, membership engagement, organizational management, policies and procedures, workgroup and board meeting structure, decision-making processes, internal and external communications, business plan and long-term sustainability.

Region Covered by Network Services

County/State
RHAA will serve all 75 counties in the State of Arkansas

Network Partners

Organization	Location	Organization Type
UofA Winthrop Rockefeller Institute (WRI)	Morrilton, AR	Community Development Organization
AR Care	Augusta, AR (NE Arkansas)	Federally Qualified Health Center (FQHC)
AR College of Osteopathic Medicine (ARCOM)	Fort Smith, AR	College/University
AR Rural Health Partnership (ARHP)	Lake Village, AR (SE Arkansas)	Critical Access Hospital (CAH)
UofA for Medical Sciences (UAMS) Regional Programs	Little Rock, AR (Statewide)	Area Health Education Center
Community Health Centers of AR (CHCA)	Little Rock, AR (Statewide)	Federally Qualified Health Center (FQHC)
AR Office of Rural Health & Primary Care	Little Rock, AR (Statewide)	Government
AR Foundation for Medical Care (AFMC)	Little Rock, AR (Statewide)	Medicaid Managed Care Organization
UofA for Medical Sciences (UAMS) Institute for Digital Health and Innovation	Little Rock, AR (Statewide)	College/University
Arkansas Center for Health Improvement (ACHI)	Little Rock, AR (Statewide)	Public Health

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Arkansas

White River Health System

Arkansas Community Health Network

P10RH33058

Project Focus Areas: Network Organization/Infrastructure Development

Other Focus Areas: Behavioral Health
Increase Health System Efficiencies
Substance Abuse/Addiction-Other than Opioid
Telehealth

Network Statement

"Rural" is often utilized as a deceptively simple term for a remarkably vast collection of places. In fact rural life is becoming more diverse and its challenges more complicated. As health care rapidly transforms, rural life is becoming more vulnerable to the availability of critical services like health care and emergency services.

With over 1-in-3 Arkansans living in rural areas, the health status of the State is intertwined with the health care needs of its rural communities. Enter Arkansas Community Health Network ("ACHN"). Formed by Baxter Regional Medical Center, North Arkansas Medical Center, Unity Health and White County Health System, ACHN was created to lead care, strengthen rural communities, and embrace the health challenges facing the approximately 375,000 people living across the 17 north central counties served by these four health systems. While each system is organized and governed independently, the group shares a similar vision and purpose.

Although ACHN is newly formed, its members have a rich history and deep commitment to serving rural communities. By working together and supporting each other, the network of hospitals is working to enhance access and availability to physicians and essential services, improve the delivery and coordination of care, and address the health needs and outcomes of its rural residents. We also intend to focus on the unique and growing behavioral health needs throughout the region. Relying on trusted relationships, shared knowledge and experiences, and a common desire to create value, we strive to lead, strengthen, and embrace rural life.

Leading Care | Strengthening Communities | Embracing Challenges

Network Development

Arkansas Community Health Network, LLC ("ACHN") is a consortium composed of four independent health systems in north central Arkansas. The Network has been organized as a limited liability company (LLC) and is governed by a formalized and executed operating agreement, which articulates the role and responsibilities of the Network and its members. In addition to Arkansas Community Health Network, a sister organization known as Arkansas Community Hospital Network – Shared Services Organization, LLC was also formed and is operational. The Network has a stated purpose, defined governance structure, set of operating principles, and defined service area.

Trusted relationships amongst system leaders, shared industry knowledge and experience, common rural service area needs and challenges, and similar organizational and governance structures are a few of the factors that contributed greatly to the successful development of this partnership. However, lack of resources, some competitive forces between the members, and early priority setting were challenges. These were minimized and managed by ensuring equal ownership, governing, input, and responsibility. Frequent and consistent

communication and regular face-to-face meetings were invaluable. Plus, the members engaged a known, trusted, and neutral third party to help establish and implement the Network.

While not necessarily innovative, gaining a thorough understanding of the challenges, opportunities, capabilities, and risk tolerances of the Network members (individually and as a group) helped to inform programming and create "early" value. Early success (albeit small and targeted) built confidence and momentum for future success and greater collaboration and risk tolerance.

Programmatic Development

ACHN's purpose includes: improving efficiencies; enhancing access, delivery, coordination, and transition of care; and, accommodating innovative and alternative programs. Specifically, ACHN engaged in several initiatives and programs including (i) ownership in an Arkansas provider-led entity for behavioral health and developmentally disabled Medicaid beneficiaries, (ii) response to the opioid epidemic, and (iii) certain efficiency efforts. In addition, ACHN organized and facilitated the identification and sharing of third-party expertise, education, and information amongst Network members in the areas of behavioral health, telehealth, population health, cost management, and funding opportunities/alternatives.

Interestingly, vision, purpose, and commitment were not challenging. Limited resources (such as robust time/human, data/information, and technical expertise) proved to be program developmental obstacles. These were overcome by identifying what was needed, when, and by whom. Trusted advisors were engaged to gather and provide meaningful, easily understandable, and actionable information. The Network learned where/when to focus "broadly" and where/when to execute with precision and tactically. Both minimized challenges.

From an innovation perspective, ACHN studied and learned from other successful organizations, but did not feel compelled to be limited by/to any set frameworks or formulas. Two unique organizations were created, which fit the members' and region's unique characteristics and needs. While some success stories can be studied, learned, and replicated, we found it important to remain flexible, creative, and open to unchartered approaches. An example of this is ACHN's investment and involvement in Arkansas' provider-led shared savings entities.

Sustainability

ACHN will continue to exist and function beyond the Network planning grant period. From the onset, ACHN has been primarily funded by member contributions. While the Rural Health Network Development Planning grant was an invaluable addition, member commitment and financial support has been critical. Creating "early" value for Network members helped to strengthen commitment and the likelihood of future and ongoing member funding. Not only was value created through focused initiatives and programming, it was documented and communicated on a regular basis. For both budgeting and periodic operational/financial reporting purposes, a quantifiable and qualifiable "value" document was formally reported to all Network members.

ACHN will continue to function and be sustained by (1) revenue generating programs and services, (2) financial return on certain investments, (3) non-governmental, private funding sources, (4) cost sharing/savings initiatives, and (5) continued, albeit potentially lessened, member funding. During this grant period and as part of the strategic planning process, ACHN identified a private funding opportunity through an existing third-party relationship. ACHN is seeking funding both separately and in conjunction with another (partnering) organization. Such funding will specifically address access to primary care and behavioral health, substance abuse, and telehealth services.

Region Covered by Network Services

County/State	County/State
Baxter, AR	Boone, AR
Carroll, AR	Cleburne, AR
Fulton, AR	Independence, AR
Izard, AR	Jackson, AR
Lawrence, AR	Marion, AR
Newton, AR	Prairie, AR
Searcy, AR	Sharp, AR
Stone, AR	White, AR
Woodruff, AR	

Network Partners

Organization	Location	Organization Type
Baxter Regional Health System, including Baxter Regional Medical Center	Mountain Home, AR	Healthcare System
North Arkansas Medical System, including North Arkansas Regional Medical Center	Harrison, AR	Healthcare System
Unity Health, including White County Medical Center & Harris Medical Center	Searcy, AR Newport, AR	Healthcare System
White River Health System, including White River Medical Center & Stone County Medical Center	Batesville, AR Mountain View, AR	Healthcare System

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Colorado

Memorial Regional Health
Branches of Hope

P10RH33049

Project Focus Areas: Behavioral Health

Other Focus Arears: Care Coordination
Increase Health System Efficiencies
Network Organization/Infrastructure Development
Telehealth

Network Statement

The overall health of our rural community is an indicator of Moffat County's well-being as a whole. Unfortunately, the well-being of our community is currently unstable. The populations of concern include community members struggling with substance abuse issues, chronic mental illnesses, and/or complex medical conditions. In the past year, Moffat County residents have faced the following stressors: a high rate of mental health issues, leading to the highest number of completed suicides in more than 20 years; an increase in drug and alcohol abuse, including the recent legalization of recreational marijuana facilities in our city limits; and an increase in complex chronic illnesses due to the high cost of healthcare services and residents' tendency to avoid preventative care. These three populations can represent commingled challenges for individuals, with residents often struggling with components of all three. Not only do these barriers affect individuals, but the negative impacts also radiate through these individuals' friends, families, and community members. To compound these problems, local coal mines and power plants have also recently announced timetables for the impending closures of these facilities, all of which provide jobs with high starting wages and benefits including high quality health care for many residents. As such, Moffat County is in a time of great flux.

Branches of Hope came together in 2019 to support people in need across local communities. Our goal is to meet people where they are, on their turf, where they are most comfortable, employing peer support specialists as an ever-present resource. Once our peers connect with an individual, they begin to work what our network partners have lovingly dubbed as their "magic." Ultimately, the peers connect with the individual/community in a nonjudgmental way, using shared experiences to show individuals how they can overcome their challenges, heal, and survive on the other side of their struggle. The momentum of this concept has taken off, and our peers are currently improving the lives of Moffat County residents with substance abuse issues, chronic mental illnesses, and/or complex medical conditions every day.

Network Development

Over the course of the past nine (9) months we have united six (6) incredible organizations, coming together and committing to help our community with struggles around mental health, substance abuse and complex chronic illnesses. The commitment was formalized November 20, 2019, when everyone signed an MOU to continue to work together to help our community. Weekly meetings continue to solidify partnership and decisions to enhance the success of the program.

Through the incredible support from this team, we have been able to overcome several challenges as we worked collaboratively to navigate the best process for our group. One core example of the growth of shared learning and adaptation as a network relates to our core strategy, Peer Support Specialists. We have struggled for the past seven

months to find a second Peer Support Specialist. During this time, we were truly able to develop a better, more systematic approach to a screening and interview process that landed us an incredibly dynamic Peer Support Specialist team. As a team, we have also developed a more robust documentation system that allows us to capture precious data providing the ability to determine if the work the Peer Support Specialist complete is measurable and valuable to the individuals they work with.

At one time or another, each and every partner in our team has stepped up and utilized their strengths to help develop and design more efficient processes as and for the network. The screening and interviewing of the Peer Support Specialist is a critical component to the work this team had done and serves as evidence of the maturation of the network.

Programmatic Development

By following the Recovery-Oriented System of Care (ROSOC) evidence-based model, the Peer Support Specialists have become an integrated part of our local Emergency Department and Medical Surgical Unit. We have had the opportunity to utilize the Peers to de-escalate clients in the ED and comfort and provide support to lonely clients on the Medical Surgical Unit, which has evolved with continued care coordination after discharge from the hospital. The Peers have also been integrated into the workflow of MindSprings Health and Providence Recovery Services working with clients and assisting in sustaining strength to their new way of living. The Peers have also provided support to individuals that are in the court system. The Peers have also provided training to community groups around Mental Health and Suicide. Recently, we started utilizing virtual resources to connect with clients during the COVID-19 stay-at-home mandates. The virtual resources have allowed the Peer Support Specialist to stay connected with their clients and visually see how they are doing as well as continue important communication and support during this stressful and often lonely time. As a team, we also utilized the strengths of our team to develop a more robust and easy charting system for the Peer Support Specialists. This charting now provides a much better snapshot of how the individual and peer interact as well as if progress were made during the interaction. Now that we have a more robust charting system, we are finding that our Peer Support Specialists do not take as much credit for the amazing work that they accomplish. Our task now is to teach them clinical charting skills to document all of their work.

Peer Support Specialist support and development has been an incredibly valuable aspect of the development of the program. Our partner MindSpring Health, Peggy Sammons, has met with the Peer Support Specialists weekly to review the interactions they have had, the struggles they have encountered and personal challenges that may have been disrupted during their interactions. Peggy has had the opportunity to help or Peer Support Specialists maintain personal strength and help them to grow individually more than we could have ever imagined. This has been an incredibly valuable and important aspect to the successful work the Peer Support Specialists have been able to accomplish. We have also started to provide adaptive trainings for QPR (Question, Persuade, Refer) and ASIST (Applied Suicide Intervention Skills Training) in the community. These trainings are being provided on a virtual platform so that the clients and community can remain at home in a safe environment away from the exposure of COVID-19.

The biggest challenge that our team overcame was the hiring of the second Peer Support Specialist. We had hired a total of 3 other Peer Support Specialists that for one reason or another were not far enough into their own personal healing that they were able to complete the Peer Support Specialist Training. This struggle allowed us to enhance our interviewing and screening process to find the perfect Peer Support Specialist. We now have an incredibly dynamic team of Peer Support Specialists with complementary strengths and weaknesses. COVID-19 has created several challenges that were unpredictable when we started this grant process. Our team has been amazing at overcoming these challenges and working through Zoom to maintain our weekly meetings and continue the momentum. Our Peer Support Specialists have been working with the client first through phone calls but have had increased success with different web based virtual tools. They feel that they are able to obtain a much better assessment when they are able to see the client and they do not feel like so much of the human element has been lost. We have been incredibly excited about the adaptability of our team and community to this challenge.

Sustainability

Since our grant was awarded during the summer of 2019, we have been able to formalize our partners and staffing. We are currently working on a sustaining model that will allow the Peer Support Specialists the freedom to work with fewer constraints than what many current models follow. We would like for our Peer Support Specialists to set goals on how many clients they see but also provide the ability to continue to work out in the community developing relationships and working with clients that wouldn't necessarily seek help when needed. We have looked into the AmeriCorps program to help sustain the workforce and may pursue a grant in the winter of 2021. Currently, MindSprings Health and Providence Recovery Services, two of our partners, are contracted with Rocky Mountain Health Plans and are working on a sustainability model to bill for the Peer Support Specialists' services.

Our goal is to sustain all elements of our initial services and programs. We have applied for a no-cost extension of this Planning grant. If granted, this will allow us to continue to work on our network for several more months as we secure a sustainability model and platform allowing us to bill for Peer Support Specialists services.

Region Covered by Network Services

County/State
Moffat County / CO

Network Partners

Organization	Location	Organization Type
Memorial Regional Health	Craig, CO	Hospital
MindSprings Health	Craig, CO	Behavioral Health
Moffat County Sheriff	Craig, CO	Law Enforcement
Craig Police Department	Craig, CO	Law Enforcement
Open Heart Advocates	Craig, CO	Other
Providence Recovery Services	Craig, CO	Behavioral Health

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Colorado

Mountain Family Health Centers
Western Mountain Regional Health Alliance

P10RH33050

Project Focus Areas: Population Health/Social Determinants of Health

Other Focus Areas: Behavioral Health
Increase Health System Efficiencies
Integrated Health Services
Network Organization/Infrastructure Development

Network Statement

West Mountain Regional Health Alliance service area includes a mix of ranch land and mountain slopes along the Roaring Fork and Colorado rivers, comprising 5,627 square miles. This rural resort region (Eagle, Garfield, Pitkin counties in Colorado) creates a beautiful natural environment and a strong tourism economy; it also generates a high cost of living and many challenges with the vast distances between communities. The region is home to many working-class families and individuals who struggle financially because there are substantial wealth differences. Often our greatest strengths create our most significant health challenges, as many cannot afford adequate housing, health insurance, and food. We are working to solve challenges by collaborating with diverse partners to create a community where residents can thrive.

WMRHA formed as an informal regional entity in 2010 to examine the access to care gap of prenatal care for low-income women. This gap was solved with an ongoing Prenatal Program. This collaborative solution led to continued dialogue, and then WMRHA became a nonprofit in 2016. Today, the Alliance consists of over 100 committed members from various sectors impacting health. These partners collaborate to build upon strengths, close gaps and create flexible and innovative solutions. Over the last three years, WMRHA has aligned many regional efforts including screening for social needs at clinics, homelessness, food insecurity, and mental and behavioral health. As the Alliance continues to grow and expand our status as a neutral convener, the community see value in our partnership and recognize at the state and national level. We are excited to build an integrated health system to achieve optimal health for all people who live in the West Mountain region.

Network Development

WMRHA has a diverse board consisting of hospital partners, county government (all three counties), an FQHC, a behavioral health organization, a health data exchange, and a university. The grant has assisted us to be more prominent in our strategic aim i.e. alignment of key stakeholders, advocacy for integrated health care for all, and improving access to care. Our network partners have increased from 34 organizations to 110 organizations. The increased partners have identified common aligned goals. Also, network development has helped us to disseminate collaborative ideas to many organizations in the community. WMRHA plays a key role to voice the need, facilitate, and create opportunities for community partners to collaborate.

WMRHA's initiatives have given direction on where to prioritize efforts for the betterment of our community. The Accountable Health Communities Model has provided a way to measure social determinant of health needs around food, housing, utilities, transportation, social isolation, and interpersonal violence. This data has shown consistently that the top three needs are food, housing, and transportation. We have worked to develop strategies to address behavioral health and affordable housing with a specific emphasis on Permanent Support Housing. The planning grant has allowed us to communicate and integrate programs with network members. The platform we have shared with

community partners to communicate includes quarterly partner meetings, monthly board meetings, monthly newsletters, an annual report, a Facebook page, and an updated web site. With the support of this grant, we can continue to develop a strategic map for WMRHA with the help of staff, board, and network partners. We have been able to integrate efforts, align partners and initiatives; share data, and create collaborative solutions for a better health system.

As we developed the network, initially we saw partners hesitant to take on extra work even for initiatives viewed as important. Perseverance was the key to get buy-in from community partners to take on new responsibilities that would impact the health system. As conveners and supporters, the Alliance led efforts and demonstrated value for our partners. During different times partners can become less involved, and to mitigate this, the communication avenues keep them informed, and we reach out to reengage partners as needed. Overall, the network has progressed with new collaborations, initiatives, and expanded partnerships for success.

Programmatic Development

WMRHA programs have identified the community's social needs through survey data, involved partners to take ownership, reduced duplication between the partners, and improved communication strategies of the social needs and ways to address them. We currently have 20 clinical organizations administering social screening, since our start in October 2018. This has helped us to identify the vulnerable patients, connect them to relevant services and for those patients with two ER visits and a social need to care coordination. The social screening data showed food and housing as the first and second highest needs of patients, respectively. As the food is being addressed by a coalition, WMRHA decided to look at affordable housing, and since Permanent Supportive Housing (PSH) would meet the needs of our most vulnerable individuals around health, WMRHA decided to facilitate and convene a process to move PSH forward. As a regional entity, we have brought our perspective and influenced projects to move from more community-based to regional such as fostering a combination of two opioid response planning grants to work together to pursue an implementation grant. The social needs data we share with the community monthly has given clinical, government, and community partners opportunities to collaborate and eliminate duplication. WMRHA has promoted partners to participate in social needs screening, PSH, opioid response planning, the Community Resource Network, which will be a social information exchange and care coordination platform, and the Hospital Transformation Program. These partnerships have fostered shared goals and initiatives to connect health and human service systems to address emerging challenges together. It was apparent how far our group had aligned when at a January quarterly meeting, the WMRHA housing consultants said that they were surprised at how many people were on board for a PSH project, as in many communities that is not the case.

The challenges we have faced in building the network are some limited network partner support, focus on organizational interest, and overworked partners. We had stayed in contact with various network partners and keep shared goals as a priority. We reach out to partners through various platforms such as in-person meetings, emails, newsletters, monthly board meetings, and quarterly meetings.

The innovations that WMRHA has undertaken include stepping up as the lead for Built for Zero, a national initiative to move toward zero homeless. As the Alliance is pursuing PSH for the homeless population with medical and behavioral needs, it made sense to more clearly identify the vulnerability of homeless individuals to identify those who need Permanent Supportive Housing to stay housed.

Sustainability

Beyond the Network Planning grant, WMRHA will continue to function with 2 to 3 employees and volunteers when possible. Funding the Alliance is a year-round process with seeking grants, board member fees, and contracted service work. In fall 2020, WMRHA will roll out a partner membership benefit plan to request other organizations formally join the Alliance. All the current initiatives will be sustained and continued. One of the key sustainability factors is having grants with multi-year funding, which helps to sustain initiatives. For example, WMRHA initiatives like the

AHCM program has contributed data, which helps make the case to seek other funding opportunities. Our data and strong network partners have helped us diversify our financial status. At this moment as an alliance, we are not completely dependent on one grant source. HRSA Network Planning funding has been instrumental, and we appreciate the technical assistance and support provided.

Region Covered by Network Services

County/State	County/State
Pitkin, CO	Eagle, CO
Garfield, CO	

Network Partners

Organization	Location	Organization Type
Mountain Family Health Center	Glenwood Springs/ Rifle/ Basalt/ Edwards, CO	Federally Qualified Health Center (FQHC)
Valley Health Alliance	Basalt, CO	Non-Profit
Quality Health Network	Grand Junction, CO	Non-Profit
Aspen Valley Hospital	Aspen, CO	Hospital
Pitkin County Public Health	Aspen, CO	Public Health
Valley View Hospital	Glenwood Springs, CO	Hospital
Garfield County Human Services	Rifle/Glenwood Springs, CO	Government
Grand River Health	Rifle, CO	Hospital
Eagle County Public Health	Eagle, CO	Public Health
Vail Health	Vail, CO	Hospital
Mind Springs Health	Grand Junction/Glenwood Springs/Rifle/Aspen/Vail/Eagle, CO	Behavioral Health
University of Denver	Glenwood Springs, CO	University

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COLORADO

Southeast Mental Health Services
Southeast Colorado – Workforce Innovation Network (SECO-WIN)

P10RH33053

Project Focus Areas: Behavioral Health

Other Focus Areas: Integrated Health Services
School Based Health Services
Telehealth
Workforce Development

Network Statement

Southeast Colorado has a rich history, diverse culture, and deep agricultural roots. Our communities are close knit, but we are struggling to maintain our way of life. Substance use and mental health challenges are too common among our youth and families, and it is becoming harder to recruit behavioral health counselors to meet the growing demand.

The Southeast Colorado Workforce Innovation Network (SECO-WIN) plans to change all that. Our innovative statewide partnerships are designed to find, train, and employ post-graduate behavioral health fellows who will appreciate working with us, and thrive in that relationship. We invite you to join us in our efforts to advance the wellbeing of individuals and families in our communities and become part of the "grit" that makes our communities healthy and resilient.

Network Development

SECO-WIN utilized support from Clover Consultants to review and discuss potential network partners and to come to agreement on network partnerships that would allow us to advance together to meet our common goals. We discussed each potential partner and came to an agreement based on level of interest, capacity to contribute, and ability to participate in a meaningful way. We kept our network tight and focused for the duration of our planning grant in order to stay on track and meet our goals. Once we identified our potential partners, we engaged them in meeting the team and discussed needs and contributions. A formal MOU was created and signed by all network partners.

We found it important to generate a list of all possible partners, discuss reasons for involvement, and be open to differing ideas. We also found it helpful to keep our network simple and small with the understanding that we can expand at any time if we need to do so for furthering our reach or expanding our goals. We faced challenges initially around finding partners who would align with our goals. We discussed various partners and reached out to some who were unable to engage with us for various reasons. We had to openly discuss relationships with other agencies, barriers in delivery of services, and mission alignment. These discussions helped us to narrow down our partnerships and ultimately landed us in a good position with our current partners.

Programmatic Development

SECO-WIN began with a vision of establishing a behavioral health residency program in Southeastern Colorado. The network developed around an innovative idea of using the resources, networks, and established residency program of the Denver-based Maria Droste organization to help recruit and train residents placed in Southeastern Colorado,

utilizing the networks and resources of Southeast Health Group. This vision quickly began to take shape during monthly meetings that were used to determine capacity for community training, areas of community need, funding needs and resources, and sequencing of recruitment events. Over the course of the training year, the network determined that there was capacity and funding to support 2 two-year fellowship positions and concluded that one fellow would be recruited to work with children and families and the second one with adults. Another important milestone was in finalizing the financial agreements and roles between the network partners that was formally agreed do during the signing of a Memorandum of Understanding (MOU) and a subsequent Service Agreement contract. The most prominent milestones of the network to date has been the successful completion of its inaugural recruitment, interviewing, and hiring cycle that resulted in two accepted fellowship positions for the upcoming training year.

The network has faced several challenges, including determination of who would serve as the actual employer for the fellows, the ability to seek reimbursement for services the fellows would provide, facilitation of distance learning and supervision, and recognition that limited housing options would create a barrier to fellowship placement. Additionally, the network came to realize that local resource limitations may prohibit the network's ability to recruit a new cohort each year. The network was able to address these challenges by agreeing on a "placement" approach to training wherein the fellows would be employed and clinical supervised by Maria Droste fellowship faculty and placed at the Southeast Health Group and associated sites for their training. The network piloted the use of distance technology, including Zoom Videoconferencing, during its network meetings to help prepare and plan for distance training and supervision activities. This proved to be especially helpful in the wake of the COVID 19 pandemic, as the network was able to utilize this technology to conduct distance interviews and use recordings to provide virtual tours of the housing and facilities. In recognition of potential resource limitations, the network agreed to revise its committed recruitment window to every two years but allowed for the possibility of recruiting telehealth fellows in the off years as a way of lessening resource demands.

One of the most innovative solutions the network adopted was the use of Tiny Homes as a solution to the housing shortages. Southeast Health Group had offered two purchased Tiny Homes to house the fellows during their training, which then allowed the network to advertise housing as an included benefit to prospective fellows.

Sustainability

SECO-WIN will continue to work toward our workforce development goals after the network planning grant ends. We are currently finalizing budgetary needs for agencies involved and reviewing time needs from our network partners. We will likely reduce full network meetings to quarterly and increase communication between key partners to ensure services are delivered appropriately. We will sustain our funding and programming by providing billable services through Southeast Health Group who will then reimburse Maria Droste for the employee's efforts to provide care in our communities. Funding for positions will be reliant upon services. SECO-WIN will continue to seek grants and funding opportunities that align with our goals and workforce development needs. We will continue to review funding opportunities as a network and seek out solutions together.

Region Covered by Network Services

County/State	County/State
Otero County, Colorado	Adams County, Colorado
Baca County, Colorado	Arapahoe County, Colorado
Crowley County, Colorado	Broomfield County, Colorado
Kiowa County, Colorado	Denver County, Colorado
Prowers County, Colorado	Douglas County, Colorado
Bent County, Colorado	Jefferson County, Colorado

Network Partners

Organization	Location	Organization Type
Maria Droste Counseling Center	Denver, CO	Behavioral Health
Southeast Health Group	La Junta, CO	Rural Health Center
Rocky Ford Family Health Center	Rocky Ford, CO	Physicians' Clinic
Rocky Ford School District	Rocky Ford, CO	School System
Metro State University School of Social Work	Denver, CO	College/University
University of Denver Center for Rural School Health	Denver, CO	College/University

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Florida

St. Johns River Rural Health Network
Putnam County Care Connect (PC3)

P10RH33054

Project Focus Areas: Increase Health System Efficiencies

Other Focus Areas:
Behavioral Health
Care Coordination
Network Organization/Infrastructure Development
Telehealth

Network Statement

"Connecting in technology and improving community wellness for a healthier tomorrow."

Families living in our rural areas are the binding threads in the fabric of American society. However those living in small quiet towns are often disconnected from larger city resources and face multiple barriers to accessing quality health care. Especially in the 830 square miles of Putnam County, rural families are challenged by shortages of healthcare workforce, health facilities, and transportation options, all inhibiting their ability to pursue happier, healthier lives.

Since 2019, Putnam County Care Connect (PC3) has leveraged its multidisciplinary member organizations to strengthen collaborative partnerships, share resources and innovative technology solutions, and address the health disparity issues directly impacting those in the rural fabric. PC3 is determined to ensure that Putnam County's rural communities receive wholistic person-centered care by promoting the Health in All Policies model and by implementing virtual wellness technology, resulting in efficient rural healthcare reform.

Connect with us! Join PC3 in our work to improve health outcomes for a healthier, vibrant tomorrow in rural Putnam County.

Network Development

St. Johns River Rural Health Network, SMA Healthcare, and Health Planning Council of Northeast Florida, Inc. formed a partnership to address behavioral health disparities in Putnam County. After an extensive needs assessment of primary and secondary data, it was evident that Putnam County's behavioral health must be addressed in three parts: resource management, virtual wellness through technology, and a data dashboard to drive project sustainability. This provided a clear focus for each organization's role within the network. Partnerships were formalized with Memorandums of Agreement, and service contracts were signed based on the memorandums. The organizations agreed to utilize the St. Johns River Rural Health Network bylaws for meeting governance.

The 2019-2020 year presented our network with multiple challenges. Aside from coordinating multiple schedules and pressing deadlines, the network experienced a hurricane and the COVID-19 pandemic. As each challenge presented itself, we remained flexible, drawing on the strengths of multiple people to provide input. Virtual meeting platforms were tested, and we found that Zoom was the most economical and easiest platform for users of varying technology levels.

Programmatic Development

The need for resource management, virtual wellness through technology, and a data dashboard for project sustainability provided the basis for program development. PC3 addressed the need for resource management through the use of Cureo by engaging with the program developer. By expressing network needs and working with Cureo to ensure that the product would be able to handle multiple users at multiple connectivity hubs, PC3 was able to design a platform to meet desired network needs. CareClix provided a telehealth platform utilizing cellular technology for virtual wellness visits to mitigate broad band connectivity issues. The data dashboard will assist with project sustainability by providing a one-stop shop proposals and community impact.

The three partners met the challenge of not losing focus on Putnam County by allotting meeting time through HRSA technical assistance calls, monthly behavioral health consortium meetings and quarterly network meetings to address network needs. Research into new technology provided the perspective to expand the thought of virtual health and wellness beyond the scope of telehealth. PC3 continues to keep up-to-date information on new platforms and wearable technology to assist patients beyond the virtual telehealth appointment. These new innovations will continue to provide a reassessment of our strategic plan and vet each new partner or project into the network.

Sustainability

PC3 will continue to seek resources from multiple diverse funding streams. Staffing is maintained under current funding streams and does not need additional funding to continue beyond the planning period. Shared costs of the platforms will be written into new grants for specific project implementation and sustainability. New telehealth billing made available under COVID-19 is currently used but will be reassessed as the pandemic crisis is resolved.

Region Covered by Network Services

County/State
Putnam County, FL

Network Partners

Organization	Location	Organization Type
St. Johns River Rural Health Network	Palatka, FL	Non-Profit
Health Planning Council of Northeast Florida	Jacksonville, FL	Non-Profit
SMA Behavioral Health Care	Palatka, FL	Behavioral Health

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Georgia

Glascock County Board of Education
Tri-County School Health Network

P10RH33044

Project Focus Area: School Based Health Services

Other Focus Areas: Behavioral Health
Health Education
Increase Health Efficiencies
Network Organization/Infrastructure Development

Network Statement

The overall health of a community's children is an indicator of the well-being of the community as a whole. Unfortunately, the well-being of children in Warren, Glascock, and Taliaferro counties is at risk. Poverty, single parent homes, lack of comprehensive health care, low educational attainment, and unemployment all contribute to economic and emotional distress in our communities. Research indicates that large numbers of our children suffer from low self-esteem, depression, and many have endured traumatic events.

Recognizing the importance of improving the lives of our children, the school systems, Family Connections, the district and local health departments, and the federally qualified heath centers in our three counties formed the Tri-County School Health Network to focus on access to health care, with an emphasis on mental health services. Having completed a comprehensive Community Health Needs Assessment, we are working to expand mental health services in our schools through screenings/assessments and creating partnerships to bring trained counselors into the school setting and utilizing telehealth where appropriate. We are excited about this opportunity to bring our communities together to create a thriving, healthier future for everyone.

Network Development

Regularly revisiting the differentiators that distinguish a Rural Health Network provided a barometer for gauging progress throughout the planning cycle. Network members met during structured monthly regional meetings and communicated regularly via teleconferencing, local meetings, and email to engage in shared decision making. Providing an opportunity for everyone to be heard and waiting patiently for thoughtful input ensured joint responsibility for outcomes.

During network development planning quarterly cycles 1 and 2, the lead partners were clearly our school organizations. As we entered cycle 3, relationships became more mutual and reciprocal as the local community health care systems and grassroots collaboratives increased their involvement, bringing added value through their unique perspectives and innovative approaches. The passion of our members intensified as we crafted our vision and mission statements and finalized the network statement. Care coordination and shared responsibility for outcomes ramped up with the onset of COVID-19 as partners brought telehealth services on board within their own service delivery systems. Partners realized they could effectively join forces by onboarding with telemedicine platforms ESE Telehealth and eClinicalWorks TeleVisits.

Our network has engaged throughout the planning cycle to leverage resources to support organizational infrastructure and development, as well as project implementation. Our network submitted applications for three grants totaling $650,000 in award funding over the next 5 years. Member derived investment from Family Connection of Glascock and Taliaferro Counties included the provision of office space, internet access,

computers, and phone service for local project coordinators. Our network schools provided conference rooms, office space, computers, internet access, printers, ink, and paper. Each of our three school systems provided salaries for reimbursement of a fulltime school nurse.

A challenge we faced in network development arose with member engagement. Representatives of some network partners had demanding schedules that often interfered with their direct network involvement. We seized the opportunity to expand input by including other key members within these organizations for active participation. Their voices added value, brought fresh perspectives, and energized the network as a whole. When the restrictions of COVID-19 in mid-March interrupted in person engagement, our members made use of virtual meeting opportunities via Zoom to overcome this challenge and stay connected.

Programmatic Development

One of the first strategies we conducted during our planning year was a comprehensive health needs assessment process that began in August 2019 and ended in September 2019. This assessment included: distributing and collecting parent surveys involving the parents of all students (Pre-Kindergarten - 12th grade) in our school systems; distributing and collecting staff surveys involving all school system staff members in each of the three counties; conducting focus groups with community leaders, healthcare providers, faith based community; school system administration; school nurses; and parents of special needs children; reviewing the results of the annual Georgia Student Health Survey 2.0 administered and analyzed by the Georgia Department of Education; and collecting existing student health data from school-based and community-based health providers. A total of 743 parents, 507 middle and high school students, 163 school system staff members and 41 focus group participants provided input. Approximately 82% of the families and 71% of the middle and high school students enrolled in our school systems were represented in our findings.

We utilized the results of the needs assessment to inform the work of our network. Warren County Schools increased efforts to engage families in school-based telehealth services and added tele-mental services in January 2020. Glascock County Schools initiated implementation of the Georgia Apex School-Based Mental Health program in January 2020. By early 2020, Community Health Care Systems (CHCS) in each of our three counties had added the option of telehealth services. Additionally, our three local CHCS clinics brought mental health services on board via in-person or telehealth by adding two Licensed Clinical Social Workers to their staff. As evidenced by the implementation of these services in response to the comprehensive needs assessment, the efforts of our network have expanded access to essential health care services, as well as behavioral healthcare, throughout our tri-county service area.

A significant challenge our network faced regarding implementation of in school telehealth services involved a lack of understanding from parents. We had anticipated eager acceptance and rapid engagement in these services; instead, we were met with hesitancy, and to an extent, a lack of trust. We responded by increasing community awareness of these services in the form of flyers sent home by students, school Facebook page postings, email messages to parents, and PSAs communicated via the local radio station and newspaper. Ultimately, we also offered face-to-face assistance with completion of the necessary forms to initiate services. We discovered the power of one-on-one connection to build trust and plug our families and children into the services we were providing.

Sustainability

At our first monthly regional meeting, we made the decision to be proactive regarding funding beyond the end of the planning grant. We engaged Norris Consulting Group, Inc., for assistance with scanning the environment for funding opportunities and follow-up. With help from our consultant, we conceptualized and submitted applications for three grants totaling $650,000 in award funding over the next 5 years. We also hope to tap resources from a $403,000 grant awarded to Mercer University in February 2020, from the U.S. Dept of Agriculture to equip 8 rural counties, including Warren County, with telehealth technology to address behavioral and mental health needs.

In the event that we receive no funding from grants, we have a contingency plan. It is highly likely that our four paid staff members can continue to engage in network activities through the school systems and local collaboratives. Although we had hoped to hire a licensed professional counselor to provide in school behavioral health services at each school in our network, we will be able to provide these services to students in alternative ways. ESE Telehealth, already onboard in Warren County Schools, provides behavioral health services, has an insurance billing component, and operates at no cost to school systems. ESE Telehealth also has protocols in place for meeting the needs of students who have no health insurance coverage and no means to pay for services. Another avenue for meeting students' behavioral health needs is through the Georgia Apex School Based Mental Health program. This program funds providers to deliver in-school therapy services, in-school and in-home case management, social and interpersonal skills building groups, as well as other behavioral health services, at no cost to Georgia school systems. The Georgia APEX Program is already operating in Glascock County Schools.

Our network partners represent all organizations currently providing healthcare services in our three counties. These include all three local public-school systems, all three local non-profit grassroots collaboratives, our public health district, and the Federally Qualified Health Center serving our three counties. These partners will continue to form the network's core moving forward. We plan to expand our partnerships to include representatives from local faith-based and civic organizations, as well as from local government and law enforcement, the Georgia Rural Health Innovation Center, and Mercer University.

Region Covered by Network Services

County/State	County/State
Glascock, GA	Taliaferro, GA
Warren, GA	

Network Partners

Organization	Location	Organization Type
Glascock County Board of Education	Gibson, GA	School System
Taliaferro County Board of Education	Crawfordville, GA	School System
Warren County Board of Education	Warrenton, GA	School System
Glascock County Family Connection and Communities in Schools of Glascock County	Gibson, GA	Collaborative
Taliaferro County Family Connection Collaborative	Crawfordville, GA	Collaborative
Warren County Family Connection and Communities in Schools of Warren County	Warrenton, GA	Collaborative
East Central Health District	Augusta, GA	Public Health
Community Health Care Systems, Inc.	Gibson, GA	Federally Qualified Health Center (FQHC)
Community Health Care Systems, Inc.	Crawfordville, GA	Federally Qualified Health Center (FQHC)
Community Health Care Systems, Inc	Warrenton, GA	Federally Qualified Health Center (FQHC)

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Illinois

Arukah Institute of Healing, Inc.
C5-Rural: Collaborative Complementary, Conventional & Community-Based Care for Rural Populations

P10RH33037

Project Focus Areas: Behavioral Health

Other Focus Areas: Care Coordination
Integrated Health Services
Mental Illness/Mental Health Services
Population Health/Social Determinants of Health

Network Statement

Recognizing that mental health affects our ability to live, laugh, love, learn and function in today's world, the C5-Rural Network came together in 2019 to break down barriers and empower young adults (ages 16-24) in Bureau, Putnam and Marshall Counties so they can easily access the mental healthcare they need. This area has some of the highest rates of youth suicide, substance abuse, and depression in Illinois, which when untreated, result in longer episodes of mental illness, higher symptom severity, more hospital admissions, and greater risk of comorbid diseases, all creating persistently higher healthcare costs throughout their adult lives.

Our network brings together primary care, behavioral health, complementary and community-based providers to integrate care strategies and provide individualized, whole-person treatment, including that for social, spiritual, physical, and educational needs. We are actively expanding our network to include stakeholders that interact with and serve young adults, as well as possess a passion for innovating the ways in which we reduce social stigma and shame, improve mental healthcare access on-demand, and empower self-driven health through technology. We look forward to the future with great anticipation as we facilitate this culture shift, reducing rural health disparities and social inequalities, and creating sustainable health for generations to come.

Network Development

Our network has accomplished many milestones over the past year that have been integral in our development. We have worked diligently to build high-trust relationships with one another, which has involved open, honest, and regular conversation involving difficult issues and divergent viewpoints. We facilitated collaborative contribution from all network partners by sharing the lead facilitator role at monthly meetings. This enhanced buy-in and motivation, ensured a balanced representation of network partners voices and viewpoints, and promoted active participation of each member. We tripled network capacity by adding 10 new members to the formative 5, totaling 15 total members. We also built critical connections with community leaders and other stakeholders, creating a shared understanding of issues. Our network partners worked to formalize the network and created by-laws as well as a mission and vision statement under which our network is governed. Our adaptive capacity and value proposition were constructed by regular surveillance regarding how the network was providing benefit to network partners workflows at their individual organizations, and how these benefits were valuable to them as providers or community members. Pain points were regularly assessed, and the network value was connected to these to ensure continued usefulness and importance to members.

A few challenges our network faced in development were the potential time constraints of certain members, e.g., primary care providers, working through differences in philosophies of health and progress among different

members, and pulling in newer partners that may in some ways feel "on the fringe" of network activities. We worked to overcome time constraints of clinicians through offering virtual connections for monthly and *ad hoc* meetings through professional meeting software, enabling screen sharing and other functionalities necessary for live information exchange. We addressed divergent health philosophies through purposeful, regular communication on defining and standardizing measures of care and progress among network partners. We overcame potential distancing of new network partners by creating additional opportunities for them to be engaged, including electing them to serve as lead facilitator on agenda items, and actively seeking out their opinions on various network matters.

Programmatic Development

We have made substantial progress over the past year of planning in building a novel collaborative and integrative behavioral healthcare model for Bureau, Marshall, and Putnam counties of rural northcentral Illinois. Our network partners are highly engaged in the strategic planning process, and we have woven together an impactful and innovative strategic plan through regular and effective planning and discussion. Included in our plans are building both internal and local infrastructure that is scalable and allows for rapid implementation. Specifically, we established network entry points within the community that represent critical points of access for our target population (16-24 years). We also established billing and referral schemes, including diverse payer options for supporting integrated care plans. Moreover, we created and administered a community-wide survey assessing perceived barriers of mental health access. This tool enables ongoing and regular assessment of our population. We implemented community-wide education through integrated behavioral health events that combined the clinical expertise of our network partners, as well as weekly educational campaigns via social media and email for community awareness of collaborative care (monthly reach of 8,000+ in the catchment area). We implemented clinician education through newsletters illustrating research findings and educational seminars given by experts at top academic institutions and other Rural Health Networks. Finally, we constructed data monitoring plans as well as integrated care policies and procedures to standardize our data collection and unify our clinical workflows.

Perceived challenges encountered by our network include securing alternate sources of funding. Partners worked diligently to construct and submit a Rural Health Network Development implementation application, but we understood that we could not rely solely on this source of income. A way we overcame this was to come to the table and construct a plan for securing diverse revenue streams. We sought out and identified additional funding opportunities from parallel entities that would support either entire network activities or more focused initiatives involving a smaller subset of our partners. We ultimately see that our network will benefit from a diverse portfolio of revenue streams (e.g., supporting basic functions and infrastructure, integrated service delivery, and innovation), to ensure solid growth and sustainability.

The chief innovation developed by our network was our data-driven plan for integrated, collaborative behavioral healthcare. Our network conducted a data workshop where network partners met and developed workflows and measures to: (1) detect untreated mental illness among community partners, (2) streamline and reduce barriers for their access to services, (3) rapidly screen and assess risk, (4) develop integrated, person-centered care plans involving complementary and conventional services as well as care for social determinants, and (5) monitor response to treatment and treat to target.

Sustainability

C5-Rural has services that meet the needs of our members and provide value to them that surpasses what any of them could achieve individually. Taking a collaborative approach and using ongoing and proactive planning and participative solutions for improvements is how we approach our sustainability. Building high-trust relationships through an assessment and improvement process will allow C5-Rural to be more effective in delivering needed and valued services. C5-Rural will match our costs to our revenue streams while engaging with members to meet our

mission and vision. Our intention is to build on our planning funding to develop our capacity as a network and engage with our members for collective impact well into the future.

The strategies the network will utilize to sustain the project involve community buy-in, combining of resources, continued formalization of our network as an independent entity, a staffing plan that adapts to the evolving mission of the Network, and diverse funding portfolio. Our network will continue to promote awareness of programs and collaborative care within residents of the catchment area to enhance community buy-in. Network partners will develop shared services and combining of resources so as to achieve efficiencies and reduce costs for integrated care. Our network will periodically assess network formalization and growth, e.g., 501c3 status, as well as adding appropriate staff to carry out mutually agreed upon functions of the network. We will implement diverse funding mechanisms to support the models developed in this application, including but not limited to fundraising, commercialization and revenue generation from products/services, and more traditional approaches of grant writing and in-kind support.

The Advisory Committee and Network Board will be essential in developing strategies for sustaining the collaborative care network past the funding period and helping to determine which programs and services will be sustained and which will be discontinued or repurposed. We have built significant flexibility within our model of development, leaving room for innovation, changes in policy and best practices, and alterations in the acute needs of our rural populations. Our sustainability will be bolstered by providing valued services, programs, and digital products to its network partners and proactively planning for future innovation. The services of C5-Rural are designed to be collaborative and to build on the strength of each member. Through its aligned, cooperative, and collaborative model and excellent strategic, operational, and financial infrastructure, C5-Rural will be engaged with our communities well into the future.

Region Covered by Network Services

County/State	County/State
Bureau, IL	Marshall (village of Henry, IL only), IL
Putnam, IL	

Network Partners

Organization	Location	Organization Type
Perry Memorial Hospital	Princeton, IL	Critical Access Hospital (CAH)
St. Margaret's Health	Spring Valley, IL	Hospital
Gateway Services/Open Doors Counseling	Princeton, IL	Behavioral Health
Northcentral Behavioral Health Systems	LaSalle, IL	Behavioral Health
Arukah Institute of Healing	Princeton, IL	Behavioral Health
LW Schneider, Inc.	Princeton, IL	Other
Washington Mills	Hennepin, IL	Other
People Church	Princeton, IL	Non-Profit
Bunker Hill Church	Buda, IL	Non-Profit
Perfectly Flawed Foundation	LaSalle, IL	Non-Profit
Community Partners Against Substance Abuse	Princeton, IL	Non-Profit
Second Story Teen Center	Princeton, IL	Non-Profit
Hall High School	Spring Valley, IL	School System
LaMoille High School	LaMoille, IL	School System
Bureau Valley High School	Manlius, IL	School System

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Iowa

Avera Health
Emmet County Behavioral Health Network
P10RH33038

Project Focus Areas: Mental Illness/Mental Health Services

Other Focus Areas: Behavioral Health
Health Education
School Based Health Services
Telehealth

Network Statement

The Mental Health of youth is a valid concern that every rural community has. Understandably, rural communities struggle having resources available to address youth mental health concerns. Though limited geographically, the city of Estherville and the surrounding communities are determined not to let geographical limitations prevent our youth from getting the mental health care and resources they need. In 2018, Avera Holy Family, Emmet County Public Health, and the Estherville Lincoln Central School District united together to address youth mental health needs in the Emmet County area.

Addressing youth mental health concerns is a priority for the Three Network Partners. The collaboration recognizes that youth can struggle with mental health issues for a variety of reasons. It acknowledges that the local resources available in the surrounding area, although limited in number, are putting forth their best efforts of care. However, the Three Network Partners understand there is more that can and needs to be done. With a focus on mental health awareness, creating opportunities for youth enhancement, and fostering more community and parental involvement being the forefront work in the network, the Three Network Partners are confident that the youth who are struggling with their mental health will receive the care and attention that they need through the efforts of this grant and the work done through the grant.

Network Development

Our Network continues to make great strides in formalization, creating a mode of stability for our efforts. The catalyst behind the creation of the Network was the number of suicide attempts in Emmet County, IA. This led to the Estherville School District (ELC), Avera Holy Family (AHF), and Emmet County Public Health (ECPH) forming a task force that would seek out avenues to address the concern of youth suicides and, maybe more importantly, addressing the mental health needs that need to be addressed to reduce the number of suicides in the area. After applying and being awarded the HRSA Grant, a memorandum of understanding was signed by all three entities, The Three Network Partners.

The three entities (ELC, AHF, and ECPH) serve as the Governing Board for the HRSA Grant project. More partners were needed for the project to be successful and therefore, we extended an invitation to numerous citizens, mental health professionals, other school systems within Emmet County, and law enforcement. The Network meets monthly to discuss concerns, project ideas, data from listening sessions, and research, as well as determining next steps in our work.

Programmatic Development

The COVID-19 pandemic presented us with a unique opportunity in the school system. Due to the traumatic impact COVID-19 has had on the students in our community, the school district trained all their employees on trauma-informed care. The training was done in preparation for the returning students who may have had traumatic experiences during their time away. This was an unforeseen opportunity that brought training in mental health that was being sought after in the school system. The local library also alerted the Network Partners about the possibility of holding youth programs, acting as a local youth center, when it reopens. These unique opportunities have presented us with additional possible methods and ideas that we can integrate when we are all able to reconvene physically in one space.

The uniqueness of life and our schedules have presented problems for us all. Work commitment and schedules have presented complexity for our Three Network Partners, resulting in not all being able to attend meetings or remain as committed as we would like to be to the project. To overcome this, we have made a continuous effort to accomplish the project goal of improving the health care of our youth. We have made efforts to devote time weekly to HRSA amid our hectic schedules and commitments. We are committed to continue the work of our HRSA goals, knowing our youth need this now more than ever and at greater numbers.

Sustainability

Sustainability is a major concern for the Network. We must continue to look at ways to secure funding, staffing, and partners who are committed to our rural area for a long-term commitment. Possible avenues for funding would include applying for additional federal and state grants. We have begun to look at grant funding and the criteria required for being awarded the grant. We have found the following grants thus far: 1) NIMH Mentoring Networks for Mental Health Research Education, 2) Initiation of a Mental Health Family Navigator Model to Promote Early Access, Engagement, and Coordination of Needed Mental Health Services for Children and Adolescents. We are also looking at innovative ways to supply staffing through volunteer hours from community members, possibly coordinating work study hours with the local college, also an entity within our community, and so forth. These are some of the avenues we are looking into.

To mitigate the cost and maintain sustainability, we are looking at some of the creative ideas we received during the listening session with the students. The students suggested a yearly assembly for mental health awareness, a bi-monthly Master's Class in ELC that will cover life skills needed for adulthood, and a local youth center. We have resources and mental health professionals available to conduct a student assembly, the City has discussed the idea aiding with the Master Class as a joint effort with ELC, and Estherville Public Library offered the use of the facility for youth center activities. Keeping costs down will help sustain a program for our youth in regard to their mental health.

Region Covered by Network Services

County/State
Emmet County, IA

Network Partners

Organization	Location	Organization Type
Emmet County Social Services	Estherville, IA	Government
Avera Health	Estherville, IA	Hospital
Heart Kinnections	Estherville, IA	Behavioral Health
North Union School District	Armstrong, IA	School System
Estherville Lincoln School District	Estherville, IA	School System
Family Crisis Center	Milford, IA	Behavioral Health
Estherville Police Department	Estherville, IA	Law Enforcement
Emmet County Sheriff's Office	Estherville, IA	Law Enforcement
Champion State of Mind	Estherville, IA	Behavioral Health

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KENTUCKY

Livingston Hospital and Healthcare Services, Inc
Livingston Crittenden Lyon (LCL) Health Alliance

P10RH33048

Project Focus Areas: Behavioral Health

Other Focus Areas: Telehealth

Network Statement

The LCL Health Alliance was created in response to the identification of growing health concerns, as well as lack of accessibility to needed healthcare providers, in our tri-county area of rural Kentucky. The LCL Health Alliance was formalized in 2019 as an opportunity to bring our community together to create a healthier future for everyone and now includes 25 members and partners.

The tri-county area of Livingston, Crittenden, and Lyon counties are designated as Health Professional Shortage Areas (HPSA) for Primary Care, Dental Health and Mental Health and are designated as Medically Underserved Communities/population. Through our growing partnership among regional healthcare, mental health, substance use disorder and community services providers, we are able to build capacity for evidenced-based, coordinated services to better meet the healthcare and behavioral health needs of our community. Our momentum is growing as we expand our partnerships and focus our collaborative efforts on the top health disparities in our rural communities. We are committed to creating a community health improvement plan to serve our tri-county area and to positively influence the overall health of the communities we serve.

Network Development

During this year, we have been able to establish the formal LCL Health Alliance network, hire the inaugural Network Director, form the network board with elected board officials and engage in the series of activities to establish our first network strategic plan. The LCL Health Alliance Network has experienced growth with our memberships and partnerships. Since November 2019, the Network has added 2 new members and 4 new partners. With these new members and partners - the Network has received knowledge of new evidence-based programs that may benefit our rural community.

The Network is now at a total of 25 members/partners/supporters from across the healthcare, behavioral health, academia, education, local government, philanthropy, and community services sectors from the three counties. We continue to gain exposure with our growing working relationships, such as with the evidence-based programs of Millstone Counseling, Voices of Hope, KentuckyCare, and The Fletcher Group.

Programmatic Development

With the ongoing alignment among original and newer partners, our relationships have built capacity in our tri-county area for identified priority services, including peer-to-peer recovery programs, mental health counseling, MAT/Betty Ford 12 Step, SMART Recovery, recovery housing, workforce programs, opioid treatment, and a local treatment center. In addition, the Network completed a tri-county Resource Guide to be utilized by the community of 27,000 to communicate the resources they may not otherwise be aware of within their living area. The guide supports increased access to mental health providers and substance use disorder treatment centers in our outer area within 50+ miles.

One outcome of our community outreach is that there has been an increased community utilization of telehealth services in lieu of in-clinic patient, one-on-one care with providers. KentuckyCare, one of our partners, has documented in patient feedback a greater comfort level among their patients with telehealth. They find that patients are more open to discussions about their treatment plans in a tele-health environment.

Our primary challenge within our tri-county rural community is a lack of mental health providers, substance use disorder treatment, recovery housing, peer-to-peer programs, transportation, and telehealth. The Network will consider strategies to address these health workforce shortages.

Sustainability

The Network will continue to build partnerships with our local community supporters, health providers, mental health/substance use programs and centers. The Network will continue to engage in a continuous iterative process of assessing and responding to community needs. Together, the network members will analyze data compiled by a variety of agencies and community needs assessments (LHHS, Cooperative Extensions, school districts, family resource centers, courts, social services, etc.) and identify reliable and valid health trends, intervention impact, and community perceptions.

The Network's current partnerships with Millstone Counseling, 4 Rivers Behavioral Health, and KentuckyCare will assist our future sustainability to continue our program goals of increasing access to telehealth, peer-to-peer recovery, MAT, mental health, and substance use disorder treatment. The Network is confident that, with our local government support, grant funding opportunities, and The Fletcher Group as partner, we can launch our transition and adaptation to ongoing growth for our future plans for a strong recovery ecosystem in the LCL Health Alliance tri-county community.

Local funds are an important component of the sustainability of the community health resource centers, support group network, and outpatient substance rehabilitation program. Outside of member resources, the Network will work with the local chapter of United Way to provide financial support for operations and the Community Foundation of Western Kentucky to build an endowment that can sustain the program long into the future. In addition, the Network will see partnerships with state and national organizations and apply for grants to assist with funding the rehabilitation program.

Region Covered by Network Services

County/State	County/State
Livingston County, KY	Crittenden County, KY
Lyon County, KY	

Network Partners

Organization	Location	Organization Type
Livingston Hospital and Healthcare Services, Inc.	Salem, KY	Critical Access Hospital (CAH)
Grand Lakes Clinic	Grand Rivers, KY	Physicians' Clinic
Eddyville Family Medical Clinic	Eddyville, KY	Physicians' Clinic
Millstone Counseling	Paducah, KY	Behavioral Health
Livingston Care Clinic	Salem, KY	Physicians' Clinic
Livingston County School District	Smithland, KY	School System

Organization	Location	Organization Type
Lyon County School District	Eddyville, KY	School System
Purchase Area Health Education Center	Murray, KY	Area Health Education Center
Livingston Hospital Foundation	Salem, KY	Philanthropy/Foundation
Community Foundation of West Kentucky	Paducah, KY	Philanthropy/Foundation
Pennyrile District Health Department	Eddyville, KY	Public Health
Livingston County UK Cooperative Extension Service	Smithland, KY	College/University
Livingston County Emergency Medical Services	Smithland, KY	Emergency Medical Services (EMS)
Livingston County Attorney	Smithland, KY	Law
Salem Baptist Church	Salem, KY	Religion
Lyon County Judge Executive	Eddyville, KY	Government
Crittenden County Judge Executive	Marion, KY	Government
Livingston County Judge Executive	Smithland, KY	Government
KentuckyCare	Paducah, KY	Physicians' Clinic
Four Rivers Behavioral Health – Prevention	Paducah, KY	Behavioral Health

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Michigan

Central Michigan District Health Department
Central Michigan Regional Rural Health Network

P10RH33039

Project Focus Areas: Integrated Health Services

Other Focus Areas: Behavioral Health
Network Organization/Infrastructure Development
Population Health/Social Determinants of Health
Workforce Development

Network Statement

The Central Michigan Rural Health Network was formed in 2015. This expanding collaboration of community partners includes health, human service, and educational agencies and organizations committed to improving the health and wellbeing of the population in a six-county region in central rural Michigan. Working together, we share information on the many needs of our underserved rural population and strategize as to how we can leverage assets collectively to address those needs. Health Network members and participants strive to improve access and integrating services. Through collaboration, we leverage our combined capabilities adding value to better our community members' health and wellbeing. Our partners work together to address the needs of our communities to be resilient, healthy, strong, and viable.

Network Development

The Central Michigan Regional Rural Health Network is guided by an Operating Agreement and is governed by a Governance Committee, consisting of not more than 18 members and 4 Officers, that meets each month. At each of the monthly meetings, the Governance Committee receives reports from each of the five Health Network subcommittees (Finance/Sustainability, Administrative/Rules, Legislative, Outreach and Communications, and Operations/Technical) and determines actions to be taken to further network infrastructure development and programmatic activities. The Health Network maintains and regularly updates a website that includes links to the Health Network Member Directory (which includes links to members' websites and employment webpages), Community Calendar, Resources Library, Health Network Meeting Archive (which includes audio/visual recordings of all meetings and presentations), and Health Network Member materials. Development of bylaws is planned for the future.

The primary challenge to network development has been the advent of the COVID-19 health crisis. Previously, health network participants were able to attend the meetings (monthly full network and Governance Committee meetings, as well as subcommittee meetings and ad-hoc planning meetings) either in person or virtually via videoconference. By the beginning of April 2020, the monthly meetings had been converted to all virtual participation as part of crisis response, and subcommittee and ad hoc meetings are largely postponed due to need to devote resources to immediate-term crisis response. The format of full health network meetings was altered to accommodate information sharing in a time in which information changes daily. Previously, the monthly meetings included discussions related to programmatic developments and planning, as well as a presentation by a partner. Now, the meetings comprise an update from the health authority/lead network member followed by a series of 20-minute, three-person panels with updates about COVID-19 response and organizational needs provided by representatives from the heath care, behavioral health, human/life needs, educational, and economic relief/workforce sustainability sectors. All meeting participants are also encouraged to provide updates about their organizations' efforts and needs and post questions and comments via the chat log. The information captured in the log is later provided to the full network contact list of

more than 100 organizations and individuals. The innovation changes implemented by necessity have served to stimulate interest in attendance. Those who attend are able to hear from a range of professionals, many of whom are teaming together to provide a quick response to burgeoning needs and prepare for the future.

Programmatic Development

The Health Network is focusing on strategies that: increase multi-sector capacities to provide integrated, person-centric treatment, care, and programming; and/or increase the number of individuals accessing available capacity. The network's overlapping programmatic goal areas include:

- Providing mental health and trauma informed care and building community resiliency.
- Enhancing clinical-community linkages delivery by facilitating individuals' access to new or enhanced delivery systems, including increasing use of community health workers in integrated care systems, and increasing use of emerging technologies:
- Providing harm reduction-based care for those impacted by substance misuse.
- Encouraging healthy lifestyles.
- Enhancing maternal and child health.
- Expanding and extending the reach of regional health professional workforce education, training, recruitment, and retention activities.

As with network development, the primary challenges to programmatic development are those related to COVID-19 response. At the advent of the crisis, the focus was changed to immediate response by all sectors to protect their workforce and community members at-large to help stop the spread and care for those impacted. Network members participated in a review of the goal areas in light of COVID-19. Mental health remained the highest priority. Even in light of COVID-19, all of the goal areas remain crucial to improving the health of community members in the region. Progressing into the future, the focus will include a framework of "safety first" as the foundation as programs that have been halted are re-implemented and new efforts begun. It is anticipated that there will be challenges in the near and long-term resulting from all partners facing budget reductions and a decrease in the availability of resources. Costs will also most likely increase for partners due to the increase in safety measures needed to ensure the health of both employees and clients. The forum provided by the network, in which collaborative partnerships are developed and members are able to leverage their combined capabilities, is more importance than ever before. COVID-19 has shown us that facing challenges together is crucial to ensuring that we are providing the services our communities need in the safest, most efficient way possible.

Sustainability

The Health Network will continue operations beyond the Network Planning grant with ongoing monthly meetings of the full Health Network, the Governance Committee, and the five subcommittees, with continued development of programmatic efforts. Network members and participants will provide staffing and resources on an in-kind basis with staffing levels and programmatic activities to be expanded based upon availability of funding. Potential resources include member contributions, grant awards from public and private sector entities, and additional in-kind contributions. The primary challenge faced by the Health Network is a lack of resources dedicated to development of funding applications, which, at this point, has been exacerbated by increased demand upon partners' staff due to COVID-19 response. Additionally, there have been reductions in workforces across sectors, further lessening members' abilities to devote resources to network development. When possible, Health Network participants will continue to collaborate on funding opportunities in an effort to gather the resources needed to serve our community as efficiently and safely as possible.

Region Covered by Network Services

County/State	County/State
Arenac County, MI	Isabella County, MI
Clare County, MI	Osceola County, MI
Gladwin County, MI	Roscommon County, MI

Network Partners

Organization	Location	Organization Type
211 Northeast Michigan	Midland, MI	Other
Central Michigan District Health Department	Mt. Pleasant, MI	Public Health
Central Michigan University College of Medicine	Mt. Pleasant, MI	College/University
Central Michigan University The Herbert H. and Grace A. Dow College of Health Professions	Mt. Pleasant, MI	College/University
Community Mental Health for Central Michigan	Mt. Pleasant, MI	Behavioral Health
Everyday Life Consulting, LLC	Beaverton, MI	Consultant
Ferris State University College of Health Professions	Big Rapids, MI	College/University
Gladwin City/County Transit	Gladwin, MI	Transportation
Gratiot-Isabella Regional Education School District	Ithaca, MI	School System
Great Start Collaborative – Bay-Arenac Intermediate School District	Bay City, MI	Collaborative
Great Start Collaborative – Clare Gladwin Regional Education School District	Clare, MI	Collaborative
Great Start Collaborative – Gratiot-Isabella Regional Education School District	Rosebush, MI	Collaborative
Isabella Citizens for Health, Inc.	Mt. Pleasant, MI	Federally Qualified Health Center (FQHC)
Kirtand Community College	Roscommon, MI	College/University
Life Choices of Central Michigan	Mt. Pleasant, MI	Social Services Agency
McLaren Central Michigan	Mt. Pleasant, MI	Hospital
Michigan Health Improvement Alliance, Inc.	Bay City, MI	Collaborative
Michigan State University College of Human Medicine	East Lansing, MI	College/University
Michigan State University Extension	Cadillac, MI	Other
Michigan Works Region 7B Consortium	Harrison MI	Other
Mid Central Area Health Education Center	Mt. Pleasant, MI	Area Health Education Center
Mid Michigan College	Mt. Pleasant, MI	College/University
Mid Michigan Community Action Agency	Farwell, MI	Social Services Agency
Mid Michigan Community Health Services	Houghton Lake, MI	Federally Qualified Health Center (FQHC)
Mid Michigan Health	Midland, MI	Other

Organization	Location	Organization Type
Mid Michigan Health – MidMichigan Medical Center Clare	Clare, MI	Hospital
Mid Michigan Health – MidMichigan Medical Center Gladwin	Gladwin, MI	Critical Access Hospital (CAH)
Mid Michigan Health – MidMichigan Medical Center Mt. Pleasant	Mt. Pleasant, MI	Hospital
Munson Healthcare Grayling Hospital	Grayling, MI	Hospital
My Community Dental Centers	Stanton, MI	Oral Health
Northern Lower Regional Area Health Education Center	Houghton Lake, MI	Area Health Education Center
Recovery Pathways, LLC	Essexville, MI	Behavioral Health
Region VII Area Agency on Aging	Bay City, MI	Area Agency on Aging
Roscommon County Transportation Authority	Prudenville, MI	Transportation
Rural Community Health Worker Network	Sanford, MI	Collaborative
Senior Life Solutions/ Psychiatric Medical Care, LLC	Gladwin, MI	Behavioral Health
Spectrum Health Reed City Hospital	Reed City, MI	Critical Access Hospital (CAH)
St. Mary's of Michigan Standish Hospital	Standish, MI	Critical Access Hospital (CAH)
Sterling Area Health Center	Sterling, MI	Federally Qualified Health Center (FQHC)
Ten16 Recovery Network	Clare, MI	Behavioral Health

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Michigan

Huron County
Thumb Community Health Partnership

P10RH33046

Project Focus Areas: Increase Health System Efficiencies

Other Focus Areas: Care Coordination
Integrated Health Services
Network Organization/Infrastructure Development
Population Health/Social Determinants of Health

Network Statement

Living in a rural community is often perceived as idealistic. Rural Michigan is where many families go to play, relax, and enjoy the beauty of the Great Lakes. However, the tranquil rural setting in the Thumb area of Michigan can mask deep and rooted health problems. Making health disparities worse are poverty, lower education levels, and limited income opportunities. Obesity-related chronic diseases and behavioral health are significant issues. Untreated and uncontrolled, these conditions are compounded by limited services and barriers to accessing services. These circumstances interfere with health and wellbeing in our rural community.

Beginning in 2018, our multi-sector partnership embraced the opportunity to join our neighbors, family, and friends on the journey to optimal health and a healthier community. We recognize that our collective resources and collaboration are critical to effectively address the persistent barriers and conditions that prevent all individuals from achieving greater levels of health.

Members of the Thumb Community Health Partnership are ready to empower our community on the journey of health and wellness.

Network Development

The Thumb Community Health Partnership was formed in response to fragmentation and isolated efforts around health needs assessment and population health. Partners had experience working together on specific projects but had made minimal efforts in creating a regional approach to improving population health outcomes. The region served by the partnership includes the area of the mitten shaped state of Michigan commonly referred to as the Thumb. This region includes Huron, Sanilac, Tuscola counties, and rural census tracts in Lapeer County. Partners met and agreed that forming a partnership that included agencies across sectors (public health, hospitals, primary care, behavioral health, and human services) would increase efficiencies within the system and result in improved community health. The current partners met two times in the fall of 2018. After the grant award, the partnership began meeting monthly. A team of contractors with needs assessment and collaboration expertise was assembled to lead the initiative forward.

All seventeen partners are represented on the decision-making body of the partnership. Membership includes four public health departments, four community mental health agencies, eight hospitals (seven of which are critical access hospitals), and one human service agency. During the project, the Partnership has used a workgroup structure to compile data, establish priorities, research strategies, and create a strategic plan. Two workgroups have been established: Data Workgroup and a Priority Project Planning Workgroup. The project has built capacity for implementing system wide improvements, moving forward regional projects, and improving quality of care across the care continuum.

Challenges faced by the network included time constraints to moving past the needs assessment and prioritization stage. These time constraints were mostly related to the impact of Covid 19 on member organizations and restrictions on holding meetings. In response to these challenges, network members continued to meet virtually and suspended or adjusted activities that required in person communication. One of the strategies identified early in strategy discussions was the need to increase consistent messaging around priority issues. It was decided that our first effort in this area would be around May is Mental Health Awareness Month and a social media campaign was developed. Information regarding Covid 19 and mental health was integrated into the campaign. Thumb Community Health Partnership has balanced the use of technology for efficiency and in person time for trust building from the beginning of the Network. This strong foundation made the necessary transition to virtual meetings seamless and enable the network to continue much of its work during social distancing.

Programmatic Development

Presently the Thumb Community Health Partnership is focused on broad areas of improvement. The two main purposes of the project are to align community health assessment processes and to identify priorities for regional strategies. Through developing this network of providers, the Partnership has increased health efficiencies by moving toward coordinated and integrated care across multiple sectors. This work targets improvements in population health outcomes. Currently, the consortium has identified priority population health needs of Behavioral Health and Obesity related Chronic Diseases. Strategies to address these priority areas are being created. These foci were chosen as a result of a regional needs assessment guided by the Mobilizing Action through Planning and Partnerships (MAPP).

The Thumb Community Health Partnership utilized the MAPP framework (National Association of County and City Health Officials) to guide its assessment process and environmental scan. Strategies are being developed that involves a comprehensive system change approach using multiple frameworks such as ABLe Change (Foster-Fishman and Watson, System Exchange, Michigan State University) and Collective Impact (Kania and Kramer, Stanford Social Innovation Review). Input from the community has already been gathered through needs assessments conducted in 2018 and 2019. Programs will be developed as pilot projects and sustained through a variety of sources. The resources needed for each strategy depend largely on if the strategy is a budget neutral or low-cost strategy, a small project, or a large initiative. Evidence based programs are in the process of being reviewed and will be further explored during a conference opportunity originally planned for June 2020, but postponed due to limitations on social gatherings.

Sustainability

As we approach models, we will use key collaborative and sustainability models to ensure that TCHP partners develop relationships of trust, experience mutual benefits, and realize meaningful return on investment. Project partners have integrated the Sustainability Framework from the Georgia Health Policy Center (GHPC) and the Sustainable Network Model from CRL Consulting. Specific factors included in the GHPC framework include: Strategic Vision, Collaboration, Leadership, Relevance and Practicality, Evaluation and Return on Investment, Communication, Efficacy and Effectiveness, and Capacity. We will also be utilizing a continuous learning frame such as the one presented in the Sustainable Network Model (scanning, leveraging, adding value, sense making) or the Plan, Do, Study, Act (PDSA) cycle. We will also foster relationships of trust where partners feel comfortable and confident in bringing concerns about financial risks to the partners or TCHP Team. Plans for sustaining programs will be discussed during strategic planning in the summer of 2020 but are likely to include grants, cost savings, fee for services, budget neutral activities, shared services, and sponsorships.

Region Covered by Network Services

County/State	County/State
Huron County, MI	Sanilac County, MI
Lapeer County, MI (Northern Rural Census Tracts)	Tuscola County, MI

Network Partners

Organization	Location	Organization Type
Deckerville Community Hospital	Deckerville, MI	Hospital
Harbor Beach Community Hospital	Harbor Beach, MI	Hospital
Hills and Dales Community Hospital	Cass City, MI	Hospital
Human Development Commission	Caro, MI	Community Development Organization
Huron Behavioral Health	Bad Axe, MI	Behavioral Health
Huron County Health Department	Bad Axe, MI	Public Health
Lapeer County Health Department	Lapeer, MI	Public Health
Lapeer County Community Mental Health	Lapeer, MI	Behavioral Health
Marlette Regional Hospital	Marlette, MI	Hospital
McKenzie Health System	Sandusky, MI	Hospital
McLaren Hospital-Caro	Caro, MI	Hospital
McLaren Hospital- Lapeer	Lapeer, MI	Hospital
Sanilac County Health Dept.	Sandusky, MI	Public Health
Sanilac County Community Mental Health	Sandusky, MI	Behavioral Health
Scheurer Hospital	Pigeon, MI	Hospital
Tuscola Behavioral Health Systems	Caro, MI	Behavioral Health
Tuscola County Health Department	Caro, MI	Public Health

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Missouri

Taney County
Ozarks Wellness Network (OWN it)

P10RH33055

Project Focus Area: Population Health/Social Determinants of Health

Other Focus Areas: Network Organization/Infrastructure Development

Network Statement

Between seven and eight million tourists make their way to Stone and Taney counties in southwestern Missouri every year, and yet these counties are faced with the struggles many other rural counties face: poverty, limited access to medical and mental healthcare, substance misuse and other factors affecting quality of life. The area is fortunate to have excellent health and service organizations working every day to address these challenges.

Is this work making a difference? How can the community tell?

Ozarks Wellness Network brings partners together to collect and analyze data needed to develop life-changing strategies for Stone and Taney counties. The Stone and Taney County Data Dashboard supports health and social service organizations by providing highly localized data highlighting progress and opportunities. Community-level information enables service providers to plan work strategically and respond to trends as they develop, resulting in positive, lasting impacts that will benefit Stone and Taney counties for generations to come.

Network Development

Through the Rural Health Network Development Planning grant, Ozarks Wellness Network (OWN it) partners engaged in activities requiring honest reflection on and evaluation of the purpose and value of the network to the two southwest Missouri counties served. Completing an External Environmental Scan, developing a Network Statement, and undertaking a Network Organizational Assessment helped focus the network on a clearly defined path. OWN its mission to collect and analyze data to support planning, implementation and evaluation of services provided by social service agencies in Stone and Taney counties will allow the network to expand. Through the development of the Stone and Taney County Data Dashboard, OWN it will work with these partners to address the social determinants of health and improve the health and wellness of Stone and Taney county residents and collectively work toward eliminating poverty.

OWN it is actively taking part in a range of community organizations, forming a valuable alliance with the Poverty Initiative. Attendance at network meetings is growing as key partners have joined the network board of directors. Scanning and sense-making is a regular part of network planning. OWN its programmatic focus no longer exists in its own silo but is part of a two-county effort to eliminate poverty.

While maintaining a balanced portfolio of financial resources is a challenge, OWN it is positioned to begin identifying financial resources beyond grant funding. As more and more community partners become aware of our program, and understand the benefit to their own organizations, funding opportunities will grow.

Programmatic Development

Ozarks Wellness Network engaged the Missouri Center for Applied Research and Engagement Systems (CARES) for assistance in planning a data dashboard, an online center to house highly localized information about the health and healthcare status of Stone and Taney counties in southwest Missouri. The dashboard is a tool that tracks progress in the social determinants of health and identifies where there are gaps to be bridged.

During the grant period, OWN it developed relationships with key area services that use and collect information around the social determinants of health, and learned their particular needs and goals as they plan their work of serving others. At the same time, the Poverty Initiative of Stone and Taney Counties prepared its road map to solving the problem of poverty in this area. The goals of the Poverty Initiative closely matched the social determinants of health OWN it planned to measure; and at this point, a partnership between OWN it and the Poverty Initiative began. OWN it is aligned with the Poverty Initiative as its data provider.

Sustainability

Ozarks Wellness Network is energized by its revived direction and focus to support other service organizations with data that will help them to plan their work more effectively and efficiently. At this writing in the midst of the COVID-19 pandemic, OWN it is formulating an emergency plan to ensure the operations of the network proceed uninterrupted, and the support of member organizations can continue or be modified if needed. OWN it and its fiscal agent, the Taney County (MO) Health Department, will seek federal and local grant funding to move to the next step, construction of the data dashboard. In addition, other funding sources are being identified by the Poverty Initiative. The goal is to have a first iteration data dashboard available by December 2020.

Region Covered by Network Services

County/State	County/State
Taney County, MO	Stone County, MO

Network Partners

Organization	Location	Organization Type
Taney County Health Department	Branson, MO	Public Health
Stone County Health Department	Galena, MO	Public Health
Christian Action Ministries	Branson, MO	Food Bank
Cox Medical Center Branson	Branson, MO	Hospital
Poverty Initiative of Stone & Taney Counties	Branson, MO	Collaborative
Ozarks Wellness Network	Branson, MO	Collaborative

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Missouri

West Central Missouri Community Action Agency Health and Wellness Network

PH10RH33057

Project Focus Area: Transportation

Other Focus Areas: Increase Health System Efficiencies
Network Organization/Infrastructure Development
Population Health/Social Determinants of Health

Network Statement

Lack of transportation options is directly linked to poor health outcomes and economic stagnation in rural west central Missouri. Without reliable rides, patients miss health care appointments and delay needed treatments. As a result, patients experience health complications, and higher costs put stress on already financially tenuous rural hospitals, clinics, and ambulance districts. Additionally, lack of transportation options prevents youth, workers, and families from accessing job opportunities and other needed social services.

An alliance of area healthcare and community organizations aims to help the region's people and places thrive by bridging our rural transportation gap. The nine-county rural Health and Wealth Network will coordinate and improve transportation resources through its Rides to Health and Wealth program. More than 40 organizations have joined forces to combine community mobility coordination services with cutting-edge technology in the HealthTran ride scheduling platform. This work includes building and coordinating pools of trained volunteer drivers to help get people where they need to go. It also includes engagement of members beyond healthcare, from workforce, education, and civic interests. As Network partnerships strengthen and grow, so will this alliance's capacity to work together for better health and economic solutions.

Network Development

Participants representing more than 40 health care institutions and community stakeholders participated in a regional collaborative planning approach. This collaboration launched the Health and Wealth Network to address the health disparities and increase access to care across a nine-county region, including 39 rural communities. The Network envisions a future in which residents have resources and opportunities to thrive. Its inaugural Rides to Health and Wealth program demonstrates the Network's mission of connecting resources and building collaboration. The Health and Wealth Network governing body will consist of a volunteer executive committee, appointed committees, and task forces. The Network's operating staff will ideally include a Network Director, Regional Mobility Coordinator and Project Director.

Network planning was divided into two work groups. The Network Development work group focused on organizational components for the Health and Wealth Network while the Transportation Program group focused on community mobility coordination needs and opportunities for the Network's Rides to Health and Wealth program. Each work group met every other month. Participation in meetings was open to all. The coordinating project staff sought input from all participants on draft and final work products (Vision/Mission, Network Statement, Environmental Scan, Organizational Assessment, Goals/Objectives/Timelines, and operational details, including the governing structure, membership types, annual fee scale, and Network Bylaws).

Meeting discussions included tasks and timelines for relevant project staff and participants. The project team also understood participants were volunteers, taking care to honor their time commitment, which was essential to the process. Two additional members joined the Network during the planning year: Compass Health and Cedar County Memorial Hospital.

The coronavirus pandemic complicated the fourth quarter of the planning process with quarantines beginning in March 2020, making in-person work group meetings and other in-person outreach impossible. Core healthcare and community service partners were also forced to focus on immediate and mounting patient/client and organizational needs. Strategic planning work continued, nevertheless. All meetings and communications moved online. Work group participants remained engaged.

Programmatic Development

The prospect of improving both public health and rural economies with community mobility coordination brought a diverse set of partners together to explore collaborative development and implementation of a promising practice piloted by the Missouri Rural Health Association (MRHA) called HealthTran. This ride scheduling and resourcing platform uses cutting edge technology to support community mobility coordination, utilizing a volunteer driver network solution to fill gaps in existing options. HealthTran has proven significant return on investment for members. Such returns include cost savings and revenue improvements for struggling rural health clinics as more patients gain access to transportation needed to access primary and preventative care.

During the planning process, the project "Rides to Health and Wealth" was presented by the project team at events including the first statewide transportation convening by the Missouri Foundation for Health. The Network's purpose and progress was communicated through web blogs, newsletters, and social media.

As the Health Tran technology evolves in technology and development of volunteer drivers, the Network will see significant progress through building understanding and the broadening of transportation access to health care and social services. A pivotal planning moment was in identifying and working to overcome a common assumption that the Rides to Health and Wealth program amounted to competition in the rural transit arena. The project team was able to demonstrate and advance the program's *coordination* focus through several on-the-ground situations. The city of Nevada, for example, now has a task force with Network participants involved that is dedicated to exploring ways to better meet needs with existing and new transit resources. And, the senior citizen ride service in Butler is no longer in danger of collapsing after Network engagement broadened understanding of support available through community mobility coordination, including pending HealthTran options.

Further support for building the community mobility component of Rides to Health and Wealth came in spring 2020 through an 18-month contract with the Missouri Rural Health Association to serve as one of four regional mobility coordinators in the state. This both supports community mobility coordination in west central Missouri and connects the region into statewide activity and advocacy. Included is a new partnership with the MORides, a resource directory and ride coordination effort that covers most of the state. The Health and Wealth Network will help build MORides resources in the central and southwest region. Additionally, another statewide partnership is developing with Blue Cross Blue Shield of Kansas City (Blue KC), which will grant the Network the use of Healthify, a referral technology platform. Network members could utilize Healthify to create better understanding of medical needs in the region by sharing referrals then gather data about those referrals to community resources and medical institutions.

Network members will use their completed strategic plan to guide Network development and program implementation. Next steps include signup materials for an initial HealthTran enrollment period. This will kick off ride scheduling for early program users. It will also kick off associated organizing of a regional volunteer driver network and recruitment of other ride resources for scheduling, such as handicap-accessible vans operated by independent

living organizations. Initial program users will commit to providing data needed to evaluate the program's effectiveness in increasing access to care and improving health outcomes.

Sustainability

By the end of the Network's three-year development period (June 2020 to June 2023), Network members from all nine counties will enroll with an annual membership fee and annual program fees. This income will cover a baseline component of staffing costs. The Network Director will manage daily operations, staff, committees, and finances. The Network's varied membership fee structure will accommodate the diversity of member types, which includes smaller non-profit organizations, rural health clinics, larger for-profit medical institutions, and private community organizations. Other funding needed will come from

1. Local, state, and federal public transportation funding sources. The Network expects to secure such funding over time as it demonstrates the value of community mobility coordination combined with the HealthTran scheduling platform. It will work with regional planning partners to build this collaborative and coordinated approach into transit planning for counties served. It will also work through the emerging statewide regional mobility coordination network to advocate for this approach in state transit planning.
2. Community fundraising. As Rides to Health and Wealth grows, the Network will offer opportunities for local residents and organizations, such as banks and churches, to contribute funds that can help cover ride costs (e.g. a pool of funds for senior rides), as well as some program costs.
3. Private foundation support. The Health and Wealth Network will attract private grant funding over time as it demonstrates its effectiveness with metrics showing increased access to care, improved health outcomes, and relevance to other community concerns such as workforce support.
4. A growing and diverse membership. The Network will attract paying members beyond its initial focus on the healthcare and social service fields. Its Rides to Health and Wealth program will broaden its capacity and participation, serving employers, educators, local businesses, tourism and more.

To accomplish sustainability, including further funding, the Network will:

- Track program costs and patient-specific care costs to quantify Health and Wealth program benefits for anchor health care members and others.
- Communicate cost-benefit data, return on investment, and patient/rider results through ongoing outreach and communications.
- Convene annual transportation summits to build broad understanding and engagement of community mobility coordination and the Network's Rides to Health and Wealth program for connecting and advancing stakeholder interests.
- Maintain and build relationships and resources across the transportation value chain, from *demand* partners such as hospitals, *supply* partners such as public transit, and *support* partners such as community foundations.

Region Covered by Network Services

County/State	County/State
Bates, Missouri	Hickory, Missouri
Benton, Missouri	Morgan, Missouri
Cass, Missouri	Polk, Missouri
Cedar, Missouri	St. Clair, Missouri
Henry, Missouri	Vernon, Missouri

Network Partners

Organization	Location	Organization Type
West Central Missouri Community Action Agency	Appleton City, MO	Non-Profit
New Growth Community Development Corporation	Osceola, MO	Community Development Organization
Kaysinger Basin Regional Planning Commission	Clinton, MO	Government
Golden Valley Memorial Hospital	Clinton, MO	Hospital
Nevada Regional Hospital	Nevada, MO	Hospital
On My Own, Inc.	Nevada, MO	Non-Profit
Polk County Health Dept.	Bolivar, MO	Public Health
Vernon County Health Dept.	Nevada, MO	Public Health
Vernon County Ambulance District	Nevada, MO	Emergency Medical Services (EMS)
Cedar County Memorial Hospital	El Dorado Springs, MO	Critical Access Hospital (CAH)
Compass Health	Clinton, MO	Federally Qualified Health Center (FQHC)

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Nebraska

South Heartland District Health Department
Rural Behavior Health Network

P10RH33052

Project Focus Area: Behavioral Health

Other Focus Areas: Network Organization/Infrastructure Development
Workforce Development

Network Statement

Mental health impacts a person's ability to maintain good physical health, healthy families and interpersonal relationships and is strongly associated with the outcome and recovery of chronic diseases, such as diabetes. In the South Heartland District, we are experiencing soaring rates of suicide, depression, and risky behaviors, such as substance misuse among adults and youth. Good mental health is essential for a person to live a healthy and productive life.

Partners in the South Heartland Rural Behavioral Health Network are working together with a goal to create system change throughout our four-county area that is resilient, productive, and successful. The system change promotes healthy relationships at work and home. The network partners have expertise, connections, and passion for this vision. Building upon this momentum and passion, the network is eager to launch evidence-based practices in the clinical, community and school settings to shift the mental health status in the area and engage more partners to join the cause.

Network Development

The South Heartland District Rural Behavioral Health Network functions as a group of partner agencies bound together by a formal MOU, mission and vision statement, and shared goals. The network works collaboratively across a four-county region to identify areas of behavioral health needs and address them systematically.
The partners have a history of working collaboratively together, but this is the first time all partners are working toward shared vision/mission and goals. While the network partners grapple with the mechanics of working on a common project, the development of the strategic plan with specific goals and strategies will assist network members in realizing the value of collective impact and drive the group collectively towards the mission/vision and goals set thus far. Partners have repeatedly acknowledged that they are committed to systematic, collective change in behavioral health in the four-county region yet have difficulty knowing exactly how they contribute to this project absent a strategic plan.

In the beginning of the year, the group identified that they work best face-to-face, a well ingrained culture in Nebraska. However, the COVID 19 pandemic has forced innovations in moving this work forward for network members. Face-to-face meetings became impossible due to strict social distancing. The network members continued to meet and collaborate using online video conferencing, conference calling and email. Several network development tasks were completed through virtual communications.

Programmatic Development

To inform program development, network members completed a robust behavioral health needs assessment by way of collecting secondary and primary data (i.e. surveys of local providers and consumers). Collaboratively, the network members developed a survey to assess the perceptions of the local providers and consumers around access to and awareness of behavioral health services and needs/gaps. The survey was distributed to all primary care and behavior health providers (N = 159) in the four-county region to which 135 providers responded. Additionally, the survey was distributed, through each network agency, to consumers (N = about 650) to which 139 consumers responded. While all network members have worked in the behavioral health field for several years, many members were interested in learning about the similarities, needs and gaps of the local providers and consumers. The data provided the network with a picture of their current opportunities to improve the access and education across the district. The data was used to develop the strategic plan.

The network members valued the collaborative opportunities the network offers but struggled with the "network goals"- what specifically is the network tasked to do. The network struggled with this concept the entire planning year and was unable to complete a pilot project because of this. However, the network members feel the strategic plan will address this challenge.

During the data collection phase of program development, network members were innovative in how they collected comprehensive data. Network members drew on their relationships with other agencies to request survey distribution, local data statistics, availability of behavioral services and behavioral health reach throughout the four-county region. The network developed a "script" when talking to outside agencies describing why they needed the data being requesting. All network members collected at least one piece of data from an outside source.

Sustainability

Sustainability of the network has been considered from the beginning of this grant by each member. Each network member has committed their time and agency to continue to work towards the shared mission/vision and carry out the strategic plan in the coming years. The network applied for OPIOID funding (a need identified through the needs assessment) to help support the network develop and grow. Network members will consider expanding to other agencies to leverage program goals and resources, as needed. SHDHD will continue to lead the meetings for the near future, but as the goals and objectives are developed and implemented, there may be other agencies suited to lead the efforts. Network members will likely have other ideas for sustainability once strategic planning is completed. Each of the network members has stated the value of the network. Although the future services/programs the network will offer is unknown, the partners are committed to the work mission and vision of the network.

Region Covered by Network Services

County/State	County/State
Adams County, NE	Nuckolls County, NE
Clay County, NE	Webster County, NE

Network Partners

Organization	Location	Organization Type
South Heartland District Health Department	Hastings, NE	Public Health
Mary Lanning Healthcare and The Lanning Center for Behavioral Services	Hastings, NE	Hospital
Brodstone Memorial Hospital	Superior, NE	Hospital
Quality Healthcare Clinic, LLC	Sutton, NE	Other
South Central Behavioral Services	Hastings, NE	Behavioral Health

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New York State

Council on Addiction Recovery Services, Inc. (CAReS)
Appalachia Recovery Coalition

P10RH33042

Project Focus Areas: Network Organization/Infrastructure Development

Other Focus Areas: Behavioral Health
Mental Illness/Mental Health Services
Substance Abuse/Addition-Opioid
Substance Abuse/Addition-Other than Opioid

Network Statement

Substance use disorders and mental health difficulties continue to increase at alarming rates in our community. One out of 10 people experience severe problems and the numbers keep growing. With this in mind, a group of key agencies in Allegany and Cattaraugus Counties recently came together to form The Appalachia Substance Use Disorder and Mental Health Services Coalition. These committed and like-mind agencies understood that it was critical to come together with a common goal to combat substance use disorders and mental illness in the two-county area.

Through ever increasing cooperation, the Coalition intends to strengthen local services through a set of comprehensive collaborative activities addressing staffing needs, prevention, treatment, and recovery capacities, and most importantly, coordination of care. Specific impacts targeted over the next several years address substance use and opioid use disorders and include:

- Expanding professional training programs on new, more effective forms of care
- Monitoring and improving coordination of care across behavioral health, health and community services affecting law enforcement, schools, housing, and employment
- Preventing substance use disorders and examining the impact of marijuana legalization in our community

The Coalition has already been awarded funding from the federal government to plan for a two-county joint multi-agency response, which reflects extensive cooperation between agencies in the past.

The Coalition intends to combat these disorders through joint action designed to more successfully secure funding for assessing community need and operating needed improvements, sharing resources and cutting administrative costs, and effectively demonstrating the value of local services to third party payers and government funded programs.

Network Development

The Coalition has reached a consensus on many operational principles that will be formalized during the next three months. Perhaps as importantly, considerable attention has been placed on external organizations' awareness and perception of the Coalition and its purposes with a concentration on its role as a voice and advocate for responsive substance use, opioid use, and behavioral health disorders in the two-county area. To further an understanding of the Coalition, it changed its name to the Appalachia Recovery Coalition with the subheading of Serving Allegany and Cattaraugus Counties, New York. The previous name, the Appalachia Substance Use Disorder and Mental Health Services Coalition, was viewed to be overly general and cumbersome and thereby an obstacle to effective

communication. The addition of the term “Recovery” was critical in that it emphasized the importance of *Recovery* as a fundamental goal of the service system operated by its members in the Allegany and Cattaraugus Counties area. In the western New York region in which the two-county area is located, there is a long-standing history of multi-organizational collaborative efforts, such as regional task forces, formal multi-hospital and primary care health care systems, and community alliances and networks. All of the Coalition partners are engaged in numerous “networks” and the need for an additional network was as a result approached cautiously. Coalition buy-in to the network concept was accomplished through a gradual recognition of its most important functions and how they complement rather than duplicate or compete with other network relationships. The general recognition of the uniqueness of the Coalition was cultivated in part by the application of CRL Consulting, External Environmental and Organizational Assessment tools and the recognition of the need for the two county SUD/OUD/BH “voice” as substantive influential input into the development of services in the area.

Programmatic Development

Program development is in its early stages and has been aided by a Shared Services Needs survey completed in April. Essentially, members were surveyed through Survey Monkey on their perceptions of the most needed services the Coalition should consider providing. The Survey covered four major types of programs: Community Access Roles, Economic Development, Health or Behavioral Health Services and Administrative Supportive Programs. These contained a total of 66 different types of programs and partners were asked to rate the programs based on 1. Member Capacity to Share, 2. Member Interest in Developing/Accessing Shared Service or 3. No opinion. Thirteen of the 66 individual programs received the highest ratings with the majority addressing supportive administrative services (6) and community access roles (5). These results are currently under review and will be addressed in the forthcoming Strategic Plan. The Strategic Plan will set the stage for Network Sustainability by focusing attention and energies on Coalition programs and services which represent the highest potential for financial support.

The design of questions in the Shared Services Survey is noteworthy. A major concern of members is that Coalition services do not duplicate existing service capacities of members and hence the network becomes a competitor to its members. Services with high scores for capacity to share are those services which may be “offered” through some type of Coalition mechanism but not necessarily operated by the Coalition itself, rather they would be operated by a Coalition member. There are several examples of existing shared services between individual members of the Coalition. Newly developed Coalition shared services would not disrupt those relationships and may offer the opportunity to expand them to additional members.

Sustainability

COVID-19 has impacts beyond population health in that state funded programs. Even those programs that directly support patient or client services programs are in jeopardy to some degree, casting a shadow on the relevance of “administrative” or “community access” non-patient services networks can provide. Hence, the environment for financial support for networks is increasingly competitive and network value or community benefit becomes paramount.

These areas will be thoroughly explored during the subsequent months of the infrastructure planning project. Typical methods will include developing statements on the value of the network, developing lists of potential sources of support from local, regional and national foundations, health care insurance companies, managed care administrative entities and local, state and federal government and developing proposal templates featuring components that focus communication on benefits or impact valued by funders, rather than communication which seeks to persuade them to fund a program outside their scope of giving.

Region Covered by Network Services

County/State	County/State
Allegany County, NY	Cattaraugus County, NY

Network Partners

Organization	Location	Organization Type
Council on Addiction and Recovery Services, Inc. – CAReS	Olean, NY	Non-Profit
Allegany Council on Alcohol and Substance Abuse, Inc. - ACASA	Wellsville, NY	Non-Profit
Southern Tier Health Care System, Inc. - STHCS, Olean, NY	Olean, NY	Non-Profit
Allegany County Community Services	Wellsville, NY	Government
Allegany County Public Health	Belmont, NY	Public Health
Cattaraugus County Community Services	Olean, NY	Behavioral Health
Clarity Wellness Community, Inc.	Wellsville, NY	Behavioral Health
Cattaraugus County Public Health	Olean, NY	Public Health

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North Carolina

Granville-Vance District Health Department
Integrated Care Planning Network (ICPN)

P10RH33814

Project Focus Areas: Integrated Health Services

Other Focus Areas: Behavioral Health
Network Organization/Infrastructure Development
Telehealth

Network Statement

Granville-Vance Public Health (GVPH) has been the structural glue of our rural network of health improvement initiatives. Through their Stepping Up Network they have engaged law enforcement and government supports in facilitating mental health interventions in lieu of, or in conjunction with, individuals within the correctional system. GVPH's Vibrant coalition has joined harm reduction supports with local providers and primary care, while community case management is taking a team approach to intervening with the communities most vulnerable individuals.

As our community resources have utilized these avenues to connect in novel ways, it is the goal of this planning grant to move our network beyond that of collaborative communication to a level of co-located integration. We have begun this process by identifying collaborative partners across primary care, hospitals, and mental health disciplines. As our resources grow and we expand our partnerships our efforts will focus on researching models for integration, assessing community need, finding supports for sustainability and exploring the feasibility of expanding our existing telemedicine network.

Network Development

Granville-Vance Health Department (GVHD) has been the heart of our rural network connection for years. GVHD has championed the establishment of our Five County Stepping Up initiative uniting five counties in the mission of reducing the amount of Mental Health individuals within our rural jails and has organized a V.I.B.R.A.N.T. Coalition promoting Harm Reduction across schools, police, and provider connections. The largest challenge rural networks face is access to information and resources. Our network has been able to identify multiple barriers to access throughout our system over the years. In response to these breakdowns, grants have already been utilized to lay the foundation for a telemedicine network connecting Vance, Granville, Warren, and Franklin County Health departments. This remote connection will decrease the distance between residents and providers, increasing compliance with medical care and allowing residents access to Medication Assisted Treatment that is currently not available in those areas.

With the award of this Grant and the existing foundations of these established relationships, goals and resources, it was a natural step for the network to identify key providers, stakeholders and manage care organizations to support in the expansion of our mental health integration within our greater network. Navigating this expansion has been a slow process. As stated before, the largest barrier in working with rural is access and this has certainly been a multi-step hurtle to cross. Our provider pool is limited, and often the individual participating within our collaboration meetings is also maintaining a caseload of their own resulting in the need for strategic scheduling and breaking down into more frequent smaller meetings to produce progress.

Access barriers for us also includes access to funding. Our Network has worked diligently over the years toward fairly similar and overlapping goals. This has given us the advantage of being able to pull from past resources and building

on pre-existing opportunities. This includes a community reinvestment grant provided by our local LME that will support in moving our health department to a new location more conducive for behavioral health and hospital integration. Our Network has also been able to pull in a new practice that has investment funding for its own expansion and is willing to structure their growth plan in such a way that it can accommodate the integration of GVHD led primary care.

Programmatic Development

At this time, our network is piloting our telehealth network between its existing Granville Health Department and Vance Health Department Clinics. Both clinics have similar operations as the health departments are jointly funded and operated. Both clinics are also managed by the same medical director, Dr. Shauna Guthrie. This pilot has allowed us to develop and smooth out policies, experiment with work flows and orient staff to the new system. In the next phase of our roll out, we expect to include one of our other Health department partners, integrating Medication Assisted Treatment into pre-existing primary care establishments.

Our Behavioral Health Provider, Innovative Behavioral Health, is working toward generating a MOA with the Health department to support in assessments and eventually allow for a fully bridged telehealth connection. They are also in the process of moving forward with their own clinic expansion in the south end of Granville county. Thus far, financing has been established and a preliminary blueprint for construction has been drafted. Design of the space has been made with integration principles in mind. All Clients will enter the same lobby to promote anonymity in a rural neighborhood where mental health and substance use treatment is taboo. The space will also be made in such a way that its utility can evolve, and future additions can be made to the property. As for our other location change for the Health Department, a location has been established that will work in tandem with Granville County Medical Center and a deadline has been set, but we have had set backs in establishing a moving date and will need to generate a strategic moving plan to minimize breaks in client care.

Sustainability

Beyond the Planning Grant, our network has researched telemedicine billing policies and intends on the program becoming self-sustaining. Resource maintenance has also been factored into our technology choices. Our telemedicine program functions on an internet platform that is both HIPPA compliant and Free. This will give us a longevity boost in that it can be operated on client's home technology or on computers that the state naturally budgets for upgrades for over time.

Our network has also made a point of making partnerships early on with our local managed care entity. Our crisis center, RI Internationals' Recovery Response Center, is already in talks with them around contract addendums that will support continued integration through increasing access with Peer Support and increasing the capacity and scope of practice of their facility-based crisis center.

We also expect our business plan to evolve over time as funding sources shift. Telemedicine could potentially evolve to a home -> provider link, reducing the need for building space to host patients, and reducing the need for staff. We also believe our network is likely to require a new partner evaluation as we encounter new barriers and opportunities for expansion/optimization.

Region Covered by Network Services

County/State	County/State
Granville County, NC	Franklin County, NC
Vance County, NC	Warren County, NC

Network Partners

Organization	Location	Organization Type
Granville-Vance Public Health	Henderson and Oxford, NC	Public Health
Recovery Innovations (RI) International Henderson Recovery Response Center	Henderson, NC	Non-Profit
ARC (Alliance Rehabilitative Care)	Henderson, NC	Behavioral Health
Cardinal Innovations	Henderson, NC	Medicaid Managed Care Organization
Innovative Behavioral Health	Creedmoor, NC	Physicians' Clinic

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OHIO

Hopewell Health Centers
Partnership to Achieve Compliance and Savings (PACS)
P10RH33045

Project Focus Areas: Reimbursement for Health Services

Other Focus Areas: Care Coordination
Chronic Disease Management-Diabetes
Chronic Disease Management-Other than Diabetes
Population Health/Social Determinants of Health

Network Statement

Southeastern Ohio has substantially higher rates of chronic diseases and significantly higher use of health care resources. Community Health Workers (CHWs) have demonstrated impressive results helping people control their chronic conditions but there are currently no payment mechanisms to sustain CHW services. CHWs are peers and are much less intimidating to the patients. The power of CHWs does not come from teaching patients what they need to do but in the relationships that form between patients and the CHWs. The patients improve their habits because the CHWs care about their health. There is increasing interest among government and insurance representatives to determine whether health improvements translate into savings and whether payment models can be developed to share those savings to sustain services delivered by CHWs.

The Partnership to Achieve Compliance and Savings (PACS) is investigating the impact of CHWs in reducing health care costs both by helping individuals to control their chronic conditions and by assisting individuals without a primary care physician to find one. Our partnership includes health departments, a regional Federally Qualified Health Center (FQHC), a regional AmeriCorps program, professional advocacy agencies, a major university, and several insurers. It is informed by the work of our Community Health Workers and the patients we serve. We will follow patient progress as CHWs help them with compliance strategies, nudge them down the road to better health, and act as their advocates and intermediaries to overcome cultural mistrust of institutions. It is only when health plans can calculate savings that we can expect reimbursement for CHW services. PACS is intent on showing that services delivered by CHWs will produce better health, reduce cost, benefit local economies, and improve systems of care for our most fragile residents in Southeastern Ohio.

Network Development

The Partnership to Achieve Compliance and Savings (PACS) was formed to finally break the paradigm of “when there are grants, there are Community Health Workers (CHWs), and when the grants go away, so do the CHWs”. CHWs have demonstrated remarkable success when aimed at the highest-risk populations. The model we are expanding/replicating has already demonstrated an average A1C reduction in SE Ohio of 2.5 points (CHWs based at the Washington, Athens, and Meigs County health departments). CHWs form relationships with patients, remove barriers to compliance, and assist with strategies to live a healthier life. Unfortunately, Health Plans are not able to sustain CHWs based on health improvements. They need to know what the service saves.

Determining savings due to CHWs requires a sustained effort over many years. PACS was formed to make that effort. PACS is a vertical partnership of local health departments (Washington, Ross, Meigs, and Athens), a Federally Qualified Health Center (Hopewell Health Centers) to coordinate a regional effort, and Health Plans. When the first MOU was developed between the partners, the only Health Plan that had signed on was United Health Care. One of our major successes was the addition of two more Health Plans (Molina and The Health Plan) during our planning

grant year. Another success has been the passion and commitment each member of PACS has shown to the mission of determining the savings due to CHWs.

The overriding challenge to working with CHWs is fielding them. It is expensive to hire full-time, benefited employees of health care providers. Our solution has been to use AmeriCorps members as CHWs. AmeriCorps is a Federal program that is often called the domestic version of Peace Corps. We can field seven or eight AmeriCorps CHWs for what it would cost to employ one. Nevertheless, until reimbursement is established, grant funding will still be a key to success.

The most important "innovation" developed by PACS is starting with the end in mind. As a result, we have courted insurance participation from the start of the project. If we had any advice to give programs that are looking to have insurers contribute to sustainability, it would be to make relationships with them early and get them involved early.

Programmatic Development

PACS has made great strides to position itself to immediately implement Community Health Worker-based Chronic Care Management (CHW-based CCM). The AmeriCorps program is in place and will be able to provide 10 CHWs. The appropriate CHW trainings have been developed and tested. The prospective CHW sites have had the chance to test the use of CHWs. The CHW-based CCM model has been tested, replicated across multiple SE OH sites, and has been equally successful everywhere. We are ready for a large-scale demonstration with the help of our Health Plan partners.

COVID-19 has delayed some of the issues beyond CHW-based CCM that we had hoped to investigate. PACS had hoped to also explore Pathways Hubs and to test ways to reengage insurance members attributed to Hopewell but whom Hopewell did not know. These two issues will be investigated in the future with PACS, and both represent additional opportunities for sustainability of CHWs.

Sustainability

It will be difficult but possible to continue the work of PACS without additional grant support. AmeriCorps allows us to field CHWs cheaply, and that is essential at this time. There are alternative ways of funding further work with insurers. Effectively addressing attribution (insurance members who a Health Plan says is a patient of Hopewell but who has not been going to Hopewell for care) could be valuable to Hopewell and to insurers. Hopewell's HEDIS measures will improve with effective reengagement of this population, which will increase their revenue and could then be shared for the service. These mis-attributed members are also high cost for insurers. If that cost can be reduced, the savings could also be shared. Establishing Pathways Hubs will also help fund CHWs. The concern with either of these scenarios is that it takes the focus off the CHW-based CCM model, so it will be harder to end up demonstrating savings to insurers.

We all believe there is value in PACS. We believe we will find a way to sustain this collaborative, continue to meet, and continue to find opportunities to develop programs that save insurers money, which could lead to program sustainability.

Region Covered by Network Services

County/State	County/State
Athens County, OH	Ross County, OH
Meigs County, OH	Washington County, OH

Network Partners

Organization	Location	Organization Type
Hopewell Health Systems	Chillicothe, OH	Federally Qualified Health Center (FQHC)
Marietta/Belpre City Health Department	Marietta, OH	Public Health
Ross County Health Department	Chillicothe, OH	Public Health
Athens County Health Department	Athens, OH	Public Health
Meigs County Health Department	Pomeroy, OH	Public Health
The Health Plan	Wheeling, WV	Medicaid Managed Care Organization
Molina Healthcare	Long Beach, CA	Medicaid Managed Care Organization
United HealthCare	Columbus, OH	Medicaid Managed Care Organization
Ohio Alliance for Innovation in Population Health	Athens, OH	Public Health
Community Health Improvement Associates	Marietta, OH	Public Health

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Oklahoma

Rural Health Network of Oklahoma
Oklahoma Primary Healthcare Extension System (OPHES)

P10RH33051

Project Focus Areas: Network Organization/Infrastructure Development

Other Focus Areas: Behavioral Health
Integrated Health Services
Workforce Development

Network Statement

The Oklahoma Rural Health Development Initiative (ORHDI) serves as an intentional continuation of grassroots efforts launched in 2010 to support the improvement of health outcomes for rural Oklahomans. Oklahoma's health and social outcomes consistently rank among the worst in the world. However, partnerships exist across the state that are ready to be mobilized for change. Currently lead by the Rural Health Network of Oklahoma (RHNOK), the ORHDI supports over 40 rural counties through formalizing the structure of the Oklahoma Primary Health Care Extension System (OPHES) through partnership, coordination, and data-driven solution making. Focused on the improvement of efficiencies in both traditional and non-traditional health care settings, members of the RHNOK aim to address the unique physical, behavioral, and social needs of rural communities. Moving forward, both RHNOK and OPHES will continue to synergize and combine efforts to strengthen the infrastructure of primary and behavioral health care across Oklahoma.

Network Development

During this year, partners have achieved the goal of establishing OPHES as a cohesive, rural based network focused on improving healthcare outcomes and strengthening delivery systems to improve efficiencies and increase access to care in a minimum of 50% of the County Health Improvement Organization (CHIO) certified counties. A major strategy has been the coordination and strengthening of the disparate members of the OPHES, of which Rural Health Network of Oklahoma is a founding member. Partners include traditional and non-traditional health care service providers and state agencies. During this year, we have been deploying a first of its kind, coordinated approach to organizing health care in rural Oklahoma aimed at the following:

1) improving access and quality of health care in rural areas through sustainable health care improvement programs through the coordinated efforts of localized experts working across the OPHES to align readiness and capabilities with opportunities, including workforce.
2) preparing rural health care networks for future value-based payments and population health management projects through clinical and community readiness activities.
3) demonstrating improved health outcomes and community impact through the investigation of health outcomes among communities/counties participating in coordinated health improvement activities.
4) developing and deploying diverse products and services to promote sustainable health care practices within network participants, through localized solutions with OPHES partners.
5) utilizing evidence-based strategies across traditional and non-traditional health care environments to support the adoption and adaptation of localized interventions.

These efforts were supported through coalition efforts with CHIOs, which meet a minimum of once monthly to conduct activities.

The only challenge we have faced is the pandemic. The progress for formalizing the new network, OPHES, has been right on track up until the COVID-19 pandemic shut down the state of Oklahoma after March 2020. We continued to work remotely, as possible. A couple of our key leaders were furloughed, so they were unable to do much. Our focus has been diverted to helping our healthcare system handle the changes due to the virus. We have been working with them to set up telehealth, getting help applying for aid from the federal government, getting PPE supplies, and handling the public. This has been a great opportunity for our rural communities to see how important it is to have plans in place for such an event. We are overcoming the challenges by keeping in touch remotely and keeping everyone informed on what was going on within the state.

Development of the CHIOs and developing the partnerships with universities and the state are innovations that would be particularly helpful to other communities. Rural does not always have a voice. By being more prepared and working together through OPHES, we are able to have that voice.

Programmatic Development

While we have done much of the development of the network, we are a little behind on the education and capacity-building activities at this point. Focus of these activities include cardiovascular risk reduction efforts, substance abuse and opioid management, data practices, telehealth adoption, coalition building, partnership development, community needs assessments, evidence-based strategies for population health, and service delivery models.

We were unable to complete the education and capacity-building activities due to the COVID-19. The meetings that we had planned were not all done due to some of our partners and CHIO members being furloughed. Our focus was diverted to helping our healthcare system handle the changes due to the virus. We worked with them to set up telehealth, getting help applying for aid from the federal government, getting PPE supplies, and handling the public. State restrictions are releasing in phases and we are continuing to plan for the education and capacity-building activities. We will need to assess how well our education and activities performed in preparation for picking back up to share with other communities. We filed for a no-cost extension for six more months to give help us to get back on track due to the pandemic. We will know more as we progress during the next phase of the state opening.

Sustainability

The OPHES network will continue to develop as the partners that were involved in this grant are dedicated to continuing the effort. We will continue to look for funding to hire a full-time director. In the meantime, the partners will pay part of the salary of the director to advance the network forward.

With the Universities and other partners involved, the services and programs will continue to occur each year. All elements of the program will be sustained.

Region Covered by Network Services

County/State	County/State
Texas, OK	Payne, OK
Alfalfa, OK	Creek, OK
Grant, OK	Tulsa, OK
Garfield, OK	Washington, OK
Blaine, OK	Delaware, OK
Kingfisher, OK	Cherokee, OK
Logan, OK	Sequoyah, OK

County/State	County/State
Jackson, OK	Coal, OK
Stephens, OK	Atoka, OK
Jefferson, OK	Latimer, OK
Marshall, OK	LeFlore, OK
Bryan, OK	Pushmataha, OK
Choctaw, OK	McCurtain, OK

Network Partners

Organization	Location	Organization Type
Rural Health Association	Enid, OK	Non-Profit
Public Health Institute of Oklahoma	Oklahoma City, OK	Non-Profit
Rural Health Network of Oklahoma	Hugo OK	Non-Profit
Oklahoma State University CHSI	Tulsa, OK	College/University
Oklahoma University	Norman, OK	College/University
Community Service Council of Greater Tulsa	Tulsa, OK	Community Development Organization
Oklahoma Foundation for Medical Quality	Oklahoma City, OK	Non-Profit
Oklahoma State Department of Health	Oklahoma City, OK	Public Health
Oklahoma Department of Mental Health	Oklahoma City, OK	Behavioral Health
Oklahoma Area health Education Centers	Tulsa, OK	Area Health Education Center
Oklahoma Health Care Authority	Oklahoma City, OK	Public Health

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South Dakota

Coteau des Prairies Hospital
Sisseton Area Health Network (SAHN)

P10RH33041

Project Focus Areas: Care Coordination

Other Focus Areas: Network Organization/Infrastructure Development
Population Health/Social Determinants of Health
Substance Abuse/Addiction-Opioid
Substance Abuse/Addiction-Other than Opioid

Network Statement

Together, we will make the Sisseton Area a healthier community.

The Sisseton Area Health Network (SAHN) was established in 2020 bringing together community leaders and healthcare providers to develop strategies for improving the health of our community. The SAHN completed a review of our Community Health Needs and identified a significant rate of prenatal substance abuse. Prenatal substance use is a critical public health concern that is linked to several harmful maternal and fetal consequences.

Based upon this identified priority, the SAHN formed an alliance of healthcare, educational, tribal, and community service providers working together to create a coordinated prenatal care initiative modeled on an existing taskforce through the Sisseton-Wahpeton Oyate. This is an opportunity to establish a community-wide strategy integrating education, screening, and treatment for addiction, behavioral health, and recovery support services into the healthcare plans for expectant mothers and fathers. We are encouraged by the momentum of our combined efforts to assure that mothers and infants have optimal potential for lifelong health.

Network Development

The SAHN Board members are comprised of diverse group of community healthcare, Indian Health Services, Tribal Healthcare, education, community housing, public health, and community action. Members of this diversity have signed and/or committed, for the first time, to a Memorandum of Understanding (MOU) aligning commitment with purpose and scope. The SAHN has adopted a Vision Statement with Preamble and Mission Statement.

A solid network structure of consistent SAHN Board and Steering Committee meetings, agenda and planning tasks has sustained a focus and purpose for the members. Through an assessment of our relationship with each other strengths and opportunities, members have been identified similar and unique community needs for further development with each other and stakeholders.

Programmatic Development

The SAHN Board has leveraged existing materials, an environmental scan, and organization assessment to determine strategic direction. Identification and agreement with a priority focus area of pre-natal behavioral healthcare and substance misuse has been determined. Goal development has led to formation of Clinical Transformation Committee to define care coordination objectives, resources, measures of success and action plans.

Sustainability

The SAHN Board members have committed to extend the MOU and allow time into 2021 for action planning and beginning a phase of implementation of a care coordination model. All members have expressed a new understanding, value, and importance from the work of SAHN network and commitment to improving the health of community.

Region Covered by Network Services

County/State	County/State
Roberts County, SD	Day County, SD
Marshall County, SD	Traverse County, MN
Richland County, ND	

Network Partners

Organization	Location	Organization Type
Coteau Des Prairies Hospital	Sisseton, SD	Critical Access Hospital (CAH)
Tekakwitha Living Center	Sisseton, SD	Skilled Nursing Facility
Sanford Research	Sioux Falls, SD	Non-Profit
Sanford Health Network	Sioux Falls, SD	Non-Profit
Grow South Dakota	Sisseton, SD	Non-Profit
Woodrow Wilson Memorial Health Center	Sisseton, SD	Tribal Health Clinic
Sisseton Wahpeton Oyate	Sisseton, SD	Tribal Nation
Sisseton Public Schools	Sisseton, SD	School System
Robert County Community Health	Sisseton, SD	Public Health
CDP Board Member	Sisseton, SD	Other

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Washington

Adams County Public Hospital District No. 2
Grand Columbia Health Alliance

P10RH33035

Project Focus Area: Increase Health System Efficiencies

Other Focus Areas: Care Coordination
Chronic Disease Management – Other than Diabetes
Population Health/Social Determinants of Change
Workforce Development

Network Statement

Each of seven public hospital districts (PHDs) in the fast growing, aging and increasingly diverse Columbia Basin region of Washington is the sole provider of acute care and emergency services in their respective communities. The vast majority also provide the predominance of primary care for their community. For much of the region, the next-higher level health care resource is more than 90 minutes away. Our residents repeatedly tell us that they expect more care locally, and they also want assurance that their valued, local rural health services are stable and strong.

In 2017, the PHDs formed the Grand Columbia Health Alliance (GCHA). Our goal is to address resident needs and expectations by improving access to care and reducing costs through sharing services, staff, and programs. GCHA has already reduced costs and produced efficiencies by consolidating several services. We are also developing a cardiology service, which is the #1 identified reason that residents leave the region for care. We are determined to continue to build on the unique "DNA" we share as PHDs. We are confident in our ability to advance the delivery of innovative, genuine, and community-devoted care that will support our region in realizing a future where needed services are local and operated by strong, viable PHDs.

Network Development

During the first quarter of the planning grant, an attorney provided the members with organizational/ legal structure options for our network and provided members a series of questions to address prior to selecting the option best suited for our network. We have since done a "deep dive", first on a Community Health Needs Assessment and then on the strategic plan. The data collected has allowed us to set priorities that are reflected in our strategic plan. We are now ready to work with the attorney to determine the best structure to support the priorities from the strategic plan and to finalize how the Network will be permanently structured.

We enjoy exceptionally high trust among our members, and so the challenges we faced, until COVID, were relatively few. COVID has caused significant volume and cash flow problems for our member hospitals, and this has temporarily required the members to re-focus on their respective organizations. That said, our strategic planning priorities include cost-savings and shared services programs, which should help each member.

The time invested in developing personal relationships, reaching consensus on purpose, and building trust have proven to be essential in reaching consensus on our priorities.

Programmatic Development

We have focused on our strategic plan and will commence our business planning on programs that help keep patients locally (reduce unnecessary outmigration) and help members realize financial stability. Our priority new service is a centralized cardiac clinic and basic diagnostic capabilities at each member hospital. COVID has brought to the forefront the benefit of telemedicine, and we are preparing and submitting a CARES Act COVID grant that will allow for virtual primary care visits at each hospital as well as specialty consults between hospitals. In terms of shared savings, we are prioritizing consolidating billing, coding and equipment maintenance as well as developing a shared delegated credentialing program.

Our primary challenge was the time needed to collect data that so that our financial consultant could evaluate the financial impact to each member. That work has been completed and agreed on by the members.

Sustainability

We are highly confident that the Network will exist for many years to come, as each member is already realizing benefits. We have agreed that only contiguous public hospital districts can be full members (Class A), and that we will establish a Class B level of membership for like-minded Public Hospital Districts and other entities serving our communities so that they can participate in certain efforts.

The financial analysis demonstrated that the dollars associated with billing, coding, etc. exceeds $1.5 million, and the new revenues associated with cardiac diagnostics and a clinic approach $500,000 annually. We also began a shared care coordination training, and to date, members have billed more than $75,000. We expect to identify one to two projects annually where there is shared value between all members. A percentage of the savings from each initiative (the “Return on Investment”) will be reinvested in the GHCA. We also intend to retain the nominal annual fee currently charged to Class A members and to establish a fee for Class B membership.

Region Covered by Network Services

County/State	County/State
Adams County, WA	Grant County, WA
Lincoln County, WA	

Network Partners

Organization	Location	Organization Type
Columbia Basin Hospital	Ephrata, WA	Critical Access Hospital (CAH)
Coulee Medical Center	Grand Coulee, WA	Critical Access Hospital (CAH)
Odessa Memorial Healthcare Center	Odessa, WA	Critical Access Hospital (CAH)
Othello Community Hospital	Othello, WA	Critical Access Hospital (CAH)
East Adams Rural Healthcare	Ritzville, WA	Critical Access Hospital (CAH)
Quincy Valley Medical Center	Quincy, WA	Critical Access Hospital (CAH)
Samaritan Healthcare	Moses Lake, WA	Hospital

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Washington

Columbia County
Southeast Washington Health Partnership

P10RH33040

Project Focus Areas: Network Organization/Infrastructure Development

Other Focus Areas: Care Coordination
Telehealth

Network Statement

Demographics in rural communities are changing, presenting new challenges for local health care. Families are smaller, many young adults are moving away, resulting in a larger aging population, and that is certainly evident in our three-county area of Asotin, Columbia, and Garfield counties. The Office of Financial Management predicts the 65+ population across the three counties will increase an average of 14.4% between 2000 and 2030, with the greatest increase between the years of 2020-2030. This population shift causes concern for providers due to already tight reimbursements. As the 65+ population increases, school enrollment is decreasing. This results in local school districts receiving less funding for health services within their facilities. Lastly, because our counties are rural, patients frequently have to travel greater distances for specialty provider services.

Recognizing these changing demographics and realizing the potential benefits and impact of greater collaboration across county lines, the Southeast Washington Health Partnership (SEWAHP) was formed in 2017. With a shared vision of improving the health of our communities, the partnership has completed a health needs assessment in all three counties, as well as successfully securing several grants serving the three-county area. The partnership membership is continuing to grow as additional health providers are requesting to join the SEWAHP. We are excited for the future as we continue to share not only resources, but knowledge, bringing more effective programs, less duplication, telemedicine, and better coordination of services for our residents. We envision that our combined efforts will result in healthier communities and serve as a model for other rural areas across the state.

Network Development

The SEWAHP was formed in 2017. Since its inception, the partnership had been highly functional with a history of working well together. With the awarding of the FORHP Planning grant, discussion began of becoming a non-profit corporation in the State of Washington. In late 2019, bylaws were created. In addition, a Board of Directors was elected. Upon completion of these steps, our attorney applied to the State of Washington for this status. On May 1, 2020, the State of Washington has now recognized our partnership as a WA Nonprofit Corporation and issued our Articles of Incorporation.

However, there was a challenge during this process. Small challenge, but not one we expected. The State of Washington would not allow us to have the word “partnership” in our name and returned our original application. They cited our name could not include any reference to corporate formation, i.e. corporation, partnership, LLC. The Revised Code of Washington provides the following examples: “club," "league," "association," "services," "committee," "fund," "society," "foundation," "guild," ". . . . .., a nonprofit corporation,". Our Board of Directors discussed alternative names and decided upon Southeast Washington Alliance for Health.
We have now sent in the application for federal recognition. Once we receive approval, our accountant will apply to the Internal Revenue Service for our tax-exempt status. Once all is approved, we will begin operating under our new name.

We have strong attendance at our monthly meetings, and great response to any correspondence we send out. Our partners are committed. For other communities in the beginning stages of their network development, we would share one of the reasons our attendance is strong. Even prior to COVID-19, where everyone is now on Zoom, we have always set up our meetings for accessibility by Zoom or call-in. Covering a three-county area, our partners cannot always attend in person. However, when they cannot, it is convenient to call in. Because of this, we are able to remain efficient and continue in our work consistently.

Programmatic Development

Our partnership began its Planning grant work by collecting data. We have conducted a three-county Community Health Assessment, a telehealth needs assessment for our SEWAHP members, and several interviews with local agencies including hospitals, behavioral health, and other rural health providers. The purpose of the partnership survey and the one-on-one interviews was to determine how telehealth was currently utilized, noticeable gaps in both delivery and coordination, and the barriers to implement. Poor broadband in several parts of the counties is a significant barrier. Secondly, the possible lack of State transportation funding is a deterrent to get patients to needed services. Thirdly, reimbursements rates of telehealth services to providers are inadequate.

Our partnership was having these discussions through February 2020. However, our biggest challenge presented itself the first of March in which we put our discussions on hold, COVID-19. Washington State was one of the first hot spots for COVID-19 in the United States. Our partnership consists of all health care providers and officials, in some capacity. Our work was put on hold. Our members were all predisposed with the COVID-19 planning. We did not have our March meeting due to these circumstances. A No Cost Extension for one year has been requested to HRSA.

We have since resumed our meetings through Zoom and calling in. Our meeting attendance has been high. We believe having experienced this COVID-19 outbreak together will only enhance our planning for telehealth and care coordination direct services. In many areas, our counties were forced to jump ahead with telehealth. Many agencies were awarded with additional resources to provide these services, helping with both the hardware and the accessibility issues. As we move forward this next year, we all have a greater vision for expanding telehealth services in our three-county area.

Sustainability

The Southeast Washington Health Partnership is mid-way through formalizing itself as a Washington State Non – Profit Corporation. When it has received approval from the Federal government, we will begin operating officially as the Southeast Washington Alliance for Health. Having this ability to apply for both federal and private funding will enhance our sustainability. The partnership has worked effectively since 2017. The largest challenge to sustainability in most any organization is the commitment of the members. Our partnership has demonstrated this commitment since their formation.

Due to the challenge discussed earlier, COVID-19, we are still in the planning stages of our direct services. With the approval of the No Cost Extension, we will plan throughout this next for the sustainability of any new services we develop.

Region Covered by Network Services

County/State	County/State
Asotin, WA	Columbia, WA
Garfield, WA	

Network Partners

Organization	Location	Organization Type
Columbia Co. Public Health Department	Dayton, WA	Public Health
Columbia Co. Health System	Dayton, WA	Hospital
Columbia Co. Transportation	Dayton, WA	Transportaion
Blue Mountain Action Council	Dayton, WA	Community Development Organization
Blue Mountain Counseling	Dayton, WA	Behavioral Health
SE WA Aging and Long-Term Care	Dayton, WA	Area Agency on Aging
Columbia County Commissioners	Dayton, WA	Government
Garfield County Commissioners	Pomeroy, WA	Government
Garfield County EMS/Fire	Pomeroy, WA	Emergency Medical Services (EMS)
Garfield County Health District	Pomeroy, WA	Public Health
Garfield County Hospital District	Pomeroy, WA	Hospital
Molina Health Care	Pomeroy, WA	Medicaid Managed Care Organization
Quality Behavioral Health	Pomeroy, WA	Social Services Agency
SE WA Aging and Long-Term Care	Pomeroy, WA	Area Agency on Aging
Asotin County Health District	Clarkston, WA	Public Health
Asotin County Hospital District	Clarkston, WA	Hospital
CHAS Dental	Clarkston, WA	Oral Health
Lewis and Clark Early Childhood Ed Program	Clarkston, WA	School System
Quality Behavioral Health	Clarkston, WA	Social Services Agency
SE WA Aging and Long-Term Care	Clarkston, WA	Area Agency on Aging
Tri State Hospital	Clarkston, WA	Hospital
Greater Columbia Accountable Communities of Health	Kennewick, WA	Collaborative
Community Health Association of Spokane	Spokane, WA	Federally Qualified Health Center (FQHC)
Senator Patty Murray's Office	Olympia WA	Government

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Washington

Family Health Centers

Okanogan Palliative Care Initiative

P10RH33043

Project Focus Areas: Palliative Care

Other Focus Areas: Care Coordination
Chronic Disease Management-Other than Diabetes
Integrated Health Services
Network Organization/Infrastructure Development

Network Statement

Eighty percent of Americans prefer to die at home. Despite this, 60% of Americans die in the hospital, 20% in nursing homes and only 20% at home. We believe palliative care conversations can support patients, families, communities, and providers in providing best practices, reducing costs, and improving patient satisfaction. Palliative care includes physical symptom management, support for spiritual, psychological, and social needs of patients and their families, and connections to needed resources at any time or stage of a serious illness, up to and including the end of life.

Okanogan County Palliative Care Initiative aims to transform healthcare locally as we seek to empower clients to use their voice in creating conversations about living with serious illness, addressing hopes and fears, and eliciting their own expectations and goals of care while managing chronic health issues or the end of life. We have created a network of medical and non-medical agencies in our community to support improved quality of life. Our momentum is growing with increased awareness of palliative care services within the medical community and educational offerings to providers including end of life care, advanced care planning, and serious conversation training to aid in difficult conversations. We are excited to see the community response and acceptance of palliative care and the health benefits it contributes to our community.

Network Development

We have made substantial progress in our Network development. Through our planning grant period, we have engaged our 10 Network members to join our Clinical Services and Advanced Care Planning Workgroups which engage eight members/six agencies and nine members/four agencies, respectively. All 10 agencies meet every other month at an 'All Team' Palliative Care meeting to get updates and give input. We have involved all 10 agencies in a Strategic Planning process. We have recently added two new county-wide Network members, Aging and Adult Care and the Colville Tribes.

Challenges have included continuing to engage Network members and moving to a more formal arrangement with specific members. We have tried several strategies. First, we tried moving meetings around the county so more people would attend. This was not entirely successful. Second, when the Covid19 pandemic forced us to move to Zoom for meetings, we realized this is not only a way to reduce travel (a barrier to attendance) but also allows people to attend meetings on 'equal footing'. It is hard to conduct a meeting where some attendees are in person and some on Zoom. Third, we have done in-depth interviews using Zoom with our largest Network members (Hospice, Mid-Valley Hospital, two clinic systems) to explore opportunities to share resources as a way to deepen these partnerships.

Innovations have included the use of Zoom to hold meetings, which makes it easier for Network members from all over the county to attend. We have explored partnering with one large clinic system to use their electronic medical record, billing, and telemedicine platforms to facilitate patient care as well as allowing us to see patients referred to us from other Network members. With another member (large clinic system with a palliative care hospital program outside our county) we are sharing their access to Center to Advance Palliative Care (CAPC) training, which we could not afford to pay for on our own. Finally, we are developing other non-patient care offerings including advanced care planning (ACP) workshops and community and provider education to all Network members. We are expanding the number of people involved in this work by engaging Network members in specific activities.

Programmatic Development

Since the beginning of our planning grant, we have made good progress on three of our goals, including: 1) clinical services, 2) provider education, 3) community education and outreach. For clinical service development, we have identified eight clinical providers; developed a palliative care screening tool, an intake process, and ways to document our work; set up regular interdisciplinary meetings to review patients; and started enrolling some 'practice patients' to test our processes and tools. We are developing telemedicine capabilities to provide services. For provider education, we have identified content and begun an education program for our eight clinical providers, using 'on the job' training in addition to more formal training which is ongoing. For community education/outreach, we have done several public forums and newspaper articles on palliative care. We have developed and are rolling out ACP workshops across the county. ACP work includes training the trainers outside our core staff to expand this opportunity to more patients and reduce the burden on our core palliative care staff.

Challenges have included finding adequate time to do the planning work and figuring out the most practical and efficient way to deliver services across a large county. All our clinical staff have regular paid jobs, and as our work grows, having time to do this work is an increasing challenge. We have overcome this to some extent by securing additional funding to pay them for their extra time. One of our staff has resigned from her regular job to focus full-time on our palliative care work. Connecting with Network members, palliative care staff, and patients across a large sparsely populated county has been a significant challenge. Fortunately, the Covid19 pandemic has jump-started our ability to use Zoom and telemedicine, and this facilitates meeting together with patients, particularly as a multidisciplinary team, substantially easier.

Innovations have included deepening partnerships to share tools for seeing patients (billing and telemedicine platforms and electronic medical records) and resources (e.g. CAPC membership) and engaging and training Network members' staff to lead our ACP workshops.

Sustainability

We will be working hard on sustainability of this work after the planning grant period. We have made progress in formalizing and expanding Network members, including the addition of two new members. While we have not yet created MOUs, we are working toward that with specific members. We have expanded staffing and have successfully leveraged this planning grant to secure funding from two sources for the two years following the planning grant period. Achieving financial sustainability, Goal Four of our planning grant, will be key to our success. In addition to securing additional funding, we are starting a financial strategic planning process to build a financial sustainability plan, which will include billing for patient services, grant funding for development and infrastructure maintenance, and exploring philanthropy as part of our toolbox.

Ultimately, sustainability will depend on patient referral, funding, and our ability to maintain staff to meet the community need. Through our community education and outreach we are raising awareness in our community for the need and value of palliative care. We are educating primary care providers about the value of our service. We are working with the Washington State Department of Health on developing specific billing codes for our work. We are exploring additional grant funding through state, federal, and charitable organizations. We are working on

assessing the number of providers needed and the training necessary for them to meet the increasing referral base. Telemedicine will help reduce travel time, allowing us to see more patients using less time for travel on both the patient and provider side.

Region Covered by Network Services

County/State
Okanogan County, WA

Network Partners

Organization	Location	Organization Type
Family Health Centers	Okanogan County, WA	Federally Qualified Health Center (FQHC)
Confluence Health Clinics	Okanogan County, WA	Physicians' Clinic
Regency Harmony House	Brewster, WA	Skilled Nursing Facility
Jamie's Place Adult Family Home	Winthrop, WA	Skilled Nursing Facility
Mid-Valley Hospital	Okanogan, WA	Critical Access Hospital (CAH)
3-Rivers Hospital	Brewster, WA	Critical Access Hospital (CAH)
Frontier Home Health and Hospice	Okanogan, WA	Hospice
The Lookout Coalition	Methow Valley, WA	Home Health
Methow at Home	Methow Valley, WA	Other
Aero Methow Rescue Service	Twisp, WA	Emergency Medical Services (EMS)
Aging and Adult Services	Okanogan County, WA	Area Agency on Aging
Confederated Tribes of the Colville	Okanogan County, WA	Tribal Nation

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