Grantee SOURCEBOOK

Rural Health Network Development Planning Program

2017

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.

2017 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 Network Planning Program, the twenty-three (23) FY2017 grantees in seventeen (17) states to address these challenges by bringing a broad range of partners together to form rural health networks. Partners joined together to create a foundation for their infrastructure and identify opportunities for leveraging their resources to tackle high priority needs in their communities. Fifteen (15) of the 23 networks allocated at least some portion of their grant funding to formalizing the organizational development of their partnerships.

In addition to the network infrastructure development, Network Planning grantees have examined options for expanding a range of health care services, with many having identified two or more focus areas for their networks. Creating efficiencies in the delivery of health care is an important focus for these rural health networks. Eleven (11) are planning for the integration of health services. Fifteen (15) have explored methods for coordinating the care of patients with chronic diseases such as diabetes, chronic obstructive pulmonary disease, and congestive heart failure, with two focusing specifically on the transition of care for these patients. Two (2) grantees are examining ways that health information technology can increase efficiencies. Ten (10) grantees seek to improve access to care for those who reside in their rural communities, with six (6) studying the feasibility of telehealth programs to bring specialty services to their patients. One (1) grantee sees establishing school-based clinics as a method for expanding access to care for their children, and one (1) other is seeking to expand oral health services.

In rural American, there are fewer mental health professionals per 100,000 residents than are available to those who live in urban and suburban areas. More than half of the over 3,000 rural counties in the nation (55%) have no psychologists, psychiatrists or social workers, and 82% of rural people live in a county without detoxification services. Recognizing the great need to address these shortages of services, several Network Planning grantees are developing strategies to support those with behavioral health (9 grantees), substance use/addiction (4 grantees), and mental health (3) problems.

With growing barriers to the financial sustainability of rural health hospitals and clinics, seven (7) Network Planning grantees are leveraging their resources to help alleviate the loss of health care services. Two (2) are looking at ways to attract and maintain health professionals through workforce development.

In response to the decline in the availability of local health care facilities, less access to preventive and primary care services, and greater distances to regionalized specialty care services, four (4) grantees are expanding emergency medical services, with one studying the feasibility of allowing paramedics and emergency medical technicians to operate in expanded roles through a community paramedicine program.

Understanding that the ability to obtain, process, and understand basic health information and services to make appropriate health decision is essential to promote healthy people and communities, two (2) grantees are implementing health literacy programs, and another (1) has included health education among their priorities.

Contents of the 2017 Rural Health Network Development Planning Grantee Source Book

In addition to the programmatic focus areas, this Source Book provides a description, as written and submitted by the individual grantees, of the purpose of the network, the status of the development of the network infrastructure and programs, insights on the sustainability of the network beyond the Planning grant cycle, the geographic area served by the network, a listing of network partners, and the primary contact person for the network.

2017 Rural Health Network Development Planning Grantees

Listed by State

State	Grantee	Network Name	Focus Areas
Arizona	Mariposa Community Health Center	Santa Cruz County Elder Wellness Network	Access to Care, Care Coordination, Care for the Aging, Emergency Medical Services, Network Infrastructure Development
Arizona	Northern Cochise Community Hospital	Southern Arizona Hospital Alliance	Access to Care, Behavioral Health, Care Coordination, Health Education, Integration of Services, Mental Health, Substance Use/ Addiction
Arizona	Rio Rico Medical & Fire District	Arizona Mobile Integrated Healthcare Network	Alleviating Loss of Local Services, Emergency Medical Services, Integration of Services, Network Infrastructure Development
California	Redwood Coast Medical Services	Mendonoma Health Alliance	Access to Care, Alleviating Loss of Local Services, Telehealth
Illinois	Good Samaritan Regional Health Center	Southern Illinois Collaborative for Innovative Care Coordination	Care Coordination, Care Transition, Community Paramedicine, Emergency Medical Services, Integration of Services, Network Infrastructure Development,
Kentucky	Northeast Kentucky Regional Health Information Organization,	KRHIO Telehealth Coalition	Alleviating Loss of Local Services, Telehealth
Massachusetts	Fairview Hospital	Southern Berkshire County Health Planning Network	Access to Care, Behavioral Health, Care Coordination, Integration of Services, Network Infrastructure Development
Maine	Health Access Network,	Northern Penobscot County Integration Initiative	Access to Care, Substance Use/ Addiction
Michigan	Central Michigan District Health Department	Central Michigan Regional Rural Health Network	Care Coordination, Integration of Services, Network Infrastructure Development, Workforce Development
Minnesota	Lac qui Parle Health Network	Lac qui Parle Behavioral Health Collaborative	Behavioral Health, Integration of Services, Mental Health, Substance Use/Addiction
Montana	Cabinet Peaks Medical Center	Lincoln County Health Alliance	Behavioral Health, Care Coordination, Health Information Technology, Network Infrastructure Development, Telehealth

State	Grantee	Network Name	Focus Areas
New Mexico	Rio Arriba County Health & Human Services	Northern New Mexico Rural Health Network	Access to Care, Alleviating Loss of Local Services, Behavioral Health, Care Coordination, Health Information Technology, Substance Use/Addiction
New York	Westchester Ellenville Hospital	Ellenville Area Rural Health Network	Access to Care, Care Coordination, Integration of Services, Network Infrastructure Development, Patient Engagement, Workforce Development
Oklahoma	Stigler Health & Wellness Center, Inc.	Southeast Alliance Network	Alleviating Loss of Local Services, Behavioral Health, Care Coordination, Care for Aging, Mental Health, Network Infrastructure Development
Oregon	PeaceHealth Peace Harbor Medical Center	Western Lane Behavioral Health Network	Behavioral Health, Care Coordination, Network Infrastructure Development, School-Based Clinics, Telehealth
Pennsylvania	J. C. Blair Memorial Hospital	The INCH Initiative: Integrated Network for Collaborative Healthcare	Access to Care, Behavioral Health, Care Coordination, Integration of Services, Network Infrastructure Development
Pennsylvania	St. Luke's Miners Memorial Hospital	Dental Care Coordination Planning Network	Care Coordination, Health Literacy, Oral Health, Telehealth
South Dakota	Avera St. Luke's Hospital	Integrated Community Care Solutions Network	Access to Care, Care Transition, Integration of Services
Tennessee	Paris-Henry County Healthcare Foundation, Inc.	West Tennessee Delta Network	Behavioral Health, Care Coordination, Network Infrastructure Development, Telehealth
Washington	Clallam County Public Health District #1 (Forks Community Hospital)	Community Based Long Term Care Network	Access to Care, Alleviating Loss of Local Services, Care Coordination, Care for the Aging, Network Infrastructure Development
Washington	Ferry County Public Hospital District 1	Healthy Ferry County Coalition	Network Infrastructure Development
Washington	HopeSource	Kittitas County Health Network	Care Coordination, Integration of Services, Network Infrastructure Development
Washington	Methow Valley Home Health Agency	Methow Valley Health Care Network	Alleviating Loss of Local Services, Emergency Medical Services, Integration of Services, Network Infrastructure Development

Arizona

Mariposa Community Health Center
Santa Cruz County Elder Wellness Network
P10RH31082

Project Focus Areas

Access to Care
Care Coordination
Care for the Aging
Emergency Medical Services
Integration of Services
Network Infrastructure Development

Network Statement

We live in a unique, cheerful, bicultural, bilingual border community with deep roots from families that go back multiple generations. Seniors make up a large part of our community and Latino culture. We genuinely appreciate, support, and nurture the well-being of our senior population. We are fortunate to have committed and compassionate leaders of various service agencies that have joined forces to form The Santa Cruz County Elder Wellness Network to address the needs of our growing senior population. Together they create an alliance, a team of knowledgeable, dedicated, and compassionate individuals ready to collectively make an impact on the lives of our older adults.

The Network wants to create an environment with the necessary services that will allow our seniors to live healthier, happier, and more productive lives. This environment will be created by focusing on access to healthcare, health education, coordination of health services, and an adequate referral system of information. Our Network is organized, eager, and enthusiastic to make our mission a reality. As the community understands and sees the benefits provided to our seniors, we are gaining momentum with new partners wanting to contribute and become part of the Network. This is our community; it is what makes us who we are; and together we can improve and expand the necessary services needed to better care for our older adults, insuring them a happier and healthier life.

Network Development

Our network is strong and reliable with a good foundation. Our process began by selecting members for our Elder Wellness Network. We invited representatives from older adult-serving community organizations that we knew would be vital to our network and support our purpose. These are organizations that are well established in the community and are committed to improving our seniors' lives. Some already provide services to the senior community, and we knew we would learn from them.

The members are excited to work for the senior community, and they are ready to get things done.
The principal challenge to the ongoing network development occurred with the change to a new Network Director, who had no prior experience in network development. She overcame this with help from the network members

and the Project Director and by assisting in organizing meetings, facilitating focus groups, and by simply asking questions and getting to know what every member can offer. The members of our network are very comfortable with each other. They continue to work hard, and to attend meetings and trainings. This network is committed to seeing that our seniors receive the services they need as well as the ones they want.

Programmatic Development

Our network has made good progress in developing programs for our seniors. Through the Nogales Senior Center, we are planning to implement a Meals-on-Wheels Senior-to-Senior program (a high school senior delivers and shares a meal with a senior citizen in the community). This program will serve a dual purpose: senior citizens will have the opportunity for much-needed companionship, and the high school students will fulfill a community service requirement for graduation.

We are planning various classes to be offered to seniors at different senior living locations (i.e. classes on heart health, blood pressure, nutrition, etc.) as well as presentations on technology (tablets, smartphones, etc.)
Our network will also provide presentations on finances for seniors as well as classes on advanced directives.
Our seniors face challenges regarding transportation. They need help getting to and from doctors' appointments, getting to the pharmacy and even the grocery store. Providing more transportation to seniors is also a challenge for the network members. The cost of providing this service is very expensive due to insurance premiums, maintenance, and of course, purchasing vehicles.

In August our network will host a meeting and invite council members, Chamber of Commerce members, and other community allies that can offer input into helping us provide transportation and other services for our senior community.

Sustainability

As a fully grant -funded department, Mariposa Community Health Center's Community Health Services is fortunate to have multiple funding streams that will allow us to continue providing senior services such as diabetes and cardiovascular disease prevention classes, nutrition education, Oyendo Bien (Hearing Well), a program that teaches communication strategies to people with hearing loss and their families to improve their quality of life.
Mariposa staff will also be trained by SEAHEC in advanced directives; once trained they will be able to provide these classes to our seniors.

The SCCOA (Nogales Senior Center) will continue its ongoing services to the senior community. They provide meals and recreational activities such as games, singing lessons, physical activity, knitting, bingo, and the occasional casino trip, etc. They can also provide presentations on topics such as Medicare and Legal Aid.
With the help of the Elder Wellness Network, the Senior Center will also provide a broader scope of presentations to its seniors as well as implement the Senior-to-Senior program.

Nogales Community Development Corporation will continue to offer trainings on financing, budgeting, housing counseling, starting your own business, and tax preparation, and even offer small business loans to our seniors.
Soulistic Hospice is an organization that provides support to patients and their families in their final phase of life. They provide emotional and spiritual support, short-term respite care, assistance with meals, shopping, running errands, and pain and symptom management.

We anticipate that more organizations will join the network after we host a meeting this summer for key stake holders including City Council, Chamber of Commerce, and others.

Region Covered by Network Services

County/State
Santa Cruz County, AZ

Network Partners

Organization	Location (City/State)	Organization Type
Mariposa Community Health Center	Nogales, AZ	Federally Qualified Health Center (FQHC)
Carondelet Holy Cross Hospital	Nogales, AZ	Critical Access Hospital (CAH)
SEAGO	Nogales, AZ	Area Agency on Aging
Patagonia Assisted Care Agency	Patagonia, AZ	Other
Nogales Community Development	Nogales, AZ	Community Development Organization
Santa Cruz Council on Aging	Nogales, AZ	Area Agency on Aging
Community Foodbank of Southern Arizona Nogales	Nogales, AZ	Food Bank
Rio Rico Property Owners Association	Rio Rico, AZ	Senior Center
SEAHEC	Nogales, AZ	Area Health Education Center
Jennie Mullins	Tucson, AZ	Consultant
Whitney Armijo/Lindsey Thatcher	Tucson/Amado, AZ	Consultant
Soulistic Hospice		Home Health/Hospice
Dependable Health Services	Nogales, AZ	Other
Rio Rico Medical and Fire District	Rio Rico, AZ	Emergency Medical Services (EMS)

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Arizona
Northern Cochise Community Hospital, Inc.
Southern Arizona Hospital Alliance
P10RH31097

Project Focus Areas

Access to Care
Behavioral Health
Care Coordination
Health Education
Integration of Services
Mental Health
Substance Use/Addiction

Network Statement

Opioid misuse is a national epidemic with a magnified impact in rural communities. On June 5, 2017, Arizona Governor Doug Ducey declared an Opioid State of Emergency. Our Southern Arizona communities are small, yet all are united in the belief they can and will unite to solve their healthcare and social concerns. In response, the Southern Arizona Opioid Consortium (SAOC) was established by the Southern Arizona Hospital Alliance (SAHA) with a dedicated home base of Northern Cochise Community Hospital (NCCH) in Willcox, Arizona. SOAC aspires to improve and expand care coordination related to misuse of opioids and management of opioid-use disorder in southern Arizona communities. Through a dedicated collaborative team of health care providers, first responders and educators, we are improving care coordination and reducing opioid dependence for those affected by opioid-use disorder. Together, we will diminish opioid misuse and dependence across rural communities in Southern Arizona through increased, consistent, and unified messaging. We will implement school and community education, ED opioid best practices, and increase opioid referrals to behavioral health partners.

SAOC, supported by SAHA, is built on stakeholder support such that each hospital, in partnership with their area law enforcement, substance abuse treatment centers, and schools, is the foundational support for continued improvements and success. Each entity must remain involved, communicate, and educate, share best practices, stay current, and never lose sight that opioid use is a disorder and not a lack of moral character. SAOC's strengths are embedded in the commitment of its members, their passion for the work, and their pledge to sustain the work.

Network Development

The Southern Arizona Hospital Alliance (SAHA) formed in 2015 after the closure of the Douglas Hospital on the Arizona/Mexico border. Five independent not-for-profit hospitals in Southern Arizona formed the Alliance to mitigate further hospital closures and to expand the network of integrated healthcare, further strengthening the rural health care system. The SAHA network consists of Northern Cochise Community Hospital, Copper Queen Community Hospital, Tucson Medical Center (TMC), Mt. Graham Regional Medical Center, and Benson Hospital.

SAHA received a Network Planning Grant in 2016 to support its early development and the leveraging of existing relationships, improved care coordination, and access to a higher level of care throughout Southern Arizona. In growing recognition of the importance of the worsening opioid epidemic in the region, SAHA members committed to organizing around a network response, and 11 additional relevant agencies signed MOUs. In May 2017, SAHA received a second HRSA Network Development Planning Grant that allowed for the formation of the Southern Arizona Opioid Consortium (SOAC), a group dedicated to combatting opioid-use disorder throughout the communities. Members have signed on to a Charter that defines the scope of work, mission and vision, governance and expected communication and partner commitments. Critical to the evolution of SAOC was the inclusion of existing education programs – both school and community based – with experience and trust deeply rooted in the community. Although independent teams were identified to work on care coordination, school and community education, and behavioral health, the work groups naturally formed around a Steering Committee that helped to capture and share the evolution of all work.

During this year, SOAC has engaged in a continuous process of aligning interests and action among the partners, which has required some adjustments and responses to some of the challenges associated with collaborative work. Challenges included aligning the roles and relationships among the traditional SAHA members and network staff with the grantee of this grant along with the new members to form SOAC. In addition, there has been a level of mixed priorities among opioid initiatives around competing grants and existing programs that required careful response to better align efforts. With a continued focus on the grant aims and work plan, most partners have now developed trust in SAOC's leadership. Through bi-weekly phone calls, site visits, and small group planning, the network has evolved and is more collaborative in the sharing of information and best practice. We believe this is the foundation for future network success.

Programmatic Development

The existing Arizona Department of Health Services' *Arizona Opioid Prescribing Guidelines* and the *AZ Rx Drug Misuse & Abuse Initiative Toolkits* were shared and used as a baseline for our program development. Small groups assembled to explore enhanced teaching offerings, and an additional grant to fund the needed supplies to three additional school districts was secured. School based curriculum has expanded from one school district to four, ensuring prevention best practices are shared with all children in those districts in grades 6-9. And, grassroots community education efforts remain strong with a total reach of 14,000 residents since May 2017.

Referrals to behavioral health programs increased when support for opioid patients in local clinics and emergency rooms was rolled out. Helping to identify a starting point, we found that finding available treatment centers close to home was not easy and worked to gather that information, which is an ongoing task. Thanks to members from air and ground transportation, city courts, and law enforcement and their focused, collective need to identify treatment centers that accept patients with opioid-use disorder, a treatment services location guide, referred to as the "Southern Arizona referral card," was developed and widely distributed. The SOAC partners will continue to develop, deploy, and innovate around these mutually reinforcing strategies in an aligned way to leverage existing and new opioid-related community resources to gain ever better control of the epidemic.

Sustainability

The findings of the Network Organization Assessment say 63% of our members acknowledge that SAOC work is "emerging" around new ideas. Knowing that many prior ideas and processes related to opioid-use disorder have historically failed, the resolve to work together for improvement is essential. Fifty percent of SAOC members are confident that there is trust among members and believe that collaboration will result in positive outcomes.

SAHA and SAOC recognize the importance of continued development beyond the grant. Because members recognize the benefit of a hospital-based lead, SAHA partners will remain active. Communication is also strong between all our partners, as interaction Is regular and often. The network and its programs will remain sustainable beyond the grant cycle because they are embedded in the belief that positive and effective collaboration is shared.

Region Covered by Network Services

County/State	County/State
Cochise County, AZ	Graham County, AZ
Rural Pima County, AZ	

Network Partners

Organization	Location (City/State)	Organization Type
Northern Cochise Community Hospital	Willcox, AZ	Critical Access Hospital (CAH)
Copper Queen Community Hospital	Bisbee, AZ	Critical Access Hospital (CAH)
Mt. Graham Regional Medical Center	Safford, AZ	Hospital
Benson Hospital	Benson, AZ	Critical Access Hospital (CAH)
Tucson Medical Center	Tucson, AZ	Hospital
Willcox School District	Willcox, AZ	School System
City of Willcox	Willcox, AZ	Government
Wellness Connection	Varied in Southeastern, AZ	Behavioral Health
Cochise County	Bisbee, AZ	Government
Cenpatico Integrated Care	AZ	Medicaid Managed Care Organization
LifeNet/Air Methods	AZ	Transportation
AZ Lifeline	AZ	Transportation
Willcox Against Substance Abuse (WASA)	Willcox, AZ	Other
Community Bridges	AZ	Behavioral Health
Community Medical Services	AZ	Behavioral Health

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Arizona
Rio Rico Medical & Fire District (RRMFD)
Arizona Mobile Integrated Healthcare Network
P10RH31098

Project Focus Areas

Alleviating Loss of Local Services
Emergency Medical Services
Integration of Services
Network Infrastructure Development

Network Statement

As Mobile Integrated Healthcare (MIH) programs throughout Arizona and the US continue to emerge, there remains a clear need for a consensus-building organization to support MIH development throughout Arizona. The Arizona Mobile Integrated Healthcare Network (AzMIH) was formed in 2017 to fill this role and act as a conduit for the advancement of high-quality mobile integrated healthcare (MIH) programs that will strengthen the rural health care system.

MIH is a strategy to enhance our diverse community's access to health services and other important resources via out-of-hospital/clinic resources. Community-based MIH services are designed to effectively link individuals to primary care and appropriate community resources (access to care) and to prevent emergent health system utilization. MIH programs offer enhanced access to care via in-home services and rapid communication of information to support optimal patient outcomes and system efficiency. Throughout Arizona, existing fire/EMS stations are strategically placed in communities; this allows EMS and fire-based MIH programs to provide community-based services which are physically and economically beneficial to community members and the health system at large.

Network Development

Mobile integrated healthcare is rapidly expanding throughout Arizona. With over 30 independent programs operating or in development throughout the state, a central body is needed to support program operators. With funding from a Health Resources and Services Administration Rural Health Network Development Planning Grant, the Arizona Mobile Integrated Healthcare Network (AzMIH) was formed in 2017 to fill this role and act as a conduit for the advancement of high-quality mobile integrated healthcare (MIH) programs that will strengthen the rural health care system. Focusing on rural areas where access to and delivery of health care is strained, the high-level AzMIH Network endeavors to bring MIH to scale statewide, thereby strengthening the current safety net and increasing access to quality health care services.

The AzMIH Executive Council worked throughout 2017 to identify key partners, investigate potential structures, and create a network framework. In Spring 2018, the AzMIH, with facilitative support from Community Alliance Consulting, held a strategic planning meeting to build on the framework and engage a broader group of

stakeholders from across Arizona and Tribal communities. The goals of the planning activities were threefold: 1) continue to build trust among partners, 2) create buy-in for the Network vision and mission, and 3) establish group consensus on where to prioritize Network efforts and how to move forward.

Next steps for the AzMIH Network include the creation of a strategic partnership with an existing Arizona non-profit organization to continue building capacity, including development of a governance structure and membership/funding structure. Network strategic priorities from 2018 through 2021 include providing support for technical assistance, evaluation and resource development (infrastructure, tools, funding), and billing procedures/processes; advocating for Multiple MIH Models: Community Paramedicine (CP), Treat and Refer (T&R), Readmission Reduction/Avoidance, Community Health Workers (CHWs) and identifying sustainable funding for MIH services. The network will work to create health partnerships for reimbursement models and enable standardization of data collection.

Programmatic Development

The niche of the AzMIH Network is to enhance the role of Emergency Medical Service providers to support the integration of diverse health and social services to improve overarching access to care for communities throughout Arizona. The work of the AzMIH Network from June 2017 to May 2018 has been to build relationships with leaders from the Arizona EMS system and related partners from across the health and social service system. A great deal of effort was put into the AzMIH Network's foundation to create a Network to transcend planning activities.

As of May 2018, the AzMIH has broad commitment from the founding executive council and additional partners to continue working toward achieving identified strategic priorities. The Network has met a variety of challenges, including the determination of non-profit incorporation. However, the Network partners involved are dynamic leaders who engage in democratic analysis and decision-making processes.

As the provision of new services in the realm of MIH continue to emerge, we are finding the creation of this Network to be a great avenue for sharing successes and resources while also workshopping individual challenges to create system-wide successes. A central example of workshopping challenges is exemplified by the AzMIH Network's strategic priority to lead in MIH reimbursement. Network partners have individually met challenges in this area, and the collective voice of the AzMIH Network will allow these challenges to be assessed, analyzed, and acted upon to create collective progress.

Sustainability

Collectively, the founding Network leadership and key partners have each voiced a desire to continue the efforts of the Network beyond the planning year. This will initially be accomplished by the voluntary participation of our leaders with the additional in-kind support of a variety of Network partners. The founding partners envision the steady progression of Network structure from voluntary to being inclusive of dedicated staff to support the Network vision and mission.

Short and medium-term strategies around sustainability will be to establish a membership structure which is envisioned to include Fire and EMS members with options for affiliate and sponsorship membership levels as well. Upon the conclusion of AzMIH Network planning activities, a determination of incorporation and/or strategic partnership will be accomplished to ensure the Network has the appropriate legal affiliation to continue fundraising and grant-writing activities. A funding calendar to include strategic grant and other funding opportunities will be drafted and acted upon by the completion of the current planning year.

Region Covered by Network Services

County/State	County/State
Apache County, AZ	Maricopa County, AZ
Cochise County, AZ	Mohave County, AZ
Coconino County, AZ	Navajo County, AZ
Gila County, AZ	Pima County, AZ
Graham County, AZ	Pinal County, AZ
Greenlee County, AZ	Santa Cruz County, AZ
La Paz County, AZ	Yavapai County, AZ
Yuma County, AZ	

Network Partners

Organization	Location (City/State)	Organization Type
Arizona Fire Services Institute	Avondale, AZ	Non-Profit
Arizona Ambulance Association	Scottsdale, AZ	Non-Profit
Arizona Poison & Drug Information Center	Tucson, AZ	Other
Arizona Advisory Council on Indian Health Care	Phoenix, AZ	Collaborative
Regional Center for Border Health	Somerton, AZ	Rural Health Center
Arizona Center for Rural Health	Tucson, AZ	College/University
Rio Rico Medical & Fire District	Rio Rico, AZ	Emergency Medical Services (EMS)
Daisy Mountain Fire District	Anthem, AZ	Emergency Medical Services (EMS)
Timber Mesa Fire District	Show Low, AZ	Emergency Medical Services (EMS)
Somerton Cocopah Fire Department	Somerton, AZ	Emergency Medical Services (EMS)
University of Arizona Department of Emergency Medicine	Tucson, AZ	College/University
Vitalyst Health Foundation	Phoenix, AZ	Philanthropy/Foundation
Arizona Department of Health Services	Phoenix, AZ	Government
Arizona Integrated Mobile Wellness	Tucson, AZ	Behavioral Health
Cenpatico Integrated Care	Tucson, AZ	Medicaid Managed Care Organization

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California

Redwood Coast Medical Services
Mendonoma Health Alliance
P10RH29849

Project Focus Areas

Access to Care
Alleviating Loss of Local Services
Telehealth

Network Statement

Nestled along a rugged coastline with breathtaking views of the Pacific Ocean, our unique community encompasses a diverse group of small towns strung along 60 miles of the isolated Highway 1 corridor. The Mendonoma community is both resilient and vulnerable; most residents are all too familiar with the price that comes with this treasured seclusion. From expectant mothers traveling over 4 hours round-trip on long, winding roads for prenatal appointments to aging residents forced to leave their homes to be closer to healthcare resources, no person goes untouched by the challenges of maintaining their health and wellbeing here. However, one key quality that sets this community apart is the growing movement toward better access to quality healthcare and the passion and devotion of the people supporting that movement.

Many talented residents and leaders from our thriving community organizations have dedicated their time and energy to develop the Mendonoma Health Alliance (MHA). MHA works hard to bring existing resources together in an intentional, coordinated effort. Our network works to identify what services are missing to fill gaps in access to care. MHA prides itself on taking a comprehensive approach: embracing the whole community, convening valuable resources from our partners, and striving to be a “one-stop shop” on the road to changing the overall health of our community. In collaboration with our partners, MHA stays abreast on national trends and evidence-based best practices to develop creative, community-based solutions. Through this shared problem-solving approach, we have what it takes to move mountains to bring our community to the cutting edge of optimal health and wellness. Our unique partnership will lead MHA to our ideal future: a better quality of life for all residents in our community.

Network Development

Founded in October 2016, MHA is a relatively new rural health network and is still actively growing and expanding network partnerships and membership. Currently, the network consists of our three founding members: the local Federally-Qualified Health Center (FQHC), the local ambulance service, and a regional hospital. The network frequently partners with other local organizations but has not yet established a formal procedure for expanding network partnership. To guide the network development process, MHA has a Governing Body (GB) which includes

2 representatives from each of our founding members as well as 3 community members. The GB has worked diligently with MHA's Network Director to formalize the infrastructure of MHA by developing policies, procedures, and taking the necessary steps to become a federally-qualified 501(c)3. Acquiring the 501(c)3 status will allow for MHA to pursue a wide range of funding opportunities in the future.

In addition to the Rural Health Network Planning grant focusing specifically on telemedicine, MHA concurrently received a Rural Health Network Development grant to continue overall network advancement. The core programs identified in the strategic plan for development are prevention and wellness, chronic care management, access to care, and emergency services. The telemedicine planning program fits within many aspects of the overall network initiatives, notably improving access to specialty care and chronic care management. During the Network Planning grant period, MHA partnered with two other organizations: the California Telehealth Resource Center (CTRC) and Partnership HealthPlan of California (PHP), but they were not formally made network members. However, it was valuable and exciting to participate in such a collaborative effort, and we will continue to work with both organizations in the future, as needed, during the implementation of telemedicine.

Due to severe staffing shortages facing our key FQHC partner, the Network Planning grant got a slower than anticipated start. Ultimately, we gained the participation of a retiring IT specialist within the FQHC and made our best effort to engage busy clinical staff (scheduling based on their availability, understanding they wouldn't be able to attend all meetings, and gathering their input in alternative ways, etc.). Once key FQHC staff members were identified and on board, the group quickly came together in support of telemedicine and the strategic goals that identified through the planning process. Adding to the forward-momentum of the planning process was the addition of a new Chief Medical Officer at the FQHC who has experience in and is extremely supportive of the implementation of telemedicine. Throughout process, MHA learned that developing trusting relationships in a positive environment is the key to partner buy-in and the future of a telemedicine program. While this notion is not innovative, it is inevitably rooted in developing partnerships and long-term sustainability. This is a concept that MHA would encourage other rural health networks to dedicate time and energy to in the early planning stages.

Programmatic Development

During the Network Planning grant period, MHA successfully facilitated a strategic planning effort around telemedicine with four other organizations. Included in the planning group were representatives from MHA, the local FQHC, the local ambulance service, CTRC, and PHP. With the guidance of telemedicine planning experts from CTRC, the planning group accomplished several goals. The group researched best practices, visited successful telemedicine clinics, conducted thorough needs assessments, identified potential service sites, determined technological needs, evaluated potential telemedicine specialties, and thoroughly assessed the feasibility of implementing a telemedicine program at the local FQHC. In addition to typical patient-provider telemedicine models, the group also discussed and evaluated other telehealth modalities including remote monitoring, store and forward, imaging services, and physician-to-physician consultation. The end outcome was a strategic plan that identified feasible, fiscally-responsible, and sustainable methods for implementing telemedicine services in our service area.

Key FQHC staff, including physician champions and potential telemedicine coordinators, were identified and invited to participate in a workshop led by CTRC to prepare for implementation of the strategic plan. Members of the planning group attended the CTRC Telehealth Summit to continue learning about national trends in telehealth and cutting-edge best practices.

During the Network Planning grant period, MHA secured funding to purchase and install video-conferencing equipment in a publicly-accessible meeting room that is now available to local organizations for video conferencing, accessing remote continuing education opportunities, and more. Acquisition of and access to conferencing equipment will help MHA and our partners stay up-to-date with current best-practice models and ongoing training for staff while minimizing travel-related expenses. This innovative technology opens a world of learning opportunities for our community and the population we serve. Given our unique service area and the current state of insurance reimbursements for telemedicine, one of our major challenges was to identify a sustainable reimbursement model. After some research, the group developed a few financially-attainable prototypes for preliminary, small-scale models that would focus on specific demographics or specific specialties. MHA is committed to researching reimbursement models that are applicable to our member FQHC in the rapidly-growing telemedicine industry.

Sustainability

MHA is a formalized rural health network with three official network members. In addition, MHA expanded to include two additional network partners with telemedicine expertise for collaboration during the Network Planning grant period. As MHA continues to grow, we will remain focused on membership expansion to better meet the needs of our community and to strive for better access to quality care. MHA has a 9-member Governing Body to support network infrastructure and development, consisting of representatives from each of the founding members as well as community representatives. During the Network Planning grant period, the GB established three formal committees to develop MHA's infrastructure and ensure program success/sustainability: Quality, Finance, and Nominating. In addition, the GB is in the process of establishing 501(c)3 tax status for the organization. MHA has a small but dedicated staff that is used diversely to meet the needs of the organization with the overall health of our community in mind. MHA is also currently funded by a separate 3-year HRSA Rural Healthcare Network Development grant. Both grants have given MHA the opportunity to create comprehensive strategic plans to build organizational capacity and improve access to and quality of healthcare in our community. In doing so, our team has been able to explore further funding options. For example, our member hospital has provided funding to our organization because of our Care Transitions Program, which is able to demonstrate cost-savings for the hospital while improving the health of clients who participate in the program.

After successful completion of the Network Planning grant, MHA will provide our member FQHC with a strategic plan for implementation of telemedicine. We will remain committed to pursuing relationships with CTRC and PHP to help access tele-medicine specialists and to develop reimbursement models that will allow for a sustainable project for years to come. We will support the FQHC as they use already-existing grant funding to purchase tele-medicine equipment based on guidance from CTRC. Lastly, we will expand on the education we have already provided to key

staff members through site visits, conferences, and workshops, and continue to educate them on up-to-date industry best practices using our new conferencing equipment to ensure quality, along with sustainability.

Region Covered by Network Services

County/State	County/State
Mendocino County, CA	Sonoma County, CA

Network Partners

Organization	Location (City/State)	Organization Type
Redwood Coast Medical Services, Inc	Gualala, CA	Federally Qualified Health Center (FQHC)
Coast Life Support District	Gualala, CA	Other
Santa Rosa Memorial Hospital	Santa Rosa, CA	Hospital
California Telehealth Resource Center	Sacramento, CA	Consultant
Partnership HealthPlan of California	Fairfield, CA	Medicaid Managed Care Organization

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Illinois

Good Samaritan Regional Health Center
Southern Illinois Collaborative for Innovative Care Coordination
P10RH31093

Project Focus Areas

Care Coordination
Care Transition
Emergency Medical Services
Integration of Services
Network Infrastructure Development
Other: Community Paramedicine

Network Statement

The high prevalence of chronic health conditions in our rural region has inspired a group of hospitals, EMS agencies, and other stakeholder organizations to establish the Southern Illinois Collaborative for Innovative Care Coordination (SICICC). Recognizing that the region's economic conditions present a barrier to improving health outcomes, the network members have resolved to create innovative, patient-centered methods for more efficient, effective delivery of health care to residents. We are joining efforts to share our resources, think and work collaboratively, and utilize our many talented, knowledgeable health care and community service providers in a manner that will produce substantial benefits for both our patients and our institutions.

SICICC exists for the long-term care coordination and resource sharing partnership of its member organizations. Moreover, the network collaborative aspires to advance better health care and to foster better health outcomes for the people of the SICICC region, many of whom are underserved and economically disadvantaged. The potential for future activities is limitless, and we welcome the partnership of other stakeholders and all residents throughout our service region to achieve better health and quality-of-life, together.

Network Development

The progress of the Southern Illinois Collaborative for Innovative Care Coordination (SICICC) activities should be delineated into two categories: 1) Process activities; 2) Collaboration building activities. Process activities include the development of bylaws and memoranda of understanding (MOUs), which were accomplished through a workgroup structure. After the bylaws were drafted by the workgroup, they were ratified by the full body of the network. After the ratification, and in accordance to the bylaws, officers for the SICICC network were elected. Each member organization executed an MOU that officially joined the respective organization to SICICC.

Collaboration building activities pertain to the more nebulous, team-building and trust-building exercises, which more formally occurred through workgroup meetings, conference calls, and strategic planning, and informally, through simple "check-in" meetings between network leadership and network members in the home facilities of the network members. These "check-in" meetings afford the opportunity for the individual members to speak openly about any of their

concerns and to receive more personal technical assistance about specific elements of the network's development or program operation.

Although our network planning activities have proceeded effectively and efficiently, the primary challenge that we have faced is the intra-member process for the approval by-laws, MOUs, and business associate agreements (the business associate agreements were developed by the SIU School of Medicine General Counsel). Since each of our member organizations must seek approval of each of these documents by administrative/legal officers within their organizations, this slows the overall progress of network development, and subsequently, program development. However, the diligence of the staff of our member organizations is outstanding, and this process has been relatively expedient, when considering the number of documents required for approval and the number of organizations seeking approval.

An element of our network that is both innovative and unique is the inclusion of a university academic center, which specializes in rural health research and programming. The Southern Illinois University School of Medicine - Center for Rural Health & Social Service Development provides a staff member to serve as the Network Director, and additionally, provides other essential technical assistance support for both network and program development.

Programmatic Development

SICICC leadership and the 36 staff members assigned to the network from its member organizations have achieved significant progress in both the development of the network and its care coordination/Emergency Medical Services programming, which is conducted through the construction and establishment of a community paramedicine program.

The programming development is complex and is comprised of many objectives, and it dictates that concurrent activities occur to attain these objectives. To meet these objectives, three (3) workgroups were formed: Data; Curriculum & Clinical Protocols; Process & Procedures
However, these workgroups cannot operate in silos, and one cannot proceed without progress from the others. They have achieved these significant objectives:

1. Published a first draft SICICC community paramedicine manual;
2. Tentatively settled on patient referral criteria for community paramedicine services;
3. Initiated discussions on qualifications requirements for a community paramedic;
4. Initiated discussions on training curriculum for a community paramedic;
5. Gathered patient admissions data from all the network hospitals and most of the network EMS agencies;
6. Initiated discussions on hospital-to-EMS dispatch process and EMS-to-hospital reporting process.

Perhaps the most challenging element of the network's program planning is the sheer complexity of launching a community paramedicine program, especially in the State of Illinois, where the concept is very new and even EMS regulatory authorities are largely unfamiliar with this model of care. Additionally, if the community paramedicine program model is to be comprehensively planned and "turn-key" ready for implementation, then each of the numerous components of the program must be concurrently planned, as many of components have an interdependent relationship with other components.

The essential nature of this concurrent planning does present a significant challenge, as one respective workgroup must wait on goal and objective attainment of another workgroup, before the first workgroup can proceed. However, each of the 36 staff members assigned to the community paramedicine program from the various network members are exceptional, in terms of their technical subject matter knowledge, their project management skills, and their enthusiasm for the project. The workgroups structure, facilitated by staff members of Southern

Illinois University School of Medicine - Center for Rural Health & Social Service Development (CRHSSD), has been key to meeting the benchmarks of the workplan timeline.

Sustainability

The infrastructure of our SICICC network has been constructed for long-term sustainability. Bylaws have been ratified by all the member organizations, and each member organization has executed a memorandum of understanding, which joins their organization to SICICC. Furthermore, officers for the network have been elected. Dennis Presley, a staff member of the Southern Illinois University School of Medicine - Center for Rural Health & Social Service Development (CRHSSD), serves as the Network Director.

The Southern Illinois University School of Medicine has committed $30,000 to partially fund a pilot of SICICC's community paramedicine program. The CRHSSD, on behalf of SICICC, has submitted a grant proposal to the Mary Heath Foundation in Robinson, IL, seeking funding in the amount of $20,000 for the community paramedicine pilot. Additional sources of funding for the pilot will be sought as well.

Beyond the planning period, the network collaborative will continue to meet on a regular basis, explore additional resource sharing and care coordination opportunities, and further refine components of the community paramedicine program.

Region Covered by Network Services

County/State	County/State
Clay County, IL	Crawford County, IL
Jefferson County, IL	Lawrence County, IL
Wayne County, IL	Knox County, IN

Network Partners

Organization	Location (City/State)	Organization Type
Clay County Hospital	Flora, IL	Critical Access Hospital (CAH)
Crawford Memorial Hospital	Robinson, IL	Critical Access Hospital (CAH)
Fairfield Memorial Hospital	Fairfield, IL	Critical Access Hospital (CAH)
Good Samaritan Regional Health Center	Mt. Vernon, IL	Hospital
Good Samaritan Hospital	Vincennes, IN	Hospital
Clay County Hospital Ambulance	Flora, IL	Emergency Medical Services (EMS)
Lawrence County Ambulance Service	Lawrenceville, IL	Emergency Medical Services (EMS)
Litton Ambulance Service	Mt. Vernon, IL	Emergency Medical Services (EMS)
United Life Care Ambulance Service	Robinson, IL	Emergency Medical Services (EMS)
Wayne County Ambulance Service	Fairfield, IL	Emergency Medical Services (EMS)

Organization	Location (City/State)	Organization Type
Rides Mass Transit District	Harrisburg, IL	Transportation
Southern Illinois University School of Medicine – Center for Rural Health and Social Service Development	Carbondale, IL	College/University

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Kentucky

Northeast Kentucky Regional Health Information Organization
KRHIO Telehealth Coalition
P10RH31083

Project Focus Areas

Alleviating Loss of Local Services
Telehealth

Network Statement

Patients in rural communities face many challenges when it comes to accessing health care. Travelling hundreds of miles to seek specialty care or access other health-related resources like support groups can be difficult for patients with limited financial means. Many patients also lack reliable transportation or feel unable to drive in urban areas, where these resources are typically located. As a result, many rural patients do not receive the care they so desperately need. In 2017, a group of rural providers came together to form the Kentucky Rural Healthcare Information Organization (KRHIO) Telehealth Coalition to expand the use of telehealth and help patients overcome many of these barriers to care.

Through telehealth, patients can more easily access health care providers and other health-related resources from the comfort and convenience of their local community. Patients can receive the right care, in the right place and at the right time for them.

Network Development

The KRHIO Telehealth Coalition is a network of five-member organizations which have joined together to expand telehealth and increase access to care in their rural communities. Network members include facility types such as federally qualified health centers, rural health clinics, private practice, and a medical center. We serve an 11-county region in Northeastern Kentucky. In formalizing our network, we have worked together to craft a shared vision and mission along with objectives and strategies to meet our goals. We have drafted a three-year strategic plan to grow the network and a sustainability plan to ensure the coalition continues. We've also created a telehealth advisory board to provide KRHIO's board of directors with guidance on telehealth issues and projects.

In developing our network, our largest challenge has been funding for telehealth equipment. We worked with Polycom and applied for funding through the USDA RUS Distance Learning and Telemedicine Grant and anticipated awards to be made in the fall of 2017. Unfortunately, the grant awards were postponed until January 2018. In the time between the grant's being written and the award, the USDA banned equipment providers like Polycom from financial involvement in the grant process, and because Polycom paid for our grant to be written, we were unable to purchase Polycom equipment as we had initially intended. As a result, we had to look for comparable equipment from other vendors, which has delayed telehealth project implementation and network activities.

Another challenge has been coordinating schedules to get active participation from all network members. To address this challenge, we have found it easier to meet with individual members monthly to discuss issues and

bring the whole group together quarterly. We have also begun scheduling our meetings farther in advance. These strategies so far have worked well.

Programmatic Development

The KRHIO Telehealth Coalition provides members with group purchasing opportunities, grant opportunities, and shared staffing opportunities. The Coalition has already received one grant award and will soon pursue additional grant funding. Members also receive telehealth IT support, training, and guidance and assistance with project implementation from KRHIO staff. Network members have identified potential areas of shared staffing and collaboration; however, this has been delayed due to a delay in the receipt of equipment. To provide network members with continuing education opportunities, KRHIO has partnered with our regional area health education center to provide continuing education activities through telehealth to member sites. The network has also worked with the University of Kentucky and the University of Louisville to gain access to already established telehealth clinics for specialty care.

Challenges in program planning have included limited resources. Network members are unsure how much time their providers will be able to dedicate to shared staffing and collaboration efforts, as their schedules already stay full. Since this service is not yet available for members, we are still working on ways to overcome this challenge. Another challenge has been the development of training materials. Telehealth is a complicated, especially in areas of reimbursement, legislation, and technology issues. It is further complicated because of the various types of organizations we have in or network. As a result, training development has been slower than anticipated. To overcome the issues related to training, we have invested in specialized software to produce self-guided training modules which will be available on our website. This way, network members have access to training at any time and can train new staff members as needed.

In program development, partnership with organizations has been invaluable. We recommend reaching out to other state or local organizations with allied missions. Often, they can be valuable resources.

Sustainability

After the grant period, the KRHIO Telehealth Coalition will continue to function much as it does now; however, we hope to grow the Coalition and expand the services we offer members. Looking toward sustainability, KRHIO already has an established membership model, and the Telehealth Coalition has been included in our membership structure or can be joined on an “a-la-carte” basis. Consultation services are also available for an hourly rate. Another potential source of revenue is our training modules, as Kentucky lacks telehealth resources. As part of the USDA grant we were awarded, KRHIO purchased a telehealth bridge. Leasing out meeting space on our bridge is another potential source of revenue to ensure sustainability for the Telehealth Coalition.

Region Covered by Network Services

County/State	County/State
Bath County, KY	Rowan County, KY
Breathitt County, KY	Wolfe County, KY
Lee County, KY	Elliott County, KY
Menifee County, KY	Carter County, KY
Montgomery County, KY	Morgan County, KY

County/State	County/State
Powell County, KY	

Network Partners

Organization	Location (City/State)	Organization Type
Northeast Kentucky Regional Health Information Organization	West Liberty, KY	Non-Profit
Juniper Health, Inc.	Beattyville, KY	Federally Qualified Health Center (FQHC)
Community Family Clinic	Frenchburg, KY	Rural Health Center
Casa San Pio	Stanton, KY	Rural Health Center
St. Claire HealthCare	Morehead, KY	Hospital

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Massachusetts

Fairview Hospital
Southern Berkshire County Health Planning Network
P10RH31096

Project Focus Areas

Access to Care
Behavioral Health
Care Coordination
Integration of Services
Network Infrastructure Development

Network Statement

The Southern Berkshire County Health Planning Network exists to bring together the resources in our community and find creative ways to assure that the health needs of every resident of South Berkshire County (SBC) can be met. We are a collaborative organization comprised of many of the health and service organizations that serve residents of SBC. We are uniquely positioned to be responsive and connective, prepared to look at addressing needs from many different perspectives and engaging the necessary partners to be successful. We fill a coordinating niche that can support all organizations in optimizing their positive contributions to the community and can engage all interested residents in becoming active partners in a healthy community.

The RHN has developed a strategic plan to begin to address some of the issues identified by our residents, while crafting a comprehensive but adaptable approach to population health in our community. The participating individuals have demonstrated their commitment by showing up and actively engaging in the dialogue and working collaboratively even before the plan is in place. The RHN has already demonstrated its commitment to the health of our community.

Network Development

The original network structure included three major health care providers as the core team, with numerous additional community service organizations to comprise the full network. We have identified the need to develop a network structure that includes a governance board of about 6-12 individuals, to include healthcare, community service organizations, and at least one representative of the community. We have members who have expressed a commitment to being part of the governance board. By inviting a wide array of participants to the governing body, we hope to actively engage a full spectrum of representatives in SBC with varying perspectives. The hope is to capture representation from healthcare, education, towns, councils on aging, youth organizations, faith communities, mental health, emergency responders, law enforcement and residents. Through this model, the overarching objective is to create a coordinated community care collaborative. Membership criteria will include a commitment to the mission and vision of the network, along with a willingness to contribute resources, finances, skills, personnel, or other meaningful contributions.

Our process began with simply getting to know each other and what services we each provide for the community. In a small rural area such as ours, it is important to get to know all the players. We used our monthly core team meetings to hash out our mission and vision, to define health and ideal health care systems, and to process and sort through the information and activities that took place at the full network meeting.

This allowed us to form a strong core. Our quarterly full network meetings have been incredibly exciting, as partners have engaged in learning about each other, understanding each other's perspectives, and identifying ways we could begin to work together, even as we worked to create the network structure. The partners engaged in defining the terms, identifying needs, and identifying what would make the network valuable to them.

Our challenge has been for each of the players to maintain a hold in their schedules for these meetings. We have addressed this moving forward by creating clear guidelines and expectations for our governance board membership and offering other ways to participate, particularly for those who cannot make the commitment to being present for meetings monthly. At our meetings, we made a point of having small group discussions anytime the group was larger than 5 to make sure that people got to know each other and everyone had a chance to be heard. An effort was made to separate individuals from the same organizations so there was a diversity of perspective in each group. The richness of what came from these groups was amazing, as these groups of caring and capable individuals amplified what each brought to the table.

Programmatic Development

We began this process by reviewing and obtaining data about our community. We reviewed existing data, collected more data from a multitude of sources, and began the process of identifying needs in SBC. We worked on the parameters of our work with our consultants, HCI Conduent, to help us formalize our data collection and build the bases for the work we did with the larger group of network partners. We were pleasantly surprised by the consistency of identified issues and our agreement about what were assets, opportunities, gaps, and threats in our community. Probably the most important contribution to our strategic planning process came from the community. We held 2 community forums. Using the small group model, we facilitated conversations among a diverse group of participants, to hear what they felt the needs are in this community as well as potential solutions. We also sent out a community survey, both on-line and in hard copy, to get broader input from the community itself. We have received over 200 responses to the survey, with more coming in. We view this as a good continuing surveillance tool, with plans to keep the online version open to the public.

Based on our identified concerns, a list of approximately two dozen project ideas was made. Using a strategy grid, each idea was categorized into the following: low need/high feasibility, high need/high feasibility, low need/low feasibility, and high need/low feasibility. We found this innovative tool incredibly useful to our next steps. We faced some challenges in our definition of high feasibility, with the sustainability of some existing programs being questioned by some. This conversation led to our exploring other ways to sustain and build our model to assure we have a pathway to success. Based on this information, we developed our future goal, objective, and activities. There was universal agreement that we want to create a culture of caring in our community and that we would do it through a care coordination model that has been piloted in one of our community schools with one of our pediatric practices. There was also near universal agreement that maintaining an existing successful program was the appropriate place to start. Our other two activities that support the success of the pilot and its expansion are 1) developing a tool to facilitate resource identification and communication and 2) strengthening our community health worker system. We want to assure that cultural competency is an integral part of everything we do, and we engage staff effectively to reach those in need.

Sustainability

For now, the network will continue to exist under the umbrella of Fairview Hospital. Over the next 2 years, the board will explore possibilities that include becoming an independent 501(c)3, as well as continuing under a larger organization (not necessarily Fairview) with its own governance board. This allows the benefits associated with an established organization, while maintaining objectivity and impartiality necessary for a true partnership. We are encouraging larger organizations to fund the coordinator position, while encouraging smaller organizations to provide other needs or resources in-kind.
We are confident that this will happen based on our preliminary conversations with various organizations and will therefore provide the primary means for sustainability of the network.

The goal of the network will be consensus decision-making among the members of the governance board with accommodation made for the rare situations in which this may prove impossible. Input from the larger community will be solicited on a quarterly basis, and this will inform the decision-making of the governance board on an ongoing basis.

Region Covered by Network Services

County/State	County/State
Southern Berkshire County, MA	

Network Partners

Organization	Location (City/State)	Organization Type
Fairview Hospital	Great Barrington, MA	Critical Access Hospital (CAH)
Community Health Programs	Great Barrington, MA	Federally Qualified Health Center (FQHC)
East Mountain Medical Associates	Great Barrington, MA	Physicians' Clinic

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Maine

Health Access Network
Northern Penobscot County Integration Initiative
P10RH31080

Project Focus Areas

Access to Care
Substance Use/Addiction

Network Statement

The Northern Penobscot County Integration Initiative Network is addressing the lack of local substance use services by expanding services and strengthening the rural health care system. As core members of the Integration Initiative, Health Access Network, Penobscot Valley Hospital, and Community Health and Counseling Services concur that the delivery of substance use services in Northern Penobscot County is inadequate to address the growing substance use disorder epidemic. Members further agree on the need to address the lack of substance use treatment options and identify new service models. We recognize that any new services and models will require greater community engagement, as well as closer clinical, operational, and organizational integration among our Network members. Our efforts have focused on identifying the current level of need and service gaps and exploring models of service that are appropriate for our rural setting and that can be tailored to support the emerging rural integration efforts of the Network members. In addition to the three core Network members, Save-A-Life Coalition, VA-Lincoln Community-Based Outpatient Clinic, and Lincoln Economic Development Committee participate as consultants/advisors on the escalating drug and alcohol addiction problem faced by the region.

Network Development

The goal of the Network is to identify gaps in substance use services and investigate various strategies for integration of new services as the first step toward action. The Northern Penobscot County Integration Initiative seeks to ensure that the residents of northern Penobscot County have ready access to a full continuum of rural healthcare services, especially those necessary for the treatment of drug and alcohol dependency.

Network members were chosen because they represent nearly 100% of the healthcare providers in the service area. These members also share a mission to provide critical healthcare and behavioral health services in this rural, economically-challenged area. Increased patient access is clearly an objective that all Network members and partners ascribe to and intend as an outcome of these integration efforts. Maintaining the current continuum of care is paramount to the Network members, the communities, and clinical providers. Attempting to redesign this rural delivery system, comprised of so many individual organizations, has proven to be no small task. This is especially true in the rural Northern Penobscot County communities where three major employers have closed over the last 8 years. The loss of three paper mills in these communities has created an increase in unemployment rates as well as uninsured populations. While the arrival of the marketplace insurance through the Affordable Care Act has assisted many in obtaining coverage, most individuals still rely on discounted health care programs offered by most of the Network partners. Therefore, when offering new service lines to treat substance use disorders, the Network must take into consideration where these services are best housed to keep discounted services available, such as at Health Access Network where a sliding fee schedule is offered.

Two of the three initial Network members have also had changes to the leadership teams with CEO turnover in the last year. These changes caused a slow start at the beginning of the grant period and delayed progress in the network's development. The Network team had to generate more momentum by recruiting other essential members within the community, such as municipalities, EMS, law enforcement, local school systems, and public health. The addition of these team members created a better understanding of the community's need and further strengthened the network's mission and goals.

Programmatic Development

The Network's goal of identifying clinical, operational, and organizational integration options, starting with drug and alcohol treatment, is a major undertaking. Fortunately, many other providers in the community have indicated a willingness to consider clinical and operational integration to ensure the continuation of critically needed healthcare services in the region.

Early in the program development period, the Network began conducting a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis and quickly realized the original objectives, goals, and direction needed adjustment to meet the community's needs for the treatment of substance use disorders. The goal of repurposing beds at the local Critical Access Hospital currently seems unachievable. The emerging need in the community was pointing more to outpatient care than to inpatient care. Penobscot Valley Hospital is also struggling financially and does not have the resources to start a new line of service that is non-reimbursable by most insurance plans. Due to the low economic status of most the community members, the inpatient service would not be affordable. Therefore, the program development has focused on access to existing services such as MAT programs at the local FQHC (Health Access Network) and telehealth services at Community Health and Counseling.

Community-based clinical and non-clinical providers, especially those serving substance use patient populations and or social determinates of health, have engaged with the Network and want to advance those efforts. They realize that participation with the Network has many patient and organizational advantages. Some unexpected but positive outcomes have included: prevention education regarding substance use disorders to school age children; planning efforts to create a referral system from the local Emergency Departments to the MAT program; training programs for recovery coaches in the community; and work with local law enforcement.

Sustainability

The Network intends to continue to develop methods of substance addiction service integration across all its members and the communities served to achieve sustainability. The Network recognizes the need to strengthen and sustain capacities at the Network member, community, and patient engagement levels. At each level the program will ensure effective prevention, support community engagement activities, and cultivate an environment that fosters support for intended outcomes.

The Northern Penobscot County Integration Initiative will maintain its focus on developing systems that improve access to effective services for prevention and reduction of substance use disorders. Achieving and sustaining desired population change does not happen in a year, but over many years of collaborative efforts. The Network is committed to building a health care community whose scope of work and efforts over multiple settings, locations, communities, and populations of patients focus on integrating all factors that affect a person's health. Understanding and leveraging resources to effectively address factors that contribute to substance use issues will strengthen the patient population and elevate the whole community. Ongoing communication, awareness, support

and cultivation of new stakeholders are all strategies for sustaining and developing an integrated community for treatment and prevention of substance use disorders.

Areas of focus for service sustainability going forward include: Medication Assistance Treatment (MAT) at Health Access Network; evaluating and addressing social determinants of health for substance use disorder populations; community wide education and prevention awareness; emergency room referral process to MAT program; education/prevention/treatment in the school systems; and improved care coordination between organizations for better patient outcomes. To accomplish these goals beyond the grant period, the network has secured additional funding from Federal and State agencies to assist with resources such as recovery coach training, telehealth equipment, and the employment of a MAT Registered Nurse Care Coordinator.

Region Covered by Network Services

County/State
Penobscot County, ME

Network Partners

Organization	Location (City/State)	Organization Type
Health Access Network	Lincoln, ME	Federally Qualified Health Center (FQHC)
Penobscot Valley Hospital	Lincoln, ME	Critical Access Hospital (CAH)
Community Health and Counseling	Lincoln and Bangor, ME	Home Health/Hospice
Save-A-Life	Northern Penobscot County, ME	Community Development Organization
VA CBOC – Lincoln	Lincoln, ME	Veterans Administration Clinic
Lincoln Economic Development	Lincoln, ME	Community Development Organization

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Michigan

Central Michigan District Health Department
Central Michigan Regional Rural Health Network
P10RH31090

Project Focus Areas

Care Coordination
Integration of Services
Network Infrastructure Development
Workforce Development

Network Statement

The Central Michigan Regional Rural Health Network (Health Network) was formed in 2015, expanding upon the efforts of the *Together We Can* health improvement initiative that began in 2010. We are a growing network of health, educational, and social services professionals committed to partnering together to improve the health and wellbeing of children, families, and adults, including the growing older adult population, in rural central Michigan. Working together, we share data and other information focusing on the many needs of our underserved rural population and strategize as to how we can collectively address those needs. Health Network members and other participants strive to enhance the services we provide by improving access and integrating services where possible. Through collaboration, we leverage our combined capabilities, adding value to better our community members' health and wellbeing. We stand together in building communities that are healthy, resilient, strong, and viable now and in the future.

Network Development

The Central Michigan Regional Rural Health Network (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.
The primary challenge to network development is geographically based. Most of Health Network members are dispersed over more than 3,000 square miles in the central Michigan region, with several of them located outside of the region. This results in challenges for some Health Network Member representatives if they were required to attend meetings in person, due to the extensive travel time, often lengthened due to inclement weather in winter months. To overcome this challenge, the Health Network uses an online meeting and desktop-sharing video-conferencing software application for the monthly full Health Network member meetings, the monthly

Governance Committee meetings, subcommittee meetings, and any additional meetings that are scheduled. Use of the meeting application allows participants to attend either in person or remotely.

Additionally, the meeting archive maintained on the Health Network website enables those who are unable to attend any of the meetings, as well as the public, to view audio/visual recordings of the meetings, as well as any presentations provided during the meetings. A secondary challenge faced by the Health Network is that many of the members and participants have a limited amount of time available to participate as members of the Governance Committee and/or subcommittees. One approach used to overcome this challenge is to have the Governance Committee meetings scheduled to directly precede the full Health Network meeting and the Operations/Technical Subcommittee meetings scheduled directly following the full Health Network meeting so that the participants do not need to set aside time during another day of the month to attend meetings.

Programmatic Development

The Health Network current objectives have been focused upon expanding the utilization of community health workers (CHWs); developing a plan to implement a sustainable, region wide care coordination hub; collaborating to develop and promote evidence-based or promising practices and programs that address population health needs in the Health Network's identified priority areas; and addressing regional health professional workforce education, training, recruitment, and retention issues.

Because of the Health Network activities, CHW training and certification is now available in the central Michigan region and several Health Network members are now employing CHWs. The CHWs provide care coordination services and assist in increasing access to resources associated with patient needs related to various social determinants of health. Some of the activities conducted in relation to planning for the implementation of a care coordination hub included establishing contact with and coordinating with facilitating stakeholders outside of the Health Network, including national and state agencies and organizations; reviewing existing care coordination hub organizations and models, including their sustainability/funding mechanisms; documenting pathway services provided by Health Network members, who will serve as referral sources for targeted population groups; and identifying assessment/referral protocols.

The Health Network priority areas related to population health include increasing access to health care services; improving behavioral health services, including mental health, substance use disorders, and abuse and neglect; providing reproductive and sexual health services; improving nutrition; and increasing levels of physical activity and access to recreation, with special emphasis on maternal and child health, family health, and older adult/geriatric health. To identify opportunities for collaboration, the Health Network conducted a crosswalk of the priority areas and implementation strategies included in our providers' Community Health Needs Assessments. In this way, members could leverage their combined capabilities, identify program champions and collaborative partners both within the Health Network and among other facilitating stakeholders in the community, partner to respond to funding opportunities and develop and implement programs, schedule presentations regarding priority area programs at the Health Network meetings, and encourage co-location of program events to increase collective impact and assist in promotion of events and programming.

In addressing regional health professional workforce education, training, recruitment, and retention issues, the Health Network focused on the workforce "pipeline" and the various segments which work on developing individuals, ranging from those in secondary education to those at the post graduate level. Participating Health Network team members included Area Health Education Centers, colleges and universities with health professions and medical programs, and health professions employers. Additionally, the Health Network obtained the support and assistance from additional facilitating stakeholders, such as the Michigan Center for Rural Health's Recruitment and Retention Manager and state and local employment and economic development authorities. Some of the

activities included promoting programs that afford secondary level students the opportunity to improve their health professions knowledge and skills, expanding health curriculum offerings, developing and implementing strategies to increase the availably of health profession scholarships in the region, promoting increases in the number of internship opportunities; and providing continuing education workshops and seminars.
Innovative approaches have been used: 1) encouraging input from members regarding programs of interest to their individual organizations, which serves to keep them engaged, 2) providing presentations from various health program subject matter experts regarding innovative, evidence-based ideas and programs to expand members' base of knowledge and enhance the likelihood that they will be able to develop and implement programs within their individual organizations, and 3) including multiple academic institutions in the Health Network to expand members' knowledge of practical applications related to population health research and to provide access to additional resources, both for grant application development and expansion of workforce capacity at the programmatic level.

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. Staffing levels will be maintained and potentially expanded based upon availability of funding. Potential funding sources for Health Network operations include member contributions, grant awards from public and private sector entities, and in-kind contributions. All committees are responsible for identifying funding sources, and the Finance/Sustainability Committee is tasked with continually updating the Health Network sustainability plan and opportunity "tracker," which contains information about opportunities in development as well as those that are anticipated for release in the future. The primary challenge faced by the Health Network is a lack of resources dedicated to grant application development. The Health Network has addressed this challenge by encouraging those member organizations with dedicated internal grant application development resources to develop teams including Health Network members that lack such resources and to create those teams in advance of the release of funding opportunities. The Health Network will continue to focus upon both network infrastructure development and programmatic funding, including for cost-reimbursable programs.

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 (City/State)	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

Organization	Location (City/State)	Organization Type
Community Mental Health for Central Michigan	Mt. Pleasant, MI	Behavioral Health
Ferris State University College of Health Professions	Big Rapids, MI	College/University
Gladwin City/County Transit	Gladwin, MI	Transportation
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)
Kirkland 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
Mid Central Area Health Education Center	Mt. Pleasant, MI	Area Health Education Center
MidMichigan Community College	Mt. Pleasant, MI	College/University
MidMichigan Community Health Services	Houghton Lake, MI	Federally Qualified Health Center (FQHC)
MidMichigan Health	Midland, MI	Other
MidMichigan Health – MidMichigan Medical Center Clare	Clare, MI	Hospital
MidMichigan Health – MidMichigan Medical Center Gladwin	Gladwin, MI	Critical Access Hospital (CAH)
MidMichigan 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
Region VII Area Agency on Aging	Bay City, MI	Area Agency on Aging
Roscommon County Transportation Authority (RCTA)	Prudenville, MI	Transportation
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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Minnesota

Lac qui Parle Health Network
Lac qui Parle Behavioral Health Collaborative
P10RH31091

Project Focus Areas

Behavioral Health
Integration of Services
Mental Health
Substance Use/Addiction

Network Statement

Lac qui Parle Behavioral Health Collaborative was created to coordinate and enhance services for people with behavioral health needs in our rural Minnesota communities. We are optimistic that community conversations and coordination of services will provide better outcomes to our citizens who struggle every day with mental illness and chemical dependency.

Our Network is building community capacity to increase awareness of behavioral health needs and resources and to reduce the stigma associated with mental illness and chemical dependency. Partnerships and collaboration are strong assets to this effort. Due to the robust relationships in the community and a consensus held by the partners of the Collaborative, community partners are primed and ready for action. There is a high rate of optimism and active energy that is present in the Lac qui Parle Behavioral Health Collaborative.

Network Development

We have formalized our Lac qui Parle Behavioral Health Collaborative Network by creating a Steering Committee to support and guide the efforts of the Network. The members have agreed on expectations of committee members and decision-making processes, including defining consensus, and approved a communication plan both internally for the Network and externally for the community at large.

We have completed a strategic planning process that included reviewing of all recently completed needs assessments, creating an asset map, and holding a strategic planning event. A 5-year Strategic Plan was creating using all the information obtained through this process. The Strategic plan includes both short and long-term goals and a work plan to guide the Collaborative's efforts.

Through the strategic planning process, an asset map was created that includes services and providers in our area. The asset map will be used to connect our patients/clients with needed services and will be continuously updated to identify gaps in services and innovative ways to fill the gaps.

Programmatic Development

We are building a reliable and streamlined a system for screening and referring patients with behavioral health needs. The Primary Care Providers have agreed on using the PHQ-9 for screening patients. The providers have also agreed on guidelines for referring and treating patients based on the resulting screening score. A high priority has been placed on creating a streamlined process for referrals between Primary Care and Behavioral Health providers as well as ensuring follow through with referrals and recommendations.

We recently rolled out a media campaign to reduce the stigma associated with Behavioral Health wellness, prevention, and treatment services. Each of our Network partners will assist in sharing the information through their websites, Facebook posts, and other media platforms.

Sustainability

We have expanded, and will continue to expand, our present Network to include more partners. Most partners are currently attending meetings and are engaged and committed to the outcomes of this Planning grant. Providing value to our partners is essential as we move the project forward and look at sustaining the Network. We hope one of the many outcomes is a shared cost savings that will allow each of the Collaborative organizational partners to reinvest those savings into additional strategies identified through the planning process.

Funding to enable the Project Manager to continue to coordinate and facilitate the monthly meetings and provide leadership to the partnership has not been determined past the Network Planning Grant funding period. The Collaborative will look at new funding opportunities to continue funding staff as well as the coordination of services to reduce barriers for those with behavioral health needs.

Region Covered by Network Services

County/State	County/State
Lac qui Parle County, MN	Swift County, MN

Network Partners

Organization	Location (City/State)	Organization Type
Lac qui Parle Health Network	Madison, MN	Non-Profit
Appleton Area Health Services	Appleton, MN	Critical Access Hospital (CAH)
Johnson Memorial Health Services	Dawson, MN	Critical Access Hospital (CAH)
Madison Healthcare Services	Madison, MN	Critical Access Hospital (CAH)
Woodland Centers	Willmar, MN	Behavioral Health
Countryside Public Health	Benson, MN	Public Health
Lac qui Parle County Human Services	Madison, MN	Social Services Agency
Swift County Human Services	Benson, MN	Social Services Agency
Lac qui Parle County Sheriff	Madison, MN	Law Enforcement
Swift County Sheriff	Benson, MN	Law Enforcement
Southwest EMS	Dawson, MN	Emergency Medical Services (EMS)
Lac qui Parle Valley Schools	Madison, MN	School System

Organization	Location (City/State)	Organization Type
Dawson Boyd Schools	Dawson, MN	School System
Prairie Five Community Action	Montevideo, MN	Social Services Agency

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Montana

Cabinet Peaks Medical Center
Lincoln County Health Alliance
P10RH31088

Project Focus Areas

Behavioral Health
Care Coordination
Health Information Technology
Network Infrastructure Development
Telehealth

Network Statement

Dealing with challenges related to living in a remote location with lack of economic and other resources, the healthcare providers of Lincoln County strive to limit additional barriers that exist in improving population health. While network partners may be very different, we all have one thing in common – our desire to provide exceptional care to the patients we serve since our patients are our co-workers, our friends, and our family members. Our focus on patient-centered care fueled our desire to collaborate and align our resources and strategies.

Already, our network has established our mission and vision, set priorities, and committed to working on our initiatives to become a sustainable model for improving frontier population health. Recognizing the value of timely access to secure health information to allow our providers to make right decisions at the right time about the right patient, the leaders of our organizations pledged to come together as a network to improve access and delivery of patient care in rural Montana with coordinated efforts for health information exchange. We have the potential to grow our network with other partners in our community to enhance care coordination and collaboration. We are confident that together we can improve the health of our communities across the care continuum.

Network Development

Lincoln County Health Alliance (LCHA) was formally established as a rural health network in July of 2017, with Cabinet Peaks Medical Center, Northwest Community Health Center, Libby Clinic, Center for Asbestos Related Disease (CARD), and Kalispell Regional Healthcare signing a Memorandum of Understanding. After establishing network structure and Board members, LCHA started working on initiatives with the end goal of developing a strategic plan. A Community Health Needs Assessment (CHNA) was completed by the end of August. The results helped the LCHA better understand the needs of the community and helped identify areas of focus for the telehealth strategic planning session in October 2017. The LCHA realized the value of the network through this session as each network member brought different perspectives, increasing the LCHA's ability to do things that individual organizations could not accomplish alone. With the knowledge and expertise of each Network member, the LCHA identified areas for potential telehealth strategies. LCHA was also able to discuss the potential strategies in terms of demand, practicality, capacity, and growth and to identify areas that would be most beneficial to the

community. Through this process, the LCHA realized the network's potential for resource sharing, avoidance of duplication, and better coordination for patients.
During the Care Coordination Assessment, one of the clinic network members decided to withdraw their membership in the network. While this was devastating at first, the LCHA turned this into an opportunity for another network member, thus allowing another clinic to participate in the assessment, and the Network benefitted from their participation. The Care Coordination Assessment identified opportunities for better flow of information between the clinics and education to existing care teams about team-based approach to care, including Chronic Care Management (CCM), Transitional Care Management (TCM), and Collaborative Care Management (CoCM). The Assessment also provided information on how LCHA can ensure sustainability of the network's initiatives by exploring revenue streams associated with TCM, CCM, and CoCM.

Programmatic Development

All the data collected through the CHNA, the telehealth strategic planning session, and care coordination assessment were used by the LCHA to formulate a Mission and Vision statement. The Network Development Planning Grant project provided the LCHA the forum to complete a SWOT analysis and come up with common goals and initiatives together as a network. Through this process, the LCHA discovered that majority of the facilities already have unused technology in place that can have a significant impact on facilities' ability to share health information electronically without additional financial investment. Having the expertise of a HIT consultant to help guide and direct the network was crucial in engaging the network members to commit resources needed to move forward with the initiatives related to improving health information exchange.

Through interactions within the LCHA, the network members were also able to identify other opportunities for cross-organizational collaboration. Mental health and substance abuse were identified as the most pressing health concern for Lincoln County in the 2017 CHNA. Through the telehealth strategic planning process, the network came to consensus to focus on behavioral health as the network's priority for collaboration. As a result, CPMC submitted a HRSA Rural Health Care Services Outreach Program grant application for LCHA on implementing a Collaborative Care Program, an evidence- based program shown to improve patient outcomes and reduce cost of care. Without the data and expertise obtained through the Network Development Planning Grant project, it would not have been possible to formulate a brand-new service for Lincoln County that can help address the mental health crisis in our community and still be feasible and sustainable by the Network.

Sustainability

LCHA will be able to implement the Collaborative Care Program if CPMC receives funding for the HRSA Rural Health Care Services Outreach Program. The grant funding would allow the program to be implemented and grow to the point where it will be sustainable with the payer reimbursement through CoCM services provided by the program. Even if LCHA does not receive HRSA grant funding, there are components of the program that can still be implemented by the network members to improve care coordination and information sharing between clinics.

Regardless of grant funding status, all the members of the LCHA have expressed their commitment to provide resources to continue to work on the initiatives that have been outlined in the Strategic Plan. The LCHA will continue to look for additional grant funding in the future to assist in completing all the initiatives. The LCHA has benefitted from having the opportunity to come together as a group with a common goal, and creation of the network's Mission and Vision sparked an excitement and passion among the group. While LCHA may be lacking in funds and HIT knowledge with limited resources, the LCHA is quick and nimble. Our network also realizes the importance and value of improving HIE in the community and have provider interest and support in the project. While the Network members may have differing priorities and competing initiatives, all the members have one goal

in common – improving the health of our communities across the care continuum. Our dedication and focus on our patients will help sustain the Network.

Region Covered by Network Services

County/State
Lincoln County, MT

Network Partners

Organization	Location (City/State)	Organization Type
Cabinet Peaks Medical Center	Libby, MT	Critical Access Hospital (CAH)
Center for Asbestos Related Disease	Libby, MT	Other
Northwest Community Health Center	Libby, MT	Federally Qualified Health Center (FQHC)
Kalispell Regional Healthcare	Libby, MT	Hospital

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New Mexico

Rio Arriba County Health & Human Services
Northern New Mexico Rural Health Network
P10RH31092

Project Focus Areas

Access to Care
Alleviating Loss of Local Services
Behavioral Health
Care Coordination
Health Information Technology
Substance Use/Addiction

Network Statement

Northern New Mexico has led the nation in opioid drug overdose deaths for the past two decades. Culturally, our region is diverse and has one of the highest populations of federally recognized Native American tribes and Hispanic populations in the Nation. Our rural and frontier communities have remained in this region and thrived in this region for centuries. In 2015, primary care and behavioral health providers came together to focus exclusively on substance use, integrate healthcare and behavioral healthcare systems, leverage expertise among providers, and create the norm that substance use disorder is a chronic disease and not a criminal act. By working across county lines and sovereign tribal boundaries, we are creating a community that is supportive of recovery and giving people hope.

Our Northern New Mexico Rural Health Network is united in creating a coordinated system, based in best and innovative practices, a system that utilizes health models which are supportive, positive, strength-based, and holistic. With that focus and determination, our Network understands that each of our member organizations has a stake in promoting recovered communities, and we understand our work and innovations may become a model for other rural and frontier communities. We have set priorities, added additional youth-engaging and early childhood education partners, and focused keenly on sustaining our Network's cohesion and sustainability. Together our Network is strategizing a full court press on the substance use disorder issue in the region and forging a vision of hope for the communities and families we serve because together we are stronger, can leverage additional resources, and are best positioned to do more.

Network Development

The Northern New Mexico Rural Health Network works to advance three essential goals in the Northern New Mexico region: (1) expand access to essential primary and behavioral health care, (2) coordinate healthcare delivery services across multiple health and social service agencies and (3) improve the quality of those services that enhance the delivery of healthcare in rural and frontier Rio Arriba and Taos counties, New Mexico. Our Network has added youth-serving and early childhood behavioral health service providers to better serve families who are in crisis dealing with substance use disorder. These newly added Network members are also helping the Network

address multi-generational family substance abuse which has caused high incidence rates of grandparents raising grandchildren in the region.

New partners include: Las Cumbres Community Services, Inc. (an early childhood service provider and founder of the statewide program, Grandparents Raising Grandchildren) and Taos Alive (a Program of our local Critical Access Hospital which engages youth around substance abuse prevention and education). Together, the Northern New Mexico Rural Health Network consists of ten agency members who have formalized their commitment and resources to the Network through a signed MOU. These Network members represent the behavioral health providers, federally qualified health centers, critical access hospitals, non-profits and tribal government agencies that are doing the work in community to address substance use disorder among all population demographics.

Northern New Mexico is also geographically diverse, and there are frontier areas in each county and Native American jurisdiction that are inaccessible at sometimes in the winter due to the rugged Sangre de Cristo mountain ranges. Healthcare service delivery in the region has traditionally been geographically based. To foster a greater awareness of understanding of each agency's programs and services, each Network member hosts a monthly Network member meeting and offers a tour of their agency's offices, key staff personnel, behavioral health providers and programs.

To foster trust and open communication among our Network members across local government jurisdictions, our Network has begun communications on local radio stations to inform thousands of listeners in the region about the Network's function. Our internal Network communications have also strengthened as priorities are advanced between an internal CORE team (consisting of the Project Director, Network Director, Project Coordinator and Evaluation Team) and the entire Network Membership. These open communication lines have not only improved cross-agency referrals but also made the public aware of career opportunities that exist within our Network's agencies in the region.

Programmatic Development

In 2018, our Network focused on breaking down silos which have persisted for decades within our region's healthcare system. We have added strategic partners to our Network, including but not limited to: local community foundations, local government agencies, law enforcement and media partners. These strategic partnerships have facilitated a greater understanding of barriers and solutions to substance abuse in our region, while maintaining the core identity of our Network, which is a Network of provider agency members.

The Northern New Mexico Rural Health Network has recognized that providers in different counties / tribal programs have different areas of expertise. To facilitate learning about innovations and best practices, we have implemented cross-county provider trainings to bring safer opioid prescribing practices to all prescribing practitioners in the region and promote trauma-informed care practices, including motivational interviewing and crisis intervention trainings among providers and first responders in the region.

Our Network is now focused on the problem of recouping reimbursement payments from managed care organizations for behavioral health services provided to individuals and families in the region. By harnessing our collective relationships with law makers and cultivating a team of legal experts to deal specifically with the issue, our Network members are forging new solutions to this problem and leveraging resources which were previously unknown.

Sustainability

To assure the needed level of community wide engagement to sustain this effort beyond grant funding, the CORE team will facilitate strategic partnerships among higher learning institutions, media campaigns, and community foundations, senior aging services, workforce development programs, and housing initiatives. Through these strategic partnerships, the Network will continue to raise regional awareness about substance abuse and evaluate potential models of integrated healthcare service delivery.

This planning project takes a small step toward unifying efforts across geographic and government jurisdictions to address substance abuse with its focus on opioid recovery supports. What is learned from this process will be applied to other areas. This shared mission will assure Network sustainability beyond the Network Planning funding cycle.

The CORE team is creating a grant matrix to identify Federal, State, Local, and Private funding opportunities for our programmatic activities. Together with the CORE team, the Network members and partners will plan for sustaining the Network as a formal structure and maintain its ability to conduct programing to support the members and the community and will seek resources to keep the Network and its capacity sustained over the long term.

Region Covered by Network Services

County/State	County/State
Taos County, NM	Rio Arriba County, NM
Taos Pueblo / Federally Recognized Tribal Nation, Taos, NM	

Network Partners

Organization	Location (City/State)	Organization Type
Rio Arriba Health & Human Services Department	Espanola, NM	Public Health
Taos Alive	Taos, NM	Non-Profit
Holy Cross Medical Center	Taos, NM	Critical Access Hospital (CAH)
El Centro Family Health	Espanola and Taos, NM	Federally Qualified Health Center (FQHC)
Presbyterian Medical Services	Espanola and Taos, NM	Emergency Medical Services (EMS)
Las Cumbres Community Services, Inc.	Espanola, NM	Non-Profit
Hoy Recovery Program, Inc.	Velarde, NM	Behavioral Health
Taos Pueblo Division of Health & Community Services	Taos Pueblo, NM	Tribal Nation
Rio Grande Alcohol Treatment Program	Taos, NM	Behavioral Health
Tri-County Community Services, Inc.	Taos, NM	Behavioral Health

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New York

Westchester Ellenville Regional Hospital
Ellenville Area Rural Health Network
PH10RH31089

Project Focus Areas

Access to Care
Care Coordination
Integration of Services
Network Infrastructure Development
Other: Patient Engagement
Workforce Development

Network Statement

Our community experiences serious health challenges, like so many rural regions across the nation. At the same time, our community shares a special commitment to collaboration, pulling together to improve the lives and health outcomes of area residents.

The Ellenville Area Rural Health Network leverages the expertise of diverse stakeholders, including community residents, to find innovative strategies to bridge gaps in care and overcome barriers to reaching better health. We have found that listening to the community and professionals from a variety of agencies allows us to pinpoint challenges, identify creative solutions, and work together to implement programs to support better health. Already, we have formed a solid network foundation, engaged a variety of partners, collaborated for more coordinated services, and completed a community health needs assessment with substantial resident feedback. The Ellenville Area Rural Health Network is moving toward a sustainable future with advancing measurable health improvements in our community.

Network Development

Westchester Ellenville Regional Hospital (dba Ellenville Regional Hospital), along with its partners, was awarded the 2017 Rural Health Network Planning Grant, leading to the successful development of the Ellenville Area Rural Health Network. This partnership worked together to set a strong foundation and network structure, facilitate leadership commitment, develop mission and vision statements, establish formal bylaws, begin coordinating healthcare services, implement a comprehensive Community Health Needs Assessment (CHNA), and hold stakeholder meetings to share successes of the network and facilitate community engagement. Strong commitment by network partners, including regular meetings, sharing of responsibility, and open discussion of network goals and vision all contributed to these successes.

Challenges of network development included coordinating between schedules and needs across agencies and the distance between some partner representatives. To facilitate commitment and convenience of regular meetings, the network meets bi-weekly by phone with tasks between meetings shared by members and utilizes regular email communication. Face-to-face meetings are held on a monthly or bi-monthly basis, often scheduled along with

other conference or relevant events to optimize these opportunities. Additional challenges faced by the network continue to surround funding for ongoing activities.
The network was successful in securing a HRSA Federal Office for Rural Health Policy Rural Health Care Services Outreach Grant to implement a cardiovascular disease prevention program in our community. Also, the network is collaborating to offer programs such as the Stanford Diabetes Self-Management Program and partnering with other community agencies to bring free programming to residents, such as a new walking club and nutrition classes at the local public library.

Innovations of this network include considerable participation in community coalitions and advisory boards as a means of collaboration, networking, and resource sharing with our community partners outside the network. In addition, we have brought attention to our network and the needs of our community by engaging with local and state government, inviting them to be a part of solution-finding efforts, and by leading area trainings for professionals as well as residents. The network partners demonstrate their commitment and innovation by including top leadership and decision-makers as the representatives for their agencies in the network.

Programmatic Development

Our network leadership demonstrates remarkable innovation in their commitment to collaboration. For instance, the CEOs from two of our partner agencies, Ellenville Regional Hospital and the Institute for Family Health, sit on each other's Board of Directors and have been willing to share data and electronic health records and co-locate staffing to improve coordination of care and patient access. Partners are willing to take risks together and begin implementing programs and provision of direct services, regardless of outside funding, to advance the health of community residents and shared patients. For instance, in response to community concern about a high prevalence of diabetes, the hospital and the Institute collaborate in offering the Stanford University Diabetes Self-Management Program to patients and community members alike. Both agencies promote the program by referring their patients, and the Institute's Certified Diabetes Educators facilitate the program at the hospital.

Sustainability

All partners committed to the network through letters of intent and have agreed to sign a shared Memorandum of Understanding to further formalize their dedication to our long-term success. In addition to seeking grant opportunities collaboratively to fund future programming and assure the sustainability of our network, partners have worked together to coordinate services to better serve our shared patients and community. As a valuable partner, the County has been vital in providing data and helping to promote our programs via their Healthy Ulster County Website. As mentioned, the Institute and the hospital are coordinating care through regular collaboration, co-location, and data sharing. These programs allow partners to provide better care and advance their individual missions while serving the greater purpose of the network. Coordinated activities and collaboration will persist and benefit all network efforts, again, regardless of external funding.

Our network has successfully collaborated to secure grant funding by having recently received a HRSA FORHP, 3-year Rural Health Care Services Outreach Grant to advance cardiovascular health within our community, allowing us to further formalize our network, develop direct service programming, and engage with additional partners. Shared efforts for this new initiative are underway, with a new collaborative walking group and nutrition class being held on a weekly basis at the local public library. Weekly yoga classes are scheduled to begin this summer as a part of our effort to improve cardiovascular health. A recent stakeholder forum revealed additional programming that will be meaningful to our community, such as life-skills, stress and coping, tobacco cessation, and drug and alcohol

prevention classes at existing community events or venues. We are confident that small successes through effective programming with measurable impact will help to secure our sustainability.

Region Covered by Network Services

County/State	County/State
Ulster County, NY	Sullivan County, NY (very small portion)

Network Partners

Organization	Location (City/State)	Organization Type
Ellenville Regional Hospital	Ellenville, NY	Critical Access Hospital (CAH)
The Institute for Family Health	Ellenville, NY with Admin in NYC	Federally Qualified Health Center (FQHC)
Ulster County Department of Health and Mental Health	Kingston, NY	Public Health

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Oklahoma

Stigler Health and Wellness Center, Inc.
Southeast Alliance Network
P10RH31095

Project Focus Areas

Alleviating Loss of Local Services
Behavioral Health
Care Coordination
Care for the Aging
Mental Health
Network Infrastructure Development

Network Statement

The southeast region of Oklahoma is one of the most financially challenged areas of the state. Despite all the health, social, and economic barriers our rural counties face, we are a community defined by determination and solidarity. In response to the challenges facing our community, southeast Oklahoma health care leaders and their organizations came together in 2017 to form collaborative partnerships that share resources to create sustainable, healthy communities. We feel that integrating partnerships across the spectrum of care has the potential to improve the health and well-being of our communities and increase access to care in an innovative and sustainable way. Our current priority is on aligned strategies around rural hospital sustainability with focus on care coordination, especially between hospitals and behavioral health services. Our network has set out to fulfill this mission by organizing, setting goals and priorities, and promoting this vision in our region for healthy, resilient communities. The Southeast Alliance Network is determined to improve lives in rural southeast Oklahoma as we work together for a healthy, more prosperous state.

Network Development

The Southeast Alliance Network represents eight healthcare organizations to date, including hospitals, Federally Qualified Health Centers, and social service organizations serving 15 counties in Southeast Oklahoma. To formalize the Network, a Director was hired to lead Network activities. An information session was then hosted with all organizations who were part of the initial grant application, as well as Federally Qualified Health Centers in the region, to discuss next steps in Network development. During this time, organization leaders discussed the purpose of the Network and, with the assistance of legal counsel, considered different legal structures to pursue. Subsequently, in the first official meeting of the Southeast Alliance Network, Board members and officers were elected, bylaws adopted, and committees were put in place to implement activities. Committees established to date include Care Coordination, Hospital Sustainability, Finance/Innovation, Network Development, and a new committee to focus on information technology strategies. Levels of membership were defined in the bylaws, and membership in the corporation required an agreed upon capital contribution. The Network incorporated as a not-for-profit organization in the state of Oklahoma and filed for 501(c)3 status with the Internal Revenue Service. It also adopted operational, fiscal, corporate compliance, and grant management policies.

One of the greatest challenges faced in Network development was garnering support from organizations which had committed to participating during the grant application process. Due to leadership turnover, there were several organizations that lost interest in becoming members of the Network by the time the grant period started. For this reason, different levels of membership were defined in the corporation's bylaws to provide varying options for participation in the Network's services. Currently, one of the organizations which did not become a member but signed an MOU for the grant application has engaged in revenue management activities as part of the Network's hospital sustainability activities. SEAN will continue engaging with member hospitals and other hospitals in the service region to develop hospital sustainability plans.

Programmatic Development

To develop programs and provision of services provided by SEAN, the Network collected and analyzed all existing Community Needs Assessments for the service region and created a comprehensive survey to fill in the gaps in content and geographic coverage. This survey was distributed in paper format and through an online link in the entire service area with the help of a Network member, Ki Bois, which worked with different coalitions in the area, as well as through each Network's organization's channels including patient portals, social media, mass emails, and paper surveys to patients. Survey data is currently being analyzed and a report will be created to inform future program design, funding applications, and to educate the public, legislators, and funders, among other stakeholders in the region. In conjunction with this needs assessment, a survey was developed to gather community input from stakeholders in the service area regarding unmet health needs, quality of care, and access to care in each county. The survey data was analyzed to identify qualitative trends, which will be included in the final Community Needs Assessment report.

The Network formed a committee dedicated to care coordination strategies. This committee is made up of members representing FQHCs, hospitals and social service organizations. Members meet once a month to collaborate on care coordination strategies particularly with a focus on patients who present to the emergency department with behavioral health needs. An initial assessment was delivered to assess where each Network member's organization was in terms of care coordination strategies. From there, several models for behavioral health coordination were explored and assessed. The committee decided to use the Screening, Brief Intervention, and Referral to Treatment (SBIRT) as an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. Several members were already familiar with this and implementing it in their own practices. Therefore, the gap in service was determined to be not the processes within each clinic or hospital but that patients with behavioral needs who presented to the emergency department were falling through the cracks and not receiving outpatient follow-up care, leading to poor health outcomes and increased ER utilization. The committee found that this could be addressed by putting a referral process in place using IT in which the ER discharge personnel could send a referral utilizing direct messaging to primary care providers within SEAN's network. This conclusion was reached after exploring various IT referral tools available within the region. A centralized scheduler would be utilized to receive all discharges, which will in turn route referrals to the appropriate clinics based on the patient's location and preference within the service region. The clinics will receive the referrals and bring the patient in for follow-up. Then, they will report back to the hospital to close the loop in referrals. This procedure will be presented to the Network's Board for approval, followed by development of a toolkit containing procedures, processes, and training materials to be adopted by Network members.

The network also formed a committee dedicated to hospital sustainability strategies. This committee is made up of members representing hospitals, FQHCs, and community members. It researched successful hospital turnaround models and collected examples of strategies. To identify areas for collaboration, the committee is developing a matrix of services to be offered by member hospitals. A plan has been developed to bring one of the member's

hospitals back to financial performance, to include a cash management plan and prioritized actions; and, the plan has been adopted.
Due to network membership turnover, the Network only had two official and engaged hospital members. Two of the initial members named in the grant did not participate fully in activities due to leadership turnover. Therefore, SEAN has yet to make specific recommendations to each hospital to bring it back to positive financial performance. SEAN is still engaged with the two initial hospital applicants, while working on recruiting additional hospital members. It is in the process of assisting one hospital with revenue cycle management but has yet to provide a more holistic plan to members to improve operations and revenue. SEAN has had to evolve its strategy to accommodate the varying levels of involvement from its member healthcare organizations. Considering the variances in involvement of its member organizations, the Network has yet to seek contractual and technical assistance to develop final hospital sustainability plans

Sustainability

One of SEAN's organizational goals is to build and strengthen the infrastructure of the Alliance for long-term sustainability and overall success. All programs that began with the Network Planning grant will be sustained. To do so, the Network's leadership has identified the need to form a Finance/Innovation Committee to focus on sustainability objectives. This committee will focus on identifying future financial sources, including but not limited to looking at foundations and other financial sources to target; identifying new members; continue grant writing; exploring strategic partnerships; evaluating economic incentives such as Economic Development Groups in each community; and, enlisting help of Board for 1:1 presentations and leveraging of funding network(s). In addition, this committee will develop an inventory of current people resources available to the Alliance, as well as identify revenue centers including but not limited to employee training, home health, pharmacy and after-hours calls. In addition to the sustainability efforts of the Finance/Innovation Committee, SEAN's Board will devote time to being creative and innovative, review bylaws and determine membership levels as new members join the Alliance. Furthermore, the Network Development Committee will explore shared service opportunities. Action items under this sustainability effort include planning a CFO meet-and-greet, exploring a credentialing and recruiting shared service, hosting a luncheon for SEAN with family medicine residents, and expanding MRHC's residency program to include rotations in Alliance members' organizations. These objectives will assist the Network with funding, staffing, and member recruitment to achieve long-term sustainability.

Region Covered by Network Services

County/State	County/State
Atoka County, OK	Le Flore County, OK
Bryan County, OK	McCurtain County, OK
Choctaw County, OK	McIntosh County, OK
Coal County, OK	Muskogee County, OK
Haskell County, OK	Pittsburg County, OK
Hughes County, OK	Pushmataha County, OK
Johnston County, OK	Sequoyah County, OK
Latimer County, OK	

Network Partners

Organization	Location (City/State)	Organization Type
Atoka County Medical Center	Atoka, OK	Critical Access Hospital (CAH)
Caring Hands Healthcare Centers	McAlester, OK	Federally Qualified Health Center (FQHC)
Family Health Center of Southern Oklahoma	Tishomingo, OK	Federally Qualified Health Center (FQHC)
Ki Bois Community Action Foundation	Stigler, OK	Social Services Agency
Kiamichi Family Medical Center	Idabel, OK	Federally Qualified Health Center (FQHC)
McAlester Regional Health Center Authority	McAlester, OK	Hospital
Pushmataha Family Medical Center	Clayton, OK	Federally Qualified Health Center (FQHC)
Stigler Health and Wellness Center	Stigler, OK	Federally Qualified Health Center (FQHC)

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Oregon

PeaceHealth Peace Harbor Medical Center
Western Lane Behavioral Health Network
P10RH31094

Project Focus Areas

Behavioral Health
Care Coordination
Network Infrastructure Development
School-based Clinics
Telehealth

Network Statement

Like many communities, we face some tough challenges to improving access to healthcare. But like so many of the physical features of the central Oregon coast itself, our community has always weathered its challenges with a unique combination of strength and flexibility. A grassroots coalition of local leaders in healthcare, social services, and education joined forces to fill the gaps that leave our community's children and their families struggling in the absence of adequate physical and emotional healthcare.

We seek to bring better care closer to home so that all children and families in Western Lane County have access to the care and support they need for stability and success. By drawing on the expertise, tenacity, and assets we already possess as a community, we are laying the groundwork for innovative, adaptable, sustainable school-based healthcare programs that fill the unique needs of the communities they serve. We have already secured significant grant and private funding support, and we continue to strengthen our ties to the community, medical providers, and other organizations that enthusiastically support our vision. Together, we will ensure that central coast children can count on consistent, high-quality care.

Network Development

Our Network began in 2012 as informal conversation between community partners. It was seeded by a HRSA Rural Health Network Planning grant in 2013-14 that took root through a subsequent planning grant in 2015-16 focused on behavioral health services and grew stronger through 2017-18 planning for youth behavioral health. Today we are a network of seven-member organizations that have signed MOUs and have added an additional network partner that shares the vision and has a stake in outcomes.

The network faced potential challenges when leading individuals from network partner organizations rotated off and new representatives replaced them. We addressed this challenge by keeping partner organizations informed and reminding them of how their organizational missions and goals align with the Network's collective efforts, regardless of the individual who might represent their organization, and by providing welcoming and transparent orientation for new representatives.

Programmatic Development

The West Lane Behavioral Health Network (WLBHN) has made significant progress toward our goals by working collaboratively with our member organizations and engaging the wider community to identify school-based health centers in Mapleton and Florence, Oregon, as the best options to increase accessibility of care in our community.

Through secondary research and community forums, we have also determined that each location will offer site-specific services based on the gaps in care experienced by members of the smaller communities within the Network service area. For example, the more rural Mapleton site has been identified as needing a wider range of services from primary care to youth behavioral health to parenting classes, while the medically better-served Florence site will focus specifically on youth behavioral health care.

Each Network organization has identified ways it can contribute – from expert consultation, to volunteer time, to financial investment. Additionally, all partners are actively engaged in outreach to their own professional and community networks to strengthen our ties to the community, medical providers, and other organizations to recruit additional help in realizing our vision. For instance, outreach by one of our partners has already resulted in a significant donation of time and expertise by an architectural design firm, Anderson Debrowski Architects, to develop conceptual floor plans needed to create an accurate capital construction budget for fundraising purposes.

Sustainability

We are committed to a sustainable business model for long-term stability, ensuring that children and their families can maintain access to consistent, high-quality care. Two schools have identified on-campus sites suitable for health centers and agreed to donate the space. Conceptual plans are under development to assist in identifying a private fundraising plan for capital construction. The WLBHN has applied for, and been awarded, an implementation grant from the Federal Office of Rural Health Policy to provide $600k over the next three years to pay for a child behavioral health clinician and community resource coordinator to be shared by the Mapleton and Florence clinics.

PeaceHealth, who has generously provided the Network's administrative support and grant management, has pledged funding for construction of the Mapleton clinic and will provide a practitioner one day per week at that site. The PeaceHealth Foundation is assisting the network in approaching the Oregon Community Foundation and Ford Family Foundation to set up matching grants that have the potential to make a huge impact on our fundraising capacity. A local civic club has expressed interest in major sponsorship of the effort.

In addition to implementation grants and private gifts anticipated to aid in the initial phases of the plan, the clinics are expected to largely fund their own operations on a fee-for-service basis in the long term, with Medicaid paying for a significant percentage of visits.

Region Covered by Network Services

County/State
Western Lane County, OR

Network Partners

Organization	Location (City/State)	Organization Type
PeaceHealth Peace Harbor Medical Center	Florence, OR	Critical Access Hospital (CAH)
Mapleton School District	Mapleton, OR	School System
Siuslaw School District	Florence, OR	School System
Options Counseling & Family Services	Florence, OR	Behavioral Health
The Child Center	Springfield, OR	Behavioral Health
Lane County Health & Human Services	Eugene, OR	Public Health
Trillium Community Health Plan	Eugene, OR	Medicaid Managed Care Organization
Oregon Family Support Network, Lane County	Eugene, OR	Non-Profit

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Pennsylvania

J.C. Blair Memorial Hospital

The INCH Initiative: Integrated Network for Collaborative Healthcare

P10RH31081

Project Focus Areas

Access to Care
Behavioral Health
Care Coordination
Integration of Services
Mental Health
Network Infrastructure Development

Network Statement

As mental health and social determinants of health escalate as primary factors of overall health, The INCH Initiative embraces the opportunity to impact health care models while improving access to care. Through integrated care, the interrelationship between behavioral health and physical health is emphasized as a core element of care. Integrating behavioral health services into mainstream health care settings provides an opportunity to develop comprehensive support for patients and providers in pursuit of the Quadruple Aim.

Through network activities of organizational assessments and relationship building, The INCH Initiative fosters an environment of exchange among regional providers in support of integrated care services. The network's goal is to recognize the value of integrated care principles, consider application to practice, and evaluate system readiness for program development. The INCH Initiative provides an opportunity for stakeholders from various health care settings to network, collaborate, and exchange lessons learned. By advancing the level of expertise and knowledge among network members, our region of health care providers creates a care environment where integrated behavioral health is the standard of care.

Network Development

Development of The INCH Initiative originated prior to grant funding due, in part, to organizational partnerships within the region but was formalized when funding was secured. While the network members have prior experience of collaboration, the formal network provides dedicated resources to the effort. During the grant duration, network members have been provided the opportunity to share successes and challenges, share resources, and attend trainings to obtain additional knowledge regarding integrated care practices.

The network remained at the emerging level of engagement due to several factors that include geographical location, recurring scheduling challenges, priorities of each network member organization, leadership limitations, and stage of program development. Through persistence and dedication, the network continues to move toward success to better represent integrated care principles within the region. Future network strategies should compensate for the identified challenges.

Programmatic Development

The INCH Initiative focused more on network development planning rather than programmatic development; however, program development was factored into the work plan for individual network members. Each network organization was considering integrated care services prior to the grant period and was able to further concentrate efforts and dedicate resources to program development. The network format encouraged member organizations to learn from the experiences of others and obtain additional knowledge regarding integrated care principles.

Challenges were present for each network member as program development was pursued, based on internal organizational factors, health care organization classification, personnel recruitment, license requirements, and reimbursement obstacles. These challenges were overcome on an individual organizational basis but supported by the network. Due to the evolving nature of integrated care, future network considerations should consider the identified challenges and anticipate strategies.

Sustainability

Due to The INCH Initiative, the network members have been engaged in a formal relationship that encouraged interaction among members to discuss and develop integrated care programs. Although the interaction has been limited, the network members maintain access to each other, to resources, and to future opportunities. It is anticipated that the network will maximize funding through the grant period and beyond, as permissible. Beyond the grant period, sustainability of the network will continue due to the naturally occurring level of interaction between the network members through clinical affiliation, shared disciplines and practices, and/or shared target populations. It is anticipated that the network members will continue to develop and implement integrated care programs within the region, especially in line with state-level priorities and national trends.

Region Covered by Network Services

County/State	County/State
Huntingdon County, PA	Fulton County, PA
Dauphin County, PA	

Network Partners

Organization	Location (City/State)	Organization Type
J.C. Blair Memorial Hospital	Huntingdon, PA	Hospital
J.C. Blair Medical Services	Huntingdon, PA	Hospital
Broad Top Area Medical Center	Huntingdon, PA	Federally Qualified Health Center (FQHC)
PinnacleHealth System	Dauphin County, PA	Hospital
Mainstream Counseling	Huntingdon, PA	Behavioral Health
Fulton County Medical Center	McConnellsburg, PA	Hospital

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Pennsylvania
St. Luke's Miners Memorial Hospital
Dental Care Coordination Planning Network
P10RH31086

Project Focus Areas

Care Coordination
Health Literacy
Oral Health
Telehealth

Network Statement

In Schuylkill and Carbon Counties, we are fortunate to have dedicated organizations, leaders, and community members who work collaboratively and effectively. Together, we are committed to increase knowledge, action, access, and connection to oral health care with a focus on prevention and policy improvement. The insight, recommendations, and contagious enthusiasm of our focus groups and community meetings motivate and inform our work. We are inspired by resources that we already have, such as the oral health education at Head Start and a community dental van. We plan to expand their reach and impact to include members of our community from birth through older adulthood. Partnering with our local schools, colleges, and community members, we plan to adapt and build more oral health services capacity, using our combined strengths.

While acknowledging the challenges rural counties face, such as lack of transportation, limited access to care, and cost of dental care, we are driven by a positive momentum. We continuously welcome new voices with the goal of finding efficient and feasible solutions to make a real difference in the quality of life and wellbeing of residents in Schuylkill and Carbon Counties. We are committed to advocating for our mission as we visualize health improvements in our region. We are bracing ourselves for a future full of healthy smiles.

Network Development

The Dental Care Coordination Planning Network was created in 2016 in large part in response to the St. Luke's Miners Campus (SLM) 2013 and 2016 Community Health Needs Assessments (CHNA) and the implementation priority areas of improved access to care, child & adolescent health, chronic disease prevention/healthy living initiatives, mental/behavioral health, and elder health. Through our community involvement and engagement, as well as the SLM leadership, we identified dental health as a priority unmet need in our rural area which is also a federally designated MUA (Medically Underserved Area) and a Dental Health Provider Shortage Area (HPSA). Our network has been formalized through agreements with the network partners that include St. Luke's Miners, Lehigh Carbon Community College (LCCC), and Schuylkill VISION.

SLM has brought together partners who are leaders in education, professional trainings, organizational development, and community engagement. Our network represents different disciplines blending medical, dental, education, public health, and community non-profits. The partners' expertise, combined with the clinical expertise of the hospital system, is vital for an effective and integrated program delivery model. The work of the network is

led by a steering committee that meets monthly and is comprised of network members and other stakeholders, allowing opportunities for new members to join as needed.

For network partner engagement, each partner has shared work group updates and presentations. In addition, members have invited others in the community to be involved and/or present. For consistent dialogue, we use various forms of communicating such as emails, phone calls, and in-person meetings to seek feedback and conduct shared sense-making, planning, and progress-tracking. We also have established an Advisory Council composed of state, federal, and local partners for advocacy, shared feedback and data from the steering committee and focus groups, and overall policy improvement. In addition, we have conducted three focus groups with community members for the purposes of understanding the barriers to care and building on existing strengths in our rural community.

The Network has taken on the understanding of and application of aspects of the Sustainable Network model, as presented in the grant program, and is committed to shared leadership and informed co-creation of our priorities, strategies, and successes. During the first few months, we realized we did not have the same level of engagement from all our network partners. When we have felt a partner withdrawing, we were able to recognize the signs from our adaptive leadership training and were able to maintain engagement with partners, so they could understand the importance of their role to the network and to the overall planning. We have learned to build off each other's' strengths and build our foundation to engage the community in addressing the social determinants of health (SDOH) in our planning.

Our environmental scanning and organizational assessments have been an effective tool for us to identify our strengths and weaknesses and make continuous improvements in our organizational development and capacity-building for programmatic work. We utilize the assessments to improve our process and performance and to develop an effective strategic plan. We have put recommendations from our advisory council into action, such as expanding our steering committee, and have utilized recommendations from focus groups. Our experience to date is showing early demonstration of the strength of our network as we developed a purposeful vision, mission, and network statement. We are laying the foundation for sustaining our efforts through continued opportunities for dialogue and sharing of resources and best practices.

Programmatic Development

Network committees develop programmatic ideas for consideration by the Steering Committee. All this work is supported by the Freedcamp software as an electronic database for sharing meeting notes, resources, best practices, and strategic planning. Programmatic priorities that have been considered include integration of evidence-based oral health literacy, education, and trainings into existing and new programs, along with strategies for care coordination and SDOH-related recommendations. Through the shared process of informing and critically considering priority areas and potential actionable strategies, the primary areas for programmatic focus are:

- Oral health literacy, education and prevention through our local Head Start organizations and local school districts (including promoting sealants).
- Medical-oral health programs for patients through our rural health centers which can be applied to other medical offices through our region
- Oral health education through the CHW program and through the local community colleges health explorations class
- Regional community college agreements to promote and connect dental hygiene programs to local rural students
- Oral health literacy, education and prevention integrated into the newly approved Rural Family Medicine Track with Community Medicine Block

- Telemedicine and Tele-dental recommendations for health networks
- Improved access to oral health care through exploration of development of a sustainable new rural dental access point.

As network partners, we are committed to formalizing agreements to integrate rural and oral health components to existing and new education programs in our local schools, our dental hygiene programs, and in our medical and dental residency. For example, our network community college partner will be adding a rural and oral health component to the Exploration of Health Science Careers class that all health science program students are required to take. The objective is for students in our community to understand the identified need, barriers, and opportunities our rural community faces and how their understanding and action can be integral in improving health outcomes. During this grant, our rural hospital applied for and received approval for a Family Medicine Rural Residency track which includes a Community Medicine Block. We plan to use this opportunity to educate our medical residents on the needs in our rural community. In addition, we plan to inform both our medical and dental residents at our urban hospital campuses about the rural communities' needs and about loan repayment options for those who commit to practice in dental health provider shortage areas.

We have been innovative in our recruitment of available resources. The PA Office of Rural Health has been an integral resource for us on our steering committee and keeps us abreast of state trends and opportunities. Alignment with the current CHNA process and incorporating feedback that we have gained through our advisory council and focus groups into our strategic planning have been effective strategies. A pre-meeting survey for the advisory council was used to maximize feedback in a data-friendly manner that is easy to share with members in the form of a chart and can be made available through the Freedcamp database. Reviewing local, state, and national best practices and using tools such as the Rural Health Hub assists us in strategizing how best to improve access and follow successful community models and networks.

Our experience to date in programmatic development has helped us develop adaptive capacity. There have already been important examples of challenges raised and ways by which the network has been able to address them. Through the steering and advisory council meetings, both providers and community members have shared hesitation towards telehealth, especially the concern that telehealth places more space between provider and patient. In response, our dental consultant has been able to make recommendations that take these concerns into consideration and present viable options for us to continue to explore telehealth and tele-dental services. Another example is how network and steering committee members, in the spirit of a trusting environment, raised earnest questions about developing a dental hygiene program due to the expense. These concerns provided opportunities to pursue alternative agreements with existing dental hygiene programs for the development of a CHW rural certificate program with an oral health component. We were able to utilize failing forward and instead look at how to align with existing dental hygiene programs and create formalized agreements to engage local students with the local community college and regional dental hygiene programs. Additionally, we were able to develop a relationship with the local AHEC and have our network community college partner become a hub for the new rural Community Health Worker program.

Sustainability

Our network has gained strength, awareness, and momentum throughout this planning process. The network is committed to periodic meetings, such as quarterly for networks partners and annually for advisory council partners, so that we can continue our environmental scan and planning and explore opportunities to implement and evaluate evidence-based practices to improve comprehensive oral health outcomes and connection to care. The network database will support continuous forums for communications and updates. We will continue to utilize the CHNA and implementation process as well as building local, state, and national partnerships that collaborate to improve health outcomes. As our network statement says, we are dedicated and committed to working together and

engaging others to build on the momentum that has been created to find solutions for connecting to care, education, prevention, health, and wellness.

Region Covered by Network Services

County/State	County/State
Carbon County, PA	Schuylkill County, PA

Network Partners

Organization	Location (City/State)	Organization Type
St. Luke's Hospital Miners Campus	Coaldale, PA	Hospital
Schuylkill VISION	Schuylkill Haven, PA	Non-Profit
Lehigh Carbon Community College	Tamaqua, PA	College/University
AHEC (Area Health Education Center)	Lehighton, PA	Area Health Education Center
Miners Nesquehoning Health Center	Nesquehoning, PA	Rural Health Center
Miners Hometown Health Center	Tamaqua, PA	Rural Health Center

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South Dakota

Avera St. Luke's Hospital
Integrated Community Care Solutions Network
P10RH31077

Project Focus Areas

Access to Care
Care Transition
Integration of Services

Network Statement

The health care delivery environment has transformed in the past several decades, but providers working in the industry today would argue the biggest changes are yet to come. In an era where access is key, time is more valuable than ever, and patients often see themselves as consumers, we as health care providers need to change and innovate to meet our patients' needs. The cost of care is rising dramatically, and we often find that patients who need our help the most are accessing care through emergency services: 911, ambulance. and emergency departments. Many times, these patients are not in emergent health care crises; instead they are dealing with primary care, social, behavioral, or chronic care needs that have not been addressed. While we are confident in our effort and ability to provide care for patients within the walls of our ambulance vehicles and health care facilities, we see a great and positive opportunity to help our patients be successful at home.

The Integrated Community Care Solutions Network came together with the goal to increase appropriate access to care and decrease the overall cost of care. We have convened stakeholders from varying sectors of health care to learn and discuss mobile integrated health (MIH) models that are taking flight across the country. While discovering some legislative barriers to our progress at the SD state level, we also have begun the very early steps in making the changes needed that will lay the groundwork for future MIH models. We have learned and shared a great deal and are working to secure additional grant funding to further this research and planning. This Network is committed to furthering our work toward a mobile integrated health program that will allow us to connect our patients to the most appropriate care within their community.

Network Development

Our Network is comprised of three organizations. Avera St. Luke's (ASL) is a regional tertiary care facility located in Aberdeen, SD, and Redfield Community Memorial Hospital (RCMH) is a community owned, Critical Access Hospital facility 40 miles south of Aberdeen that operates under a management contract with ASL. As the largest referral source for ASL outside of Brown County, and as a connected partner through management affiliation, it made sense during this grant application process to include RCMH as a Network partner. The third Network partner, Midwest Medical Transport Company (MWM), has been in operation for 30 years but just recently began serving the Aberdeen area. Additionally, the local leadership for MWM has 20 years' experience in fire-based EMS in the Aberdeen area and knew the area and patients very well. MWM and ASL leadership had initiated this Network after discussing trends in health care delivery and the rising concern of high utilization of emergency services and

found many areas of possible shared interest. Overall, 2 of the 3 partners, ASL and MWM, have had engaged leadership and open, honest dialogue throughout the course of this planning year.
As a small Network of three, there have been minimal challenges in our formation or understanding of one another. We have found that not having face-to-face interaction with RCMH has made the connection of this 3-part network a little more disjointed. Our discussions and research have been more heavily weighted between ASL and MWM. This isn't to any one facility's blame, just a reality of geography. Additionally, as we have discussed issues in patient care, payment trends, etc., we have found that perceptions of root cause issues regarding patient choice and behavior is different in Aberdeen than it is in Redfield. Our reimbursement models also make it such that the incentives for one organization may not be as urgent as another, although ultimately, we both know payment models overall are changing and we all need to work together to address sustainability.

Win hindsight, we learned that we might have designed a more robust Network by including other organizations, i.e. a local community mental health organization, community clinic, educational institution, etc., to get a true cross-section of care in our community. Having said all of this, we are working toward more partnerships with the above-mentioned organizations and have found all partners to be open and willing to do the work to keep this Network moving forward.

Programmatic Development

In the first few months of our work, most of our research, except the patient surveys, focused on community paramedicine (CP) programs throughout the country. We talked to programs in TX (MedStar), CO, ND, AZ, and Rapid City, SD. Our closest colleagues in this endeavor, Rapid City, shared some major struggles they have had in working with the governing board for paramedics in SD, the Board of Medical & Osteopathic Examiners (SDBMOE). Rapid City advised working with SDBMOE directly as they had not made the progress they wanted to implement a comprehensive CP program.

Six months into our grant period, we met with the Director and staff of the SDBMOE face-to-face and had a very positive and collaborative conversation. However, we learned that to make a CP program work in South Dakota, we would likely need to change legislation, which ultimately shifted our timeline to implementation in a dramatic way. The next months until now have been spent regrouping on where we need to focus our energy to get moving on a MIH program sooner, instead of attempting to change legislation that may allow for a CP program. We continue to work with the SDBMOE, the SD Department of Health, and others to make the regulatory and legal changes to lay the foundation for anyone in SD to start a CP program. In addition, we hope to utilize additional grant funding to further our research into MIH and specifically look further into Community Health Worker models in addition to, not in replacement of, community paramedicine.

Ultimately, we have been moving in a positive trajectory towards implementing a mobile integrated health solution. However, our timeline has slowed, given the legislative work we need to do, as well as the time needed to secure future grant funding to keep our project moving. Advice to others: Look first into your state laws regarding paramedics, community paramedics, and community health workers to ensure you know where the crux of your labor will first lie…in building a program or building the case for your program to your state government.

Sustainability

Our Network is currently working on securing further grant funding through another non-governmental organization. If approved, we would have up to 2 more years of funding to plan, research, and work directly with patients to build a model that meets the needs of our community.

If we do not secure future funding, both Avera and Midwest Medical, the two major partners in this Network, see the "writing on the wall" as it relates to health care reimbursement changes coming down the road.

They are both committed to moving forward with a MIH program that will pay for itself with reduced emergency department and inpatient admissions, as well as overall reduction in health care spending if we can find more appropriate avenues for patients to access resources they need.

The financial sustainability of health care providers overall falls to the ability to maintain a "reasonable" cost of care for each patient, which plays much more into the importance of coordinating care. To do this we need to invest in innovative solutions that sometimes fall outside the walls of our ambulances, hospitals, and clinics. Avera and MWM see that investing in health care workers to support our patients within their homes/communities will help in sustaining our organizations' financial strength overall.

Region Covered by Network Services

County/State	County/State
Brown County, SD	Edmunds County, SD
Marshall County, SD	Spink County, SD
McPherson County, SD	Day County, SD
Faulk County, SD	

Network Partners

Organization	Location (City/State)	Organization Type
Avera St. Luke's Hospital	Aberdeen, SD	Hospital
Redfield Community Memorial Hospital	Redfield, SD	Critical Access Hospital (CAH)
Midwest Medical Transport Company	Aberdeen, SD	Other

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Tennessee

Paris Henry County Healthcare Foundation, Inc.
West Tennessee Delta Network
P10RH31084

Project Focus Areas

Behavioral Health
Care Coordination
Network Infrastructure Development
Telehealth

Network Statement

Rural West Tennessee is noted for its agriculture and industry. Our communities share a strong sense of connectedness that is supported by the many active organizations and strong leaders in healthcare across the counties. In 2017, several of the healthcare leaders, which included many from the already developed Delta Consortium, came together to help build a healthier life for us all – one that includes better access to healthcare, coordination of care, and transportation. The West Tennessee Delta Network began the process of this mission through the establishment of a formal organizational structure and completion of a strategic plan. Our momentum is growing as we expand our partnership and begin program implementation. We are excited about our ability to bring the community together to achieve better health for those that live in rural West Tennessee.

Network Development

The Network planning partners, assisted by an external consultant, began the process of formalizing the group by outreaching to additional people and organizations and creating a Board of Directors. The consultant, with input from the Board, prepared drafts of the bylaws, memorandum of understanding (MOU), mission, vision and the network statement which were reviewed and approved by the Board. The MOU is in the review process at each organization. Membership and marketing committees were formed to facilitate the Network goals and objectives. Operational and strategic goals and objectives were developed based on the vision of the Board. A business plan is in development, which will help provide the needed mechanisms to leverage unique strengths and resources of different agencies.

Because many of these organizations have had longstanding partnerships and have been leading fixtures in the healthcare industry, our Network partners were able to embark on this journey with an established sense of trust. Meeting space and conference lines were made available by many of our partnering organizations. Challenges included trying to convene an in-person meeting that would accommodate busy schedules, but emails and telephone calls were used to accomplish the needed communication and consensus.

Programmatic Development

Network members and their organizations are vested in the improved health of West Tennessee and are willing to work together to find solutions to the immediate and emerging needs of the community. Through the development of operational, strategic, and business plans, the Network has created a roadmap for members to identify best practices and establish improved care coordination and telehealth services.
Care coordination, telehealth, and access to care were identified as priority program areas. A care coordination pilot program that includes chronic disease education will be implemented by four partners. Grant funding to implement a telehealth program will be submitted in June. The Membership Committee is exploring methods to include more nontraditional partners and expand the membership. The Network is constantly working to develop new partnerships. The Marketing Committee will work with an existing website to develop a presence for the Network as well as create social media accounts.

Many of the challenges the Network has faced have been like those of other rural areas. While many of the members already have long standing relationships and have developed a level of trust, the newer members need time to see their fit with the group but are progressing quickly. With the new governing structure that has been developed, the Network is hopeful that funding will be forthcoming. This is a priority for the group right now. Forward movement with programs will be very project-oriented and tied to grant funding and in-kind contributions.

Sustainability

The services of the Network Planning grant will be sustained through various mechanisms. Board members realize that a more integrated healthcare system is needed in West Tennessee and have pledged to continue with the formal structure and plans of the Network to improve access to care and provide higher quality services. The Board will constantly search for grants and other funding opportunities, with staff at Le Bonheur and Paris Henry County Healthcare Foundation available to provide in-kind assistance. The Membership Committee is investigating the option of member contributions or dues. As a part of the care coordination and telehealth programs, the pilot facilities and designated Board members are investigating shared purchasing arrangements and shared staffing.

Region Covered by Network Services

County/State	County/State
Benton County, TN	Carroll County, TN
Chester County, TN	Crockett County, TN
Decatur County, TN	Dyer County, TN
Gibson County, TN	Hardin County, TN
Hardeman County, TN	Haywood County, TN
Henry County, TN	Lake County, TN
Lauderdale County, TN	McNairy County, TN
Obion County, TN	Weakley County, TN

Network Partners

Organization	Location (City/State)	Organization Type
Paris Henry County Healthcare Foundation	Paris, TN	Philanthropy/Foundation
Henry County Medical Center	Pairs, TN	Hospital
Hardeman County Community Health Center	Boliver, TN	Federally Qualified Health Center (FQHC)
LeBonheur Community Health & Well-Being	Jackson, TN	Hospital
Gibson County Community Health Center	Trenton, TN	Federally Qualified Health Center (FQHC)
Governor's Foundation for Health & Wellness	Nashville, TN	Other
Hardin County Regional Health Center	Savannah, TN	Federally Qualified Health Center (FQHC)
Helping Hands of TN	Jackson, TN	Social Services Agency
University of TN at Martin	Martin, TN	College/University

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Washington

Clallam County Public Hospital District #1 (Forks Community Hospital)
Community Based Long Term Care Network
P10RH31078

Project Focus Areas

Access to Care
Alleviating Loss of Local Services
Care Coordination
Care for the Aging
Network Infrastructure Development

Network Statement

The loss of long term care services presents a serious threat for residents of Washington's most rural and frontier communities. The members of the CBLTCN (Community Based Long Term Care Network) recognize the magnitude and extent of the problem and the urgent need for creative solutions. We are actively working to build partnerships among our public hospital districts and State agencies and associations to develop effective new approaches that will help residents with chronic conditions and disabilities to continue living safely in their home communities, close to family and friends.

This will not be quick or easy, but we are determined to build on the unique composition of our public hospital districts to plan, communicate, heighten awareness, and build momentum for sustainable programming. We are confident in our ability to "move the needle" on long-term care in Washington State.

Network Development

Great progress has been made in formalizing the network. All members are public hospital districts (PHDs), and we have determined that using the unique "DNA" of PHDs and creating an interlocal agreement to work collectively is the best model. Bylaws guide interlocal agreements, and we are in the process of finalizing those bylaws.

Our greatest challenges are current reimbursement levels and staffing availability. In terms of funding/ reimbursement, we have mitigated these by working directly with the Department of Social and Health Services (DSHS), the primary payer for long-term care in the State. DSHS shares our vision and is committed to sustaining services in our rural communities. We applied for a HRSA Outreach grant which would facilitate four PHDs "piloting" services, while administrative and legislative changes proceed at the State level. Even in the absence of a grant award, we are committed to continuing this work and have been actively pursuing some State exemptions. In addition, and importantly, CBLTCN members have discussed their willingness to provide some funding during a transition period.

CBLTCN has addressed staffing issues by housing some services at a regional network level so they can be shared, not duplicated, among members. These services include RN care coordination and tele-monitoring. We have also elected to use "community care workers" embedded in primary care clinics in each community to engage elderly

residents and their caregivers, conduct home safety assessments, and take direction from the Network-wide RN care coordinator. The community care workers are typically entry level staff, of which there is generally more availability in our rural communities.

Programmatic Development

The CBLTCN started the grant with the assumption that we wanted to create a rural Program for the All-Inclusive Care of the Elderly (PACE) program. Early in the grant award, our TA Coach connected us to a national PACE consultant that after reviewing data and the distribution of our members throughout Washington State, advised that CBLTCN would not be able to sustain a PACE service. We overcame this disappointment by spending considerable time, in partnership with our State agencies and Associations, "deconstructing" PACE to identify those services most needed in the communities that could be provided without risk, and that are more likely to be attached to some existing (but new to us) reimbursement sources.

The list of deconstructed PACE services includes RN care coordination at the network level, tele-monitoring at the network level, community care workers, home health as needed through primary care clinics, day health services integrated into existing swing bed programs, home safety assessments and renovations, caregiver support, behavioral health, and transportation. We are still working on congregate housing options for those who cannot live safely in their home or the home of a family member or friend.

Sustainability

Sustainability requires achieving long term value, and demonstrating value requires data and engagement. CBLTCN's steps to create value have included: (1) a comprehensive understanding of the issues; (2) use of data to inform and develop goals and strategies to address the issues; and (3) engagement of partners. CBLTCN is also measuring sustainability in two ways: a) the sustainability of each member (who is universally the sole provider of most health care services in their respective community), and b) the sustainability of the Network and the services it offers to the direct benefit of the residents served.

CBLTCN is on the path to sustainability, but we know we will need time beyond the conclusion of the HRSA Network Planning Grant to finalize and test models. If a HRSA Outreach grant does not materialize in the coming months, we have actively pursued other paths, including demonstration funding from State agencies, transformation grants, and member funding. In addition, during its most recent session, the WA legislature funded a Joint Select Committee on Rural Health to make recommendations on how to restructure and fund rural health. The Committee begins meeting in July of 2018 and is intended to have recommendations to the legislature by late Fall, 2018. CBLTCN has already begun actively advocating to assure long-term care is included in the discussions. We are encouraged by the conversations we have had.

Region Covered by Network Services

County/State	County/State
Adams County, WA	Lincoln County, WA
Clallam County, WA	Okanogan County, WA
Columbia County, WA	Pacific County, WA
Douglas County, WA	Pend Oreille County, WA
Garfield County, WA	San Juan County, WA

County/State	County/State
Grant County, WA	
Lewis County, WA	

Network Partners

Organization	Location (City/State)	Organization Type
Association of Washington Public Hospital Districts (AWPHD)	Seattle, WA	Other
Columbia Basin Hospital	Ephrata, WA	Critical Access Hospital (CAH)
Columbia County Health System	Dayton, WA	Critical Access Hospital (CAH)
East Adams Rural Healthcare	Ritzville, WA	Critical Access Hospital (CAH)
Forks Community Hospital	Forks, WA	Critical Access Hospital (CAH)
Garfield County Memorial Hospital	Pomeroy, WA	Critical Access Hospital (CAH)
McKay Healthcare & Rehab	Soap Lake, WA	Skilled Nursing Facility
Morton General Hospital	Morton, WA	Critical Access Hospital (CAH)
Newport Hospital & Health Services	Newport, WA	Critical Access Hospital (CAH)
North Valley Hospital	Tonasket, WA	Critical Access Hospital (CAH)
Odessa Memorial Healthcare Center	Odessa, WA	Critical Access Hospital (CAH)
San Juan County Public Hospital District #1	Friday Harbor, WA	Government
Three Rivers Hospital	Brewster, WA	Critical Access Hospital (CAH)
Willapa Harbor Hospital	South Bend, WA	Critical Access Hospital (CAH)
Washington State Department of Social & Health Services	Olympia, WA	Government
Washington State Department of Health	Tumwater, WA	Government

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Washington
Ferry County Public Hospital District 1
Healthy Ferry County (HFC) Coalition
P10RH31079

Project Focus Areas

Network Infrastructure Development

Network Statement

Ferry County has more than its share of challenges, such as consistently being ranked near the bottom among Washington counties in the annual National County Health Rankings. To improve this situation and address the future health needs of the population, like-minded community members and organizations came together to create the Healthy Ferry County Coalition. The Coalition, which continues to grow, is working to coordinate services to move Ferry County toward becoming one of the Top Ten Healthiest Counties in the state.

Network Development

Healthy Ferry County (HFC) is a somewhat different coalition/network in that it is not being developed to focus on delivering a service such as telehealth, care coordination, bi-directional integration, etc. Rather, our revised Mission, “To coordinate the development of opportunities for economic growth, strong health and social service systems, and a healthy population,” articulates our network’s intent to serve a broader purpose in moving our community toward the vision, “Ferry County is consistently among the Top 10 healthiest counties in Washington State”.

Throughout the planning process, we have worked to develop the relational focus, trust, and openness among multiple entities involved in providing services in our county, especially those providing services in our county but headquartered elsewhere. Network members realize this openness and trust is essential to continue breaking down the silos which have hindered the coherent delivery of coordinated services to address the residents’ many health needs.

Programmatic Development

We are in the process of completing a multi-agency community health needs assessment, which grew to a five-county assessment through coordination and cooperation among our partners. Currently we are in the final stages of gathering qualitative data to provide additional insight to the limited quantitative survey and other data sources by following up with an on-site focus group in each of the five communities within the county.
Initially, designing the survey instrument was a barrier, but that was overcome when the scope expanded geographically to meet additional needs of area partners, which led to additional expertise involved in the project. When completed, the resulting report will be used to prioritize coordinated and focused action in addressing identified population needs.

The network is already serving as the center for coordinating our county's collaboration in four project areas within our regional Better Health Together (BHT), which is one of nine Accountable Community of Health (ACH) Regions in Washington State's Medicaid Transformation Project.
Ferry County's Transformation Project Collaborative portfolio project areas are 1) Addressing Opioid Use Crisis, 2) Chronic Disease Prevention and Control, 3) Bi-Directional Integration of Care, and 4) Community-Based Care Coordination. Network members are already conversing about expanding the project's scope beyond the targeted Medicaid population into the broader Ferry County community, using survey results to inform such action.

Sustainability Development

Sustainability is currently being addressed by first following through on completing the 501(c)3 process for achieving not-for-profit status. We anticipate that by doing so, the network will be positioned to act as the sponsoring and administrating organization of collaborative projects involving multiple members or members with non-members. Because of Healthy Ferry County's creative approach to network definition, sustainability planning has not yet been fully resolved, but our experience to be gained through the upcoming Medicaid Transformation Project will provide valuable insight.

Region Covered by Network Services

County/State
Ferry County, WA

Network Partners

Organization	Location (City/State)	Organization Type
Ferry County Public Hospital District (FCPHD)	Republic, WA	Critical Access Hospital (CAH)
Ferry County Public Hospital District FCPHD)	Republic, WA	Physicians' Clinic
Ferry County Public Hospital District (FCPHD)	Republic, WA	Skilled Nursing Facility
NorthEast Washington Alliance Counseling Services (NEWACS)	Colville, WA (HQ)	Behavioral Health
Northeast Tri-County Health District (NETCHD)	Colville, WA (HQ)	Public Health
Lake Roosevelt Community Health Centers (LRCHC)	Inchelium, WA (HQ)	Federally Qualified Health Center (FQHC)
Rural Resources Community Action (RRCA)	Colville, WA (HQ)	Social Services Agency
Rural Resources Community Action (RRCA)	Colville, WA (HQ)	Transportation
Better Health Together (BHT)	Spokane, WA (HQ)	Other

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Washington
HopeSource
Kittitas County Health Network
P10RH31087

Project Focus Areas

Care Coordination
Integration of Services
Network Infrastructure Development

Network Statement

The Kittitas County Health Network will change the way you think about healthcare. In the ideal future, imagine every provider with the power to share information, connecting patients to primary care, behavioral health, and social determinants communities (housing, food, employment, transportation) holistically. Imagine all healthcare providers as trusted advocates working together to empower patients to take control of their health and improve their lives. Imagine mobilizing a community that is inspired to ensure every person can realize their full potential because they are healthy and well cared for.

KCHN is uniquely suited for the ideal future; it already embodies the spirit of collaboration, collective impact, and widespread community engagement. KCHN is working toward an integrated healthcare system that revitalizes population health and is supported by a strong, proactive, and accessible care coordination system. Through bold leadership and the committed effort of all members, KCHN will make healthcare work for everyone. KCHN cares.

Network Development

The Kittitas County Health Network consists of 69 members from 12 participating partners. The members include representatives from healthcare, education, early learning, public safety, social services, long term care, housing, City of Ellensburg, Kittitas County, and faith-based organizations. The twelve-member Board of Directors was seated in September. The KCHN work group charters were approved by KCHN Board in October 2017. KCHN Articles of Incorporation and Bylaws were approved and signed in November 2017. The 501(c)3 documents were submitted and accepted by the IRS in February 2018. KCHN began submitting KCHN Board Minutes to the Regional Accountable Community of Health in April 2018.

The Network developed a Community Engagement and Communications Plan to strengthen community linkages between the local health care delivery system and ten sectors, including the social service sector. It was approved by the Board in March 2018. HopeSource, the backbone organization for the KCHN, provides services related to social determinants of health. In January 2018, the Community Health Needs Assessment was completed with the involvement of 37 additional community volunteers. Following the Mobilizing for Action through Planning and Partnership (MAPP) process (a community-driven strategic planning process), the Community Health Improvement Plan has identified initial strategic health issues to focus on. The next step is to create goals and strategies to implement the plan.

Challenges emerged from frameworks of Collective Impact, consensus decision-making, bidirectional communication, and cascading collaboration, which were new frameworks for current systems and ways of working. However, these challenges became opportunities. Constructively using the new frameworks required consistent attention to the vision, ground rules for meetings, and the openness of partners. The Network is stronger as a result.

Programmatic Development

The KCHN Workgroups designed the Kittitas County Health Network Consumer Council which was reviewed and approved by the KCHN Board in March 2018:

- Two care coordination team members will comprise 25% of the council. These will serve on a rotating basis depending on topic and schedules. Suggested members of the rotation will include two representatives from Kittitas Valley Healthcare, one representative from Kittitas Valley Fire and Rescue, and one representative from Community Health of Central Washington.
- Six Medicaid patients from Kittitas Valley Healthcare and from Community Health of Central Washington will participate. Criteria for selection will be developed. Three will be selected from CHCW patients and three from KVH patients after interviewing for interest and willingness to serve.
- At their first meeting, the council will develop ground rules, recordkeeping processes, confidentiality agreements, and a meeting schedule. They will also agree on member duties, including facilitation, taking minutes, and communication.

The Care Coordination Workgroup collected all archived information from 2017-18, encompassing the work with high utilizers of the emergency response system and the direct service solutions achieved during that time. They have hired a .25 FTE Intern for three months to analyze the archival information, link it to the current work of the CC Workgroup, and design a consistent system for use going forward. They have also leveraged their relationship with the Regional ACH (Greater Columbia ACH) to help design and integrate an IT Infrastructure to replace the HUB Model originally planned.

Although challenges arose in blending the priorities of the local Community Health Assessment and Strategy with the priorities of the GCACH, natural overlapping and supporting points were identified.

Sustainability

As requested by the Advisory Work Group, the KCHN Board of Directors has taken on the task of developing a sustainability plan that they will share in the cascading collaboration mode. Meetings are scheduled through May 2018, with a facilitated full-day session in late June 2018, to verify with the full Network the plan for sustainability.

Region Covered by Network Services

County/State
Kittitas County, WA

Network Partners

Organization	Location (City/State)	Organization Type
Kittitas Valley Healthcare	Ellensburg/Cle Elum, WA	Critical Access Hospital (CAH)
Community Health of Central Washington	Ellensburg/Yakima, WA	Federally Qualified Health Center (FQHC)
L. Martin, PhD, Valley Psychological Services	Ellensburg, WA	Behavioral Health
City of Ellensburg	Ellensburg, WA	Government
Kittitas County Fire & Rescue	Ellensburg, WA	Emergency Medical Services (EMS)
Kittitas County Public Health Department	Ellensburg, WA	Public Health
HopeSource	Eastern Washington	Non-Profit
Molina Healthcare	Washington, Statewide	Medicaid Managed Care Organization
Greater Columbia Accountable Community of Health	Southeast Washington	Collaborative
Department of Social and Health Services	Ellensburg, WA	Government
Southeast Washington Aging and Long-Term Care	Ellensburg/Yakima, WA	Area Agency on Aging
Central Washington University	Ellensburg, WA	College/University

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Washington
Methow Valley Home Health Agency
Methow Valley Health Care Network
P10RH31085

Project Focus Areas

Integration of Services
Alleviating Loss of Local Services
Emergency Medical Services
Network Infrastructure Development

Network Statement

The Methow Valley Health Care Network is a consortium of health care providers and social service organizations that have come together with a goal of improving the quality of health care services in the Methow Valley. This is being accomplished by breaking down traditional organizational silos and developing a more interdependent approach to patient care. The overarching strategy has embraced the Quadruple Aim of: 1) improving the health of our community members; 2) increasing patient satisfaction; 3) decreasing health care cost; and 4) improving healthcare worker wellbeing. The Methow Valley Health Care Network is a network of health and wellness providers who work together to provide the right service, to the right patient, at the right time using the right transportation, at the right cost. The Network partners have worked collectively to expand access for all patients to Whole Person Care (WPC). WPC encompasses more than just a person's medical needs. It is focused on all aspects of a person's life including physical, emotional, social, and economic needs.

Network Development

The Network has been formally meeting over the last year and has been collectively focused on developing a clear vision of how it will work and serve the community. The roles, expectations, and capabilities of each Partner have become clearer as we have focused together on problem-solving to meet our goals. There have been challenges associated with Network Development such as: lack of a point-person, lack of clarity about the network goals, busy schedules, and insufficient staffing. However, the Network has been collectively addressing these challenges and has been working to articulate barriers, identify solutions, and define roles. Our recently added tele-communication capability has been a key tool to effectively engage Network partners and is enabling more effective sharing of responsibilities.

Programmatic Development

The Network program has been developed around ten strategic tasks which include: Needs Assessment; Communication Process; Stakeholder Outreach; Patient Care Coordination; Training; Network Administration; Performance Metrics, Data Sharing; Staffing Integration; and Reimbursement/Sustainability. These tasks are in various stages of completion, ranging from completion to still in the early stages of development. Although some

of these tasks are clearly dealing with Network processes, others have focused on better defining of critical patient needs, building a broader network, and setting the stage for implementation.

One of the biggest program development challenges we have faced as a Network is the broad scope of the problem and the limited resources available to effectively address all the critical tasks that have been identified. To address this challenge, the Network has prioritized tasks and has focused on "high value" activities that are critical for enabling the Network to move forward. For example, significant Network resources were engaged to design, conduct, and evaluate the Community Needs Assessment, since this is a cornerstone task that will serve to help identify priorities and help the Network develop our strategic plan.

Sustainability

Partners see value in the Network, but the path forward is still unclear due to the complexity of the health care system in which we operate. Sustainability remains an important issue, and ongoing efforts have focused primarily on engagement of payers (Medicaid, Medicare, and Commercial Insurers) to help them understand how the strategies being developed/proposed by the Network Partners can help save money and meet the needs of our patients. It is acknowledged that continual engagement with payers of reimbursement is an ongoing need, particularly as the Network Partnership plan becomes implemented.

Region Covered by Network Services

County/State
Okanogan, WA

Network Partners

Organization	Location (City/State)	Organization Type
Aero Methow Rescue Service	Twisp, WA	Emergency Medical Services (EMS)
Frontier Home Health and Hospice	Omak, WA	Home Health/Hospice
Room One/Lookout Coalition	Twisp, WA	Non-Profit
Family Health Center	Twisp, WA	Physicians' Clinic
Three Rivers Hospital	Brewster, WA	Hospital

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