Grantee SOURCEBOOK

Rural Health Network Development Planning Program

2020

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 networks 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.

2020 Rural Health Network Development Planning Grantees – Programmatic Focus Areas

According to the Center for Disease Control and Prevention, people who live in rural areas are more likely than urban residents to die prematurely from all of the five leading causes of death: heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke. These rural health disparities have many causes that include limited access to health services, fewer health care workers, less access to healthy foods and fewer opportunities to be physically active. In addition, rural residents tend to be older, with lower incomes and less education. Collaboration is a key factor in addressing these disparities in rural health care planning, delivery, and outcomes.

The twenty-six grantees (26) in twenty-two (22) states that were awarded Network Planning grants in 2020 are addressing these challenges by bringing together a broad range of partners to form rural health networks. Recognizing the importance of leveraging their combined resources, 60 percent of these grantees are placing a primary (6 grantees) or secondary (10 grantees) focus on strengthening their network organization/infrastructure development with the intent of formalizing their collaboration by defining their leadership and decision-making structures and establishing policies and procedures.

Creating efficiencies in the delivery of health care is an important focus for these rural health networks. Seven (7) are exploring the feasibility of increasing efficiencies using telehealth. Six (6) are working on the integration of health services while ten (10) more are examining methods for coordinating patient care. Another four (4) are seeking to manage the care of patients with chronic diseases such as diabetes, chronic obstructive pulmonary disease, and congestive heart failure. Four (4) grantees view the establishment of school-based health services as a means of increasing efficiencies in the delivery of care.

Eight (8) grantees are hoping to overcome the shortage of health care providers in rural communities by focusing on workforce development. Three (3) others are seeking creative solutions for maximizing reimbursement of services.

Understanding the complexity of health and the need to promote healthy behaviors, ten (10) of the Network Planning grantees are taking a broad approach by looking at population health and taking the social determinants of health into consideration in their planning efforts. Five (5) include health education as a means of promoting healthy behaviors.

The twenty-six (26) grantees also are drawing on their combined expertise and resources to address a variety of health care issues that include:

- Behavioral Health (5)
- Child Health (2)
- Emergency Medical Services (3)
- Mental Illness/Mental Health (4)
- Oral Health (1)
- Pharmacy Services (1)
- Substance Abuse/Addiction (2)
- Women's Health (2)

Contents of the 2020 Rural Health Network Development Planning Source Book

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

2020 Rural Health Network Development Planning Grantees

Focus Areas

State	Grantee	Network Name	Primary Focus Area	Other Focus Areas
ID	Benewah Medical Center	Idaho Integrated Clinical Pharmacy Rural Network (II-CPRN)	Pharmacy	• Integrated Health Services • Workforce Development
IL	Katherine Shaw Bethea Hospital	Project Well Student	School Based Health Services	• Child Health • Mental Illness/Mental Health Services • Population Health/ Social Determinants of Health • Telehealth
IN	Indiana Rural Health Association	Rural Indiana Suicide Evaluation and Education (RISE^2)	Mental Illness/Mental Health Services	• Health Education • Network Organization/ Infrastructure Development • Telehealth
KS	Rawlins County Health Center Foundation	Rural Maternal Health Network	Women's Health	
KY	Northeast Kentucky Regional Health Information Organization	Kentucky Rural Quality Care Initiative	Increase Health System Efficiencies	• Care Coordination • Health Information Technology • Network Organization/ Infrastructure Development • Reimbursement of Health Services
ME	Medical Care Development, Inc.	Maine eConsult Network	Increase Health System Efficiencies	• Integrated Health Services • Reimbursement for Health Services • Telehealth • Workforce Development
MD	Eastern Shore Area Health Education Center	Maryland Rural Health Planning Consortium	Network Organizational/ Infrastructure Development	• Telehealth • Workforce Development
MA	Baystate Franklin Medical Center	Link2Health	Care Coordination	• Behavioral Health • Integrated Health Services • Population Health/ Social Determinants of Health • Network Organizational/ Infrastructure Development • Telehealth

State	Grantee	Network Name	Primary Focus Area	Other Focus Areas
MI	District Health Department #10	North Central Community Health Innovation Region	Network Organizational/ Infrastructure Development	• Chronic Disease Management • Integrated Health Services • Mental Illness/Mental Health Services • Population Health/ Social Determinants of Health
MI	Health Department of Northwest Michigan	Emmet County Youth Wellness Network	Child Health	• Integrated Health Services • School Based Health Services
MI	Northern Michigan University	Northern Michigan Center for Rural Health	Chronic Disease Management	• Emergency Medical Services
MN	St. Joseph's Medical Center	Central Minnesota Network	Substance Abuse/Addiction	• Behavioral Health • Care Coordination • Emergency Medical Services • Network Organizational/ Infrastructure Development
MO	Freeman Neosho Hospital	Southwest Missouri School Health Network	Care Coordination	• Behavioral Health • Network Organizational/ Infrastructure Development • School Based Health Services • Telehealth
MT	Central Montana Medical Center	Rural Healthcare Emergency Transportation (RHET) Program	Emergency Medical Services	• Care Transitions • Health Education
MT	Montana State University	Montana Regional Initiatives in Dental Education Network	Oral Health	• Health Education • Workforce Development
NH	Bi-State Primary Care Association	Food & Health Planning Network	Population Health/ Social Determinants of Health	• Care Coordination • Chronic Disease Management • Increase Health System Efficiencies • Reimbursement for Health Services
NM	Miners' Colfax Medical Center	Western United States Miners' Disease Mortality Hotspots Network	Health Education	• Network Organizational/ Infrastructure Development • Population Health/ Social Determinants of Health • Telehealth • Workforce Development
ND	Coal Country Community Health Center	Energy Capital Health Network	Network Organizational/ Infrastructure Development	• Increase Health System Efficiencies • Population Health/ Social Determinants of Health

State	Grantee	Network Name	Primary Focus Area	Other Focus Areas
OK	Rural Health Network of Oklahoma	Rural OK Collaborative for Health Information Technology (ROC-HIT)	Health Information Technology	• Care Coordination • Network Organizational/ Infrastructure Development • Telehealth • Workforce Development
OK	Rural Health Projects, Inc./NwAHEC	HOME Network	Network Organizational/ Infrastructure Development	• Care Coordination • Health Information Technology • Increase Health System Efficiencies
OR	Greater Oregon Behavioral Health, Inc.	Substance Use Disorder Network (SUD-NET)	Substance Abuse/Addiction	• Behavioral Health • Network Organizational/ Infrastructure Development • Workforce Development
SD	Rosebud Sioux Tribe Health Administration	Rosebud Connect Care Initiative	Network Organizational/ Infrastructure Development	• Care Coordination • Health Information Technology • Integrated Health Services • Population Health/ Social Determinants of Health
VT	Copley Professional Services Group dba Lamoille Health Partners	Lamoille Area Health Network	Population Health/ Social Determinants of Health	• Child Health • Women's Health
VA	Virginia Rural Health Association	The Pride of Rural Virginia	Population Health/ Social Determinants of Health	• Network Organizational/ Infrastructure Development
WA	San Juan County Public Hospital District No 1	San Juan County Community-Based Long Term Care Network	Network Organizational/ Infrastructure Development	• Care Coordination • Chronic Disease Management • Reimbursement for Health Services • Workforce Development
WI	Marshfield Clinic Health System	Western Wisconsin Rural Behavioral Health Network	Behavioral Health	• Behavioral Health • Health Education • Network Organizational/ Infrastructure Development • Population Health/ Social Determinants of Health

Idaho

Benewah Medical Center

Idaho Integrated Clinical Pharmacy Rural Network (II-CPRN)

P10RH37473

Project Focus Areas: Pharmacy

Other Focus Areas: Integrated Health Services
Workforce Development

Network Statement

Healthcare costs continue to rise exponentially for patients and insurers. Drug related morbidity, mortality and adverse drug events cost almost $3 billion annually. The occurrence of drug related deaths and adverse drug events can be reduced through a team-based approach and actively leveraging the expertise of clinical pharmacists. Such an approach improves quality of care, patient outcomes, provider satisfaction and reduces cost burden on patients, providers, and payers. However, recruiting, hiring, and funding clinical pharmacists in rural areas can be extremely difficult.

The Idaho Integrated Clinical Pharmacy Rural Network (II-CPRN) was established in the Summer of 2020 to bring together clinical pharmacists, public health, behavioral health, and subject matter experts to support rural health systems in improving access to clinical pharmacy services. Clinical pharmacy is intended to increase patient engagement and medication adherence and professional satisfaction through provider engagement in pharmacy stewardship and team-based care. In addition, the advancement of clinical pharmacy supports enhanced coordination of clinical pharmacy services through standardized processes designed to improve efficiency, limit redundancy and lead to better utilization of resources in the community among underserved and high-risk populations. The Network also engages in problem-solving around the challenge of funding restrictions to increase viability of clinical pharmacy. Through these aligned strategies among II-CPRN partners, we are positioned to reduce morbidity and mortality in our region and state to help create a healthier future in a sustainable way.

Network Development

At the beginning of the grant, the consortium consisted of Marimn Health (Benewah Medical Center), Cornerstone Whole Healthcare Organization (C-WHO), Heritage Health, Shoshone Family Medical Center and Pinnacle Integrated Medicine and was formalized by memorandum of understanding (MOU). A brainstorming session with the leaders of the consortium came up with a plan to expand the consortium and to include non-MOU participating parties from all of Idaho. An informational brochure was developed and other like-minded pharmacists from the state were contacted to assess their interest in the consortium. Over the months, we have grown our network considerably and it now includes pharmacists from all over the state, representing diverse pharmacy stakeholders.

Today, the consortium meetings are held one time monthly and active participants include Panhandle District Health, Heritage Health, Marimn Health (Benewah Medical Center), St. Luke's Clinics (4 pharmacists represented), St. Luke's hospital, Bingham Memorial Hospital, Gooding Pharmacy, Shoshone Family Medical Center, and C-WHO. Consortium meetings are held via Zoom to allow for diverse group participation. Clinical pharmacy is a burgeoning field in Idaho and the network filled a newly identified need to provide peer support and build a learning collaborative focused on clinical pharmacy. These stakeholders volunteer their time and energy to this consortium, and it is greatly appreciated.

Programmatic Development

The consortium has worked to identify and troubleshoot many different areas of increasing clinical pharmacy integration. We have tackled such issues as payment for service and the integration of new clinical pharmacy services into clinics. With this knowledge in hand, several clinics have been able to start or continue the integration of clinical pharmacy in their practice.

On Marimn Health's (Benewah Medical Center) end, we have been able to come up with a concept for a fully functional pharmacist-led hypertension clinic, along with identifying new patient populations for clinical pharmacy intervention. An additional program that was developed is crossover training for the behavioral health department. With the help of the C-WHO team, we were able to develop 30-minute "podcast" training on depression and meds for behavioral health professionals. This recording can then be used in perpetuity in other settings wherever seen fit.

Sustainability

We will sustain this consortium in some capacity by continuing to meet monthly to discuss pressing topics or actions to advance clinical pharmacy integration, or, at minimum, through an email listserv to help facilitate communication between the consortium members. Along with this, other clinics have been inspired to pursue similar grants and we hope to have many of the same consortium members take part in those grants as well, thus strengthening the relationship of the original consortium.

Region Covered by Network Services

County/State	County/State
Kootenai, ID	Bingham, ID
Ada, ID	Gooding, ID

Network Partners

Organization	Location	Organization Type
Panhandle Health	Coeur d' Alene, ID	Public Health
Heritage Health	Coeur d' Alene, ID	Federally Qualified Health Center (FQHC)
Bingham Memorial Hospital	Blackfoot, ID	Hospital
St. Luke's Hospital	Boise, ID	Hospital
Gooding Pharmacy	Gooding, ID	Other
C-WHO	Boise, ID	Non-Profit
Marimn Health	Plummer, ID	Federally Qualified Health Center (FQHC)

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Illinois

Katherine Shaw Bethea Hospital
Project Well Student

P10RH37482

Primary Focus Area: School Based Health Services

Other Focus Areas: Child Health
Mental Illness/Mental Health Services
Population Health/Social Determinants of Health
Telehealth

Network Statement

"When Students Flourish, Our Communities Flourish"

Children do not choose to whom and where they are born. Why should one child live longer, be healthier, and have a more successful life based on where they live and what occurs in their home?

Many families do not have access to adequate health care, nutrition, social and emotional support. We know this has long-lasting effects of childhood trauma which hinders the development of a healthy and productive adulthood.

Children spend 15% of their lives in school. These hours are vital opportunities to positively impact the future of children. Through the Project Well Student Network, schools, hospitals, behavioral health providers, and public health departments are coming together to support children and families beyond the traditional educational approach. By establishing School Based Health Centers, we seek to meet the unique needs of the community through delivering services to students right where they are, in school. By focusing on promoting healthy lifestyles and identifying illness early, we will prevent more serious issues later in life; and we will make health care available to many students who otherwise would not receive care.

The Project Well Student Network has a rich history of collaboration that has brought millions of dollars to our tri-county area for developing and implementing innovative services. Establishing School Based Health Centers is one more step in our commitment to reducing the effects of childhood trauma, building resiliency, and raising healthy, happier students who become successful members of our community.

Network Development

The progress made in formalizing the Project Well Student Network was enhanced by creating a subsection of an already existing network to focus on School Based Health Services. This larger network included decision makers from three counties which have an interest in the health of the community and reducing the intergenerational cycle of trauma. Network members were interested in Project Well Student as a preventative approach. A larger contingent from the school systems were invited to join the network. The committee which is focusing on this project includes individuals from the education, behavioral healthcare, social services, and healthcare sectors.

The challenges we faced were largely due to the impact of the COVID pandemic and the fluid dynamics which faced the education and health care systems (outbreaks, virtual learning, virtual meetings, State level testing, etc.). There were many competing priorities (more than usual). Meetings were held virtually with smaller groups meeting in person when allowed by the pandemic conditions. We noticed participation was dropping off. We largely are overcoming these challenges by holding individual meetings with key superintendents who want to be

engaged but generally do not have time to attend larger meetings. This has kept engagement up and the process moving forward. Views of the superintendents are then shared with the larger committee by the Regional Superintendent of Schools (who oversees the three counties).

The innovations we found to be most useful are flexibility and understanding of the priorities of the education system. The flexibility allows the project team to meet the school leadership where they are and begin meaningful engagement on a school district level. Lessons learned and individual conversations are shared accordingly with other players in larger meeting settings.

Programmatic Development

While the purpose of our grant is to develop a network, the outcome of this network is to provide a school-based health center in at least one school in each of the three counties. School districts in Lee and Ogle Counties have expressed interest and are moving forward with data gathering. Funds are being secured from the schools to cover construction costs. Another member of our network has secured funding for a mobile unit in Whiteside County to serve more remote, rural locations. As we move forward, this mobile unit and/or telehealth are being considered to serve smaller school districts where a permanent physical location may not make financial sense.

Challenges we have faced in program planning have largely been due to a drop in engagement due to competing priorities within the education and public health systems due to the pandemic. Having the support of the Assistant Regional Superintendent has been invaluable. Therefore, we have added additional meetings to garner support at whatever time and location the individual school district Superintendents are available.

We have found it is key to have a champion in the medical community along with the educational system. Our was able to visit two school-based health centers in our state. Each center had unique operational elements. This provided a template for what a school-based health center could be in our area and gave everyone a shared vision, based on local resources and needs.

Sustainability

Members of the Project Well Student Network and their organizations have a vested interest in having a healthy community. The already existing partnerships between the social service, behavioral healthcare, and medical community will contribute to the sustainability of the network. Project Well Student is a continuation of these partnerships. Our behavioral healthcare partners already have a presence in many of the schools as well as in the medical community via integrated medical home concepts. Project Well Student will allow for the design and presence of medical and behavioral services in the school. Eventually, dental and optometry services will be evaluated for service line expansion in appropriate schools.

There will be a narrower focus as to where these services will be offered, focusing on the larger school systems first. Our public health partner is securing funds for a mobile unit to take to smaller, rural schools in their county. This will hopefully be a model that will be duplicated to the other counties.

Various funding strategies, such as grants, state aide, and commercial/insurance payers, will contribute to our sustainability. Staffing models will start light and scale up as demand warrants to maintain an appropriate revenue and expense quotient.

Region Covered by Network Services

County/State	County/State
Lee County, IL	Whiteside Count, IL
Ogle County, IL	

Network Partners

Organization	Location	Organization Type
Regional Office of Education #47	Morrison, IL	School System
Dixon School District	Dixon, IL	School System
Katherine Shaw Bethea Hospital	Dixon, IL	Hospital
Rochelle Community Hospital	Rochelle, IL	Critical Access Hospital (CAH)
Sinnissippi Centers Inc.	Dixon, IL	Behavioral Health
Lutheran Social Services	Dixon, IL	Behavioral Health
Rochelle District 212	Rochelle, IL	School System
Oregon Community Unit School District	Oregon	School System
Lee Ogle Transportation Services	Dixon, IL	Transportaion
Kreider, Inc.	Dixon, IL	Behavioral Health
YWCA	Sterling, IL	Non-Profit
Polo School District	Polo, IL	School System
Sterling School District	Sterling, IL	School System
Morrison School District	Morrison, IL	School System
River Bend CUSD #2	River Bend, IL	School System
Whiteside Community Health Center	Sterling, IL	FQHC/Public Health
Ogle County Health Department	Oregon, IL	Public Health
Lee County Health Department	Dixon, IL	Public Health
Rock Falls Elementary School District #13	Rock Falls, IL	School System

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Indiana

Indiana Rural Health Association
Rural Indiana Suicide Evaluation and Education (RISE^2)

P10RH37481

Project Focus Areas: Mental Illness/Mental Health Services

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

Network Statement

Across the country, death by suicide is increasing exponentially and the impact extends far beyond the person who died. Survivors may experience overwhelming feelings of guilt, judgment, and even an increased risk of suicide themselves. With the worldwide COVID-19 pandemic contributing to isolation, financial hardships, long-term physical complications, and more, a potential mental health epidemic seems imminent. Someone must stand ready to help our neighbors when they are in crisis and the RISE^2 network is here to support our rural communities as they prepare.

Some of the biggest obstacles in rural Indiana are a lack of resources and the stigma associated with mental health. The RISE^2 network addresses both by creating a healthcare team and community that understands the importance of recognizing and addressing those who are at risk and sharing assets and best practices across our growing number of partners. We exist as a network to find alternatives for people who are considering death by suicide and helping community members who know of someone struggling with mental health or suicidality to get them the resources they need. Through collaboration, our rural communities can provide a future in which *everyone* sees an alternative to suicide.

Network Development

RISE^2 is composed of four partner hospitals (Greene County General Hospital, Deaconess Gibson Hospital, Marion General Hospital, and Rush Memorial Hospital) selected based on data indicating a high incidence of suicide in their communities. While these four had not worked together in a formal setting before, they had been involved in some larger networks and organizations that were not focused on a single subject matter. Once we had the partners selected and had their stated commitment to the network, we developed a formal memorandum of understanding to guide and govern the group.

Our initial intent was to expand our network to local stakeholders within the four targeted counties through outreach activities within the planning scope. Further, we had hoped to expand the geographic reach of our network by visiting and forming relationships in other counties. However, the major barrier of the COVID-19 pandemic but a pin in those plans. However, challenges due to the pandemic allowed some innovation which improved outcomes. We used Zoom videoconferencing for partner meetings. This allowed partners to join meetings from their desk without traveling or losing valuable working time. Due to this convenience, we were able to have nearly perfect attendance at meetings, which is better than can usually be anticipated. Of course, we were severely limited in our ability to forge *new* relationships—which often almost necessitates meeting in person when it comes to rural communities—but we will be resuming our original plans once safety can be assured.

Programmatic Development

Healthcare education is important so that everyone knows how to help and how to talk to help people get to the resources they need when they come to the hospital or otherwise reach out for help. To address this, our network distributed a survey, analyzed the results, and distributed the results to partners. We will continue to utilize this survey—which also addresses barriers to care, stigma, and more—to track trends and measure our impact.

We have developed plans for the network to train as many people as possible, from the Chief Executive Officer to Environmental Services Staff, with gatekeeper training such as Question Persuade Refer (QPR) training, Mental Health First Aid, and Applied Suicide Intervention Skills Training (ASIST). When hospital employees understand how to identify risk factors and start conversations, this can help not only patients, but also family and friends. To do this, we discussed evidence-based models at partner meetings and came to an agreed upon direction as a group. As a network, we have identified resources we have and resources we do not have. Some of our partner hospitals have realized how many healthcare providers themselves did not know what resources they already have in place.

Again, in response to challenges posed by the pandemic, we utilized virtual and remote options. Normally, to distribute a survey, we would have both online and in-person polling. However, due to the pandemic, our network sent personalized emails to key informants to gain buy-in and teamwork to distribute the survey online as well as through paper copies at local libraries and health departments. Additionally, our network offered an online lunch & learn sessions about suicide prevention. Offering online opportunities made it accessible to more people than could have otherwise attended at any given single site.

Sustainability

We will continue to hold our partner meetings, though we will shift to a quarterly basis. We will now work with the existing community resources such as national, regional, state, and local grants, foundations, and trusts (like those found at https://www.ruralhealthinfo.org/philanthropy/rhppp-members), as well as internal partner funding to obtain funding for gatekeeper trainers to train hospital staff with suicide prevention methods. In addition, we will pursue in-kind contributions from partners while constantly scanning for additional grants to sustain and grow programming.

Further, we will continue to utilize the Suicidality Survey developed during the Planning Grant on an annual basis. Having collected the baseline data for our current four counties, we will now be able to track trends and changes among the communities on a yearly basis. We will also extend the survey to other rural Indiana counties within the IRHA membership to first collect baseline data and then, beginning in 2022, be able to show changes and trends within those communities, as well. All this data will be available to RISE^2 partners and participants. Finally, we will continue to seek new members to join the network to enhance our outreach work within the four current counties and any new communities that are interested in participating in the RISE^2 network.

Region Covered by Network Services

County/State	County/State
Greene County, IN	Grant County, IN
Gibson County, IN	Rush County, IN

Network Partners

Organization	Location	Organization Type
Greene County General Hospital	Linton, IN	Critical Access Hospital (CAH)
Deaconess Gibson Hospital	Princeton, IN	Critical Access Hospital (CAH)
Marion General Hospital	Marion, IN	Hospital
Rush Memorial Hospital	Rushville, IN	Critical Access Hospital (CAH)

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Kansas

Rawlins County Health Center Foundation
NW Kansas Rural Maternal Health Network

P10RH37489

Project Focus Areas: Women's Health

Network Statement

The health of expectant mothers before, during, and after the birth of a child affects all of us and impacts the quality of life for families and for the entire community. All families should have adequate maternal healthcare regardless of economic and environmental factors. Yet women living in our region face significant challenges in accessing appropriate obstetrical care. They often must travel long distances to receive care, delay or forego seeking prenatal care, and experience higher rates of negative birth outcomes.

The Northwest Kansas Maternal Health Network was formed to build a foundation of care and take steps to identify strategies that improve the systems and environments that support families. We recognize that to maintain equitable care, we must be able to provide the level of care that families want and deserve.

The network is focused on better understanding the needs and opportunities for improving the environment for mothers, no matter their stage in the pregnancy. Through our collaborative efforts, we anticipate new obstetrical services, new pathways for comprehensive care, and improved coordination with human and social services. We are excited about the opportunity to achieve optimum maternal and infant health outcomes, making Northwest Kansas a more welcoming place to raise a family.

Network Development

The Northwest Kansas Maternal Health Network is a diverse group of stakeholders with a shared vision of improving maternal health. Initially, the network included health departments, hospitals, and clinics. However, that membership has changed with the increased interest for midwives and doulas to participate in improving maternal health care. Additionally, a business owner for new moms has also been an active member and has used the network and the networking of members to improve other regional initiatives, such as Becoming a Mom and regional breastfeeding programs. The network has made connections with other partners and programs with similar goals as well as other regional collaboratives. The network has faced challenges with the initial kickoff being pushed back and switched to a virtual platform due to a spike in regional coronavirus cases. Engaging and forming relationships with all members has been difficult with virtual meeting constraints. Involvement with area hospitals and health departments has been difficult to maintain due to the impact of COVID-19 on each county in the region and the need for them to focus on COVID testing, contact tracing, and now vaccination distribution. Additionally, organizational silo thinking is still quite present in this frontier region. Adaptive challenges have surfaced with health care organizations and a fear of losing patients, revenue, and alternative birthing providers. Alternative providers have provided a unique outlook on maternal health. Instead of taking an active leadership position in the network, the birthing hospitals have been more observers and the alternative providers have provided the momentum to keep the network going. An adaptive approach to reconvene birthing centers back to the network will be the next step in the development of this network. Furthermore, with COVID numbers, testing and vaccine distribution lower, health departments will need to be re-approached to bring in their perspective and extensive knowledge of maternal health gaps and opportunities to improve. However, the network has brought out an unexpected success as birthing hospitals have increased their pregnancy services marketing in response to the formation of this network.

Programmatic Development

The network prompted the alternative maternal health providers, the midwives and doulas, to reach out and see what was going on and to give their ideas and input on the network. This has allowed those providers to talk with each other and with other organizations to enhance engagement and be a sounding board to help coordinate programs that were already in place to reach more moms. The network has been able to engage with other regional initiatives, such as with the Kansas Perinatal Collaborative and the Becoming A Mom. The network will continue to coordinate with regional programs, initiatives, and maternal health providers.

The network has been successful in administering a survey to doctors, nurses, midwives, and other health care providers to gather information on maternal health in the region and to discover what barriers women face when receiving care for pre-natal, during and post-natal services. The network is still working on gathering qualitative analysis to establish what the concerns are from the moms needing the maternal health care.

A major program that the network had planned was the collaboration of care and establishing a network infrastructure that coordinated care and increased access to care for maternal health. Since the network has faced a challenge of silo thinking and availability due to the pandemic, these relationships have not been established.

Sustainability

The Northwest Kansas Maternal Health Network will continue to build partnerships with regional and state collaborations some of which receive funding through the Kansas Department of Health and Environment to support coordination when providing educational information regarding maternal health.

The Northwest Kansas Maternal Health Network will need to engage birthing entities to find sustainability for this network. Better engagement from members is needed to move forward with developing specific strategies to improve maternal health. The network plans to continue working on establishing a good foundation and the structure to make it sustainable.

Region Covered by Network Services

County/State	County/State
Rawlins County, KS	Sherman County, KS
Thomas County, KS	Cheyenne County, KS
Decatur County, KS	Norton County, KS
Sheridan County, KS	Graham County, KS
Wallace County, KS	Logan County, KS
Gove County, KS	Trego County, KS

Network Partners

Organization	Location	Organization Type
Rawlins County Health Center	Atwood, KS	Hospital
Goodland Regional Medical Center	Goodland, KS	Hospital
Rawlins County Health Center Foundation	Atwood, KS	Philanthropy/Foundation
St. Catherine Hospital	Garden City, KS	Hospital
Rawlins County Public Health Department	Atwood, KS	Public Health
Sherman County Public Health Department	Goodland, KS	Public Health
Northwest Kansas Ambulance Service	Goodland, KS	Emergency Medical Services (EMS)

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Kentucky

Northeast Kentucky Regional Health Information Organization
Kentucky Rural Quality Care Initiative

P10RH37487

Project Focus Areas: Increase Healthy System Efficiencies

Other Focus Areas:
Care Coordination
Health Information Technology
Network Organization/Infrastructure Development
Reimbursement for Health Services

Network Statement

The changing healthcare environment presents great challenges to the capacity of rural health clinics to address quality improvement efforts and more fully engage in value-based incentive programs. The Kentucky Rural Quality Care Initiative Network is developing a training and technical assistance program focused on value-based care activities with Medicaid Managed Care Organizations, that can be replicated throughout rural health clinics. Our vision is to advance health information technology infrastructure and Meaningful Use attestation for rural providers.

Network members bring expertise and many diverse experiences together to develop a shared mission, vision, values, and goals for the Initiative. Although, rural providers have achieved Meaningful Use stages 1 and 2, it has been difficult to be well-positioned for value-based care programs due to limited resources and lack of staff capacity. So far, we have identified what is needed by the RHCs and cross-referenced those needs with the value-based incentive programs.

Our combined efforts will provide custom quality-based tracking programs, consultation services, and quality-based resources on the state and federal levels to help RHCs continue to meet quality/incentive goals. We have a comprehensive communication/data-sharing strategic plan to keep up with the on-going changes in healthcare.

Network Development

As we examined the ever-changing healthcare environment and the rural health clinic's capacity to address quality improvement efforts, we focused on areas of strength and those needing improvement to develop our Network. Two partners, Community Family Clinic, PLLC and Knott County Health Care, brought diversity, innovative designs, and expertise to this project.

The Network members are very familiar with change and are open to learning and experiencing new processes. There are always challenges of time constraints and manpower to implement the changing systems and processes. Due to the COVID-19 pandemic, our network was under restrictions regarding working together in-person. To address these restrictions, we came together in a unique virtual way that worked well with everyone and still achieved our goals.

Our Network structure is striving to contribute to and be accountable for the organization's achievements. From diverse experience and valuable knowledge from the group, everyone also shares responsibility for the organization's success. All Network members have agreed to make long-term commitments to continue the progress.

Programmatic Development

Our programmatic development progress, in the beginning, was slow due to COVID-19 restrictions. Our consortium had to switch gears and use the Zoom meeting platform instead of meeting face-to-face. This led us to redesign our original communication plan which described how future meetings were to be conducted, how documents were to be shared with the consortium and how feedback was received. We spent a great deal of time reviewing our consortium's processes and policies. It became clear early on that one of our partners lacked the necessary resources needed to spend a great deal of time on programmatic development. The COVID-19 pandemic was causing them a great deal of stress and they could not spend a lot of time on certain project activities, specifically feedback. However, we were able to ease the burden for them through changes in how we managed feedback on tasks designated for them to complete. It helped that another one of our network partners had more available resources to dedicate to them and they were more skilled in areas such as policy development. Both network partners were able to work closely together to strengthen each other's policies and procedures throughout the grant period.

The COVID-19 pandemic proved to be challenging in that it reduced the number of face-to face meetings we were able to conduct. We primarily used Zoom to engage consortium members which worked very well. One of our members was already using Zoom to conduct telehealth sessions so it was easy for them to adapt to the change. The other partner initially struggled with the Zoom platform, but we were able to work through those IT hiccups. Also, one of our members did not have adequate resources to help with completing some of the project activities. We were able to help them by connecting with a more seasoned consortium member who had the needed resources. Both partners were able to work though the project activities together and meet the necessary goals and objectives.

Sustainability

There will be no change in the way the network functions after the Rural Health Network planning grant period ends. We will continue to meet periodically to update progress on initiatives and other quality-based metrics (Meaningful Use, reimbursements, and population health) while developing/revising policies and procedures. We anticipate expanding our network to more rural health partners in 2022.

We intend to add, by the end of 2021, Quality based consultation to the list of services provided by NeKY RHIO. We also intend to look at additional state and federal funding to help us to continue our work, which would also include network expansion. Our Network members have strengthened over the past year and we want to keep the momentum going.

Region Covered by Network Services

County/State	County/State
Knott County, KY	Bath County, KY
Montgomery County, KY	Menifee County, KY
Powell County, KY	Morgan County, KY

Network Partners

Organization	Location	Organization Type
Knot County Family Healthcare	Hindman, KY	Rural Health Center
Community Family Clinic, PLLC	Owingsville, KY	Rural Health Center
Community Family Clinic, PLLC	Frenchburg, KY	Rural Health Center
Community Family Clinic, PLLC	Stanton, KY	Rural Health Center
Community Family Clinic, PLLC	Mt. Sterling, KY	Rural Health Center
Northeast KY Regional Health Information Org.	West Liberty, KY	Non-Profit

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Maine

Medical Care Development, Inc.
Maine eConsult Network

P10RH37483

Project Focus Areas: Increase Health System Efficiencies

Other Focus Areas: Integrated Health Services
Reimbursement for Health Services
Telehealth
Workforce Development

Network Statement

Maine covers a vast geographic area that includes rugged coastline and dense forest. The nature of this geography, though full of natural beauty, brings inherent challenges for Maine's rural communities and healthcare providers. Isolation, poverty, and a poor economic outlook have been associated with poor access to medical, mental, and dental health care, as well as high levels of morbidity and mortality from chronic disease. Maine also has one of the oldest populations in the nation and a high percentage of dual Medicare and Medicaid eligibility. The level of health needs among this population, combined with the limitations of the current health care delivery system (provider shortages, long specialty wait-times, etc.) creates a critical need for innovative approaches to improve and streamline healthcare delivery across the state.

The Maine eConsult Network (MEeCN) was initiated in 2020 to address these challenges in collaboration with the Maine Rural Health Collaborative (MRHC) and Penobscot Community Health Care (PCHC). The MEeCN is working to establish a system of eConsult services to facilitate communications between rural primary care providers (PCPs) and distant specialty providers. A PCP in a rural community can initiate the consultation and request recommendations from a specialist by sending patient-specific information and questions to a secure shared electronic platform. A specialist from a selected group or pool of providers is then assigned and responds (typically within 24-48 hours) with recommendations for the PCP to consider in the care and treatment of the patient or advice that the PCP should refer the patient to a specialist. The specialist may also request additional, clarifying information from the PCP. Through implementation of this statewide eConsult Network, rural, medically underserved residents – and their providers - will benefit from extended and timely access to the specialty care they need and expect.

Network Development

Over the past year, the Maine eConsult Network (MEeCN) has worked toward network formalization through multiple activities. During the first few months of the grant period, fiscal agent of MEeCN, Medical Care Development, Inc. (MCD; www.MCD.org), confirmed network staffing and roles, including a Network Director and Network Coordinator, and grant management systems, consisting of project and budget management. Monthly meeting protocols were established with Network Members and the first monthly meeting of the MEeCN was held in September 2020. Over the first six months, the MEeCN worked to formalize the Network and governance structure including drafting a Charter with Vision, Mission, and Values statements for the Network, the structure and function of the Leadership Team, and Definitions and Roles in MEeCN.
Historically, MCD, in its role as convener of the MEeCN and host of the HRSA-funded Northeast Telehealth Resource Center (NETRC; www.NETRC.org), has worked independently with both MEeCN Members, the Maine Rural Health Collaborative (MRHC) and Penobscot Community Health Care (PCHC) on telehealth-related projects.

Through the process of formalization of the MEeCN, the value of clear communication and mutual respect was forged among Network organizations. In due course, MRHC and PCHC identified connections and areas of collaboration both inside and outside of the Network.

Programmatic Development

Progress has been made in the Maine eConsult Network (MEeCN) in programmatic development and the provision of eConsult services among Network Members. Early in the grant period, to gain a better understanding of the eConsult landscape in rural Maine, Network Members designed and disseminated two eConsult Needs Assessments, one completed by Administrative and Clinical leaders and the other by Technical leaders at Maine Rural Health Collaborative (MRHC) sites. The Assessments focused on the nuts and bolts of IT infrastructure, current experience with eConsults and other telehealth modalities, specialty services of greatest need, and Administrative, Clinical, and Technical perspectives on eConsult implementation. The MEeCN was able to leverage Penobscot Community Health Care's (PCHC's) membership in Community Care Partnership of Maine Accountable Care Organization (CCPM ACO) to disseminate these Assessments beyond the formal membership of the MEeCN, in doing so acquiring greater baseline data on community assets and needs related to eConsults. Twelve organizations in total completed the eConsult Needs Assessment, the results of which have directly informed the MEeCN strategic planning process.

Additionally, by including PCHC early in Network development, the MEeCN was able to leverage PCHC's multi-year experience utilizing this model as both a subject matter expert and eConsult adoption champion. PCHC's expertise in eConsult implementation, workflow, operations, and reimbursement helped to prepare the Network to vet perspective eConsult vendors. The vetting process of eConsult vendors for MRHC sites began in October 2020 and accelerated in subsequent months as the Network, in collaboration with MRHC and a partnering eConsult vendor, applied for HRSA's Rural Health Care Services Outreach Program to begin eConsult implementation in all MRHC sites. Though this submission was ultimately unsuccessful, the planning and project development involved in the grant-writing process served to clarify programmatic aspects of eConsult implementation and solidify some of the goals of the MEeCN. This process also opened the door for the development of self-funded eConsult pilots at two of the MRHC sites, Millinocket Regional Hospital and Houlton Regional Hospital.

Sustainability

The Maine eConsult Network (MEeCN) is approaching sustainability in a variety of ways. For our member organizations, implementation costs of the eConsult model are the biggest barrier to initiating the service line. Encouragingly however, once infrastructure is in place, eConsults are reimbursable by Maine Medicaid and Medicare, as well as some private payers in Maine. In addition, MEeCN's strategic plan includes a business model and roadmap to reimbursement to guide members to sustainable services.

In collaboration with Medical Care Development, Inc. (MCD; www.MCD.org) and the Northeast Telehealth Resource Center (NETRC; www.NETRC.org), MEeCN is exploring grant funding opportunities to support program implementation and evaluation initiatives. The MEeCN aims to leverage shared evaluation efforts to continue to gain support for reimbursement, most notably from the private payers in Maine who do not yet cover eConsults. Moreover, MRHC members who are self-funding eConsult pilot opportunities, as mentioned above, will not only provide additional data to validate the eConsult model, but also encourage the sharing of expertise in eConsult implementation, workflow, and reimbursement with other MEeCN stakeholders.

Region Covered by Network Services

County/State	County/State
Aroostook County, ME	Penobscot County, ME
Hancock County, ME	Washington County, ME
Kennebec County, ME	

Network Partners

Organization	Location	Organization Type
Medical Care Development, Inc.	Augusta, ME	Non-Profit
Maine Rural Health Collaborative	East Boothbay, ME	Collaborative
Penobscot Community Health Care	Bangor, ME	Federally Qualified Health Center (FQHC)

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Maryland

Eastern Shore Area Health Education Center
Maryland Rural Health Planning Consortium

P10RH40102

Project Focus Areas: Network Organization/Infrastructure Development

Other Focus Areas: Telehealth
Workforce Development

Network Statement

"The Maryland Rural Health Planning Consortium's mission is to achieve health equity and revitalize rural voices by assessing the impact of the Maryland Rural Health Plan and providing a framework for improvements to the health of rural Marylanders."

Rural communities on the Mid-Shore of Maryland face unique challenges to improving health. Rural residents are typically older and poorer and shoulder a greater burden of chronic health conditions such as chronic obstructive pulmonary disease and diabetes. The creation of the Maryland Rural Health Plan brought together health care providers, rural community members, and community organizations from across the state to better understand rural health behaviors and develop a set of recommendations to address these health inequities.

Now, the Maryland Rural Health Planning Consortium is expanding on the success of the Maryland Rural Health Plan. As we continue to foster our long-standing relationships, we are working together to identify the best recommendations from the Health Plan to set priorities that will ensure continued improvement of health on the Mid-Shore.

Network Development

The Maryland Rural Health Planning Consortium came together to assess the Maryland Rural Health Plan and develop a targeted strategy to make the plan a more useable document. Although the Plan was a wonderful collaboration in assessing the baseline needs throughout rural Maryland, the use of the plan is limited as it lacks SMART goals for each jurisdiction. As the Plan was a significant undertaking, it was determined that the best way to establish the SMART goals for our region of the state was to create a small consortium of Mid Shore County stakeholders from Caroline, Dorchester, and Talbot Counties.

Stakeholders from the University of Maryland Shore Regional Health (the local hospital system), Choptank Community Health Services (the largest primary care provider in the three-county region), Eastern Shore Area Health Education Center, the Horowitz Center for Health Literacy, the Maryland Rural Health Association, and the Maryland Hospital Association joined together for the project. This consortium provides a cross section of hospital, community provider, academic institutions, and healthcare advocacy organizations. Consortium members were able to communicate their similarities and differences throughout the process.

Programmatic Development

Through the completion of a SWOT analysis, the partners identified areas of opportunities, strengths, weaknesses, and threats which led to the identification of potential focus areas for the Consortium. The Consortium partners have chosen to work together to enhance telehealth services in the regional and explore avenues for addressing workforce shortages in the Eastern Shore.

Sustainability

The Consortium will explore the feasibility of aligning with the Mid Shore Local Health Improvement Coalition with the intention of operating as a subcommittee within their organizational structure. The association would expand the reach of the Consortium, prevent duplication of efforts, and allow the Consortium greater sustainability through an association with an established and funded entity.

Region Covered by Network Services

County/State	County/State
Caroline County, MD	Dorchester County, MD
Talbot County, MD	

Network Partners

Organization	Location	Organization Type
Horwitz Center for Health Literacy, University of Maryland School of Public Health	College Park, MD	College/University
Maryland Hospital Association	Elkridge, Maryland	Non-Profit
Eastern Shore Health Education Center	Cambridge, MD	Area Health Education Center
Maryland Rural Health Association	Cambridge, MD	Non-Profit
University of Maryland Shore Regional Hospital	Easton, Maryland	Hospital
Choptank Community Health System	Denton, Maryland	Federally Qualified Health Center (FQHC)
Anna Shao	College Park, Maryland	College/University

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Massachusetts

Baystate Franklin Medical Center
Link2Health

P10RH37472

Project Focus Areas: Care Coordination

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

Network Statement

People in Franklin County and the North Quabbin need help. Programs have help to offer. **Link2Health** will make sure they get connected. With Link2Health, we are building a "no wrong door" network of service providers to connect people to the help they need, when and where they need it, through close connections and technology. Link2Health is a network of healthcare, human services, philanthropic, public health, and planning agencies in our rural region. Our vision is that all residents have the opportunity to pursue healthy lifestyles, participate in shaping the systems that affect their health, and achieve social, emotional, physical, and spiritual well-being.
Since 2015, our partners have assessed, identified, and focused on addressing major health improvement priorities for the region. We are creating Link2Health to address the need for care coordination and navigation, which have consistently emerged as major community health needs for our low density, high-need, under-resourced population. Link2Health will provide the person-centered, coordinated services needed for the optimum health and welfare of our community.
Currently, Link2Health is facilitating a conversation among members, staff, and the people who live and work in our region about the value of such a network and the use of technology and telehealth to improve the necessary coordination of services. We are convinced that our citizens will consider themselves healthier and satisfied when Franklin County and the North Quabbin region is a place where those seeking help can find it, and the folks doing the helping have the support and tools to meet their needs.

Network Development

Link2Health Network members understand the value of care coordination and navigation as foundational elements impacting health and aligned with the Community Health Improvement Plan Network (CHIP) mission and vision. Our network has created strategies to assess the current state of care coordination and navigation as well as the use of telehealth and technology to improve health. We benefit from the diverse perspectives of CHIP members, front-line staff, and a broad range of community partners, which helps us to ensure that issues of health equity remain front and center, the most important work of Link2Health.
The Link2Health Network is made up of two existing groups working together in new ways to address care coordination: (1) the CHIP Network develops priority areas of focus for the health of the region, and (2) The Franklin County Resource Network (FCRN) is the front-line people who actually do the work of navigation and care coordination. The challenge is tapping the brain trust of FCRN members who have all the grass-roots ideas and creating a strategy within CHIP to prioritize and operationalize them. There is considerable overlap already between the two groups: both use a broad definition of health, and there is a shared understanding that addressing health inequities requires confronting the structural racism and other forms of institutionalized oppression that have shaped the systems we work within. Both organizations want to increase support for the front-line workers who are crucial to realizing the vision of a community where there's truly no wrong door. Equity

has clearly risen to the highest priority when considering any strategy. As its first priority, Link2Health will work to ensure that all people have equitable access to navigation and care coordination services and will be informed by those who have successfully navigated barriers.

Sharing the work of the HRSA Rural Health Network planning process with multiple stakeholders across sectors has attracted the attention of the soon-to-be-launched UMMS/Baystate Family Residency Program. Biweekly meetings with its Founding Director have generated synergistic ideas for strategies to improve health in our region through care coordination efforts. This has been a great opportunity for our Link2Health Network to navigate concerns from stakeholders about the value of the coming residency program as part of the network. We will continue working to enhance the partnership and address concerns.

Many healthcare systems have adopted or plan to adopt value-based care models. These initiatives would automatically see the value of enhanced accountability for improved navigation and care coordination. Proactively collaborating with healthcare leaders early on will help the network align with system-wide initiatives. The MassHealth (Medicaid) accountable care organization landscape complicates our work and brings the opportunity for moving toward value-based care. This has not always been an easy conversation in our planning efforts that intentionally take a broader approach in partnership with community coalitions and social service agencies. BFMC is a community hospital serving our rural county as part of a larger healthcare organization (Baystate Health) that is headquartered in a more urban area, where a five-year ACO pilot is nearing its end and MassHealth is planning the rollout of the next 1115 waiver. We have been working on developing this strategic plan and educating the community and ourselves so that community-based partnerships will be ready to go when the ACO model reaches rural Franklin County.

Finally, it must be said that the COVID-19 pandemic has had a profound impact on our intentions for the RHN planning process. We proposed a robust process involving a lot of in-person work, including meetings and focus groups, in-person surveys of stakeholders and a large number of community members out in the rural areas via our population health nurse. COVID forced a stop to all of that as the nurse needed to restructure flu clinics, respecting social distancing at outdoor facilities with many new volunteers, was re-deployed for testing and eventually vaccine distribution, we were unable to bring community members or stakeholder groups together, and even our leadership team and the CHIP met virtually throughout the grant project period. Our leadership team and the CHIP have continued to meet and are often together to work on this project, and in the early months our Zoom meetings seemed very efficient. Over time, however, the work and schedules of everyone involved (and everyone else, it seems) have become tedious. We very much look forward to working together again in person.

Programmatic Development

One key area that Link2Health addresses is providing tools, resources, and networking support for front-line staff. Link2Health addresses navigation and care coordination by reinforcing Look4Help and FCRN as foundational support. The HRSA Rural Health Network work has provided the opportunity for stakeholders to work together to address gaps in navigation and care coordination and a way to create a comprehensive framework for workforce development. Communication strategies focus on how to best support our front-line staff by encouraging bi-weekly participation at FCRN meetings (or at least to read the minutes) and reach out to this group with any service-related questions for support, and how and when to use the local Look4help resource directory. This communication strategy also reinforces each organization keep their data up to date on their page in Look4Help.

One challenge for us is that many small consortiums exist across our rural region that have successful navigation and care coordination models. We had to work hard to be inclusive and work in tandem rather than separately from other groups. We learned that it is critical to identify successful models that already exist within the service area to work with and build from rather than duplicate. We also learned by presenting our ideas to larger stakeholder groups that health equity is the number one priority for Link2Health to address, and we are pledging to keep racism and equity front and center in all of our work.

Another challenge has been the impact of the COVID pandemic on our ability to truly connect with the community in a more grass-roots way as we had intended. We are working on this but feel that our efforts have been slowed, and this has had an impact on program development in addition to our overall network efforts described above. One of the good things that came from pandemic times is the development of a twice-monthly BFMC grants group meeting, where many ideas and synergies have been generated that we were able to take back to our network leadership team for brainstorming and program consideration. This biweekly BFMC meeting includes about 8-10 people who are involved with grants (several HRSA grants and other grants) coordinating our efforts and talking about questions, challenges, and successes. Strategically aligning timelines, staffing, symmetries, and messaging has solidified a coordinated direction for the organization. We cannot overstate how valuable this regular check-in has been to our planning, in addition to our regular RHN leadership team meetings and our TA calls.

Sustainability

The CHIP (the advisory board for our RHN planning project) is an existing network that will continue beyond the time of this grant and is growing in terms of its membership to be more inclusive of missing sectors. The CHIP Steering Committee will serve as an advisory council for any new initiatives being considered or developed in the region and helps to helps to brainstorm and troubleshoot concerns. For example, we have discussed transparency for wages, healthcare contracting with existing social service agencies for CHW work, and healthcare not recruiting new CHW hires unless the work cannot be taken on by community agencies already working in this arena. These examples demonstrate the value of working to create guidelines for CHIP endorsement of new projects with an equity focus; CHIP will serve to screen prospective projects for equity and alignment with other existing programs.

During the time of this RHN planning grant, we have been working to develop relationships and networks in the areas of behavioral health and telehealth, including the UMMS-Baystate Family Residency Program, and these efforts will continue to grow and develop. We will continue to meet with these groups bimonthly and are exploring contracting for care coordination and community health workers.

The state of Massachusetts EOHHS is rolling out behavioral health reform in 2021-22 involving certified behavioral health clinics (CBHCs) addressing behavioral health, substance use disorder, and transition from incarceration. The BH roadmap and the coming Section 1115 Medicaid waiver bring opportunities for our network to integrate this care coordination model and fully embrace value-based care. These statewide initiatives are opportunities for funding care coordination efforts and accountability to outcomes. We are on the precipice and are anticipating sweeping changes that will impact our strategic planning.

Region Covered by Network Services

County/State
Franklin County, MA

Network Partners

Organization	Location	Organization Type
Baystate Franklin Medical Center (BFMC)	Greenfield, MA	Hospital
Franklin County Regional Council of Governments (FRCOG)	Greenfield, MA	Government
Community Action Pioneer Valley	Greenfield, MA	Social Services Agency

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Michigan

District Health Department #10
North Central Community Health Innovation Region

P10RH37478

Primary Focus Area: Network Organization/Infrastructure Development

Other Focus Areas:
Chronic Disease Management
Integrated Health Services
Mental Illness/Mental Health Services
Population Health/Social Determinants of Health

Network Statement

Where people live, work, learn, play, and age powerfully influences health. In the North Central Community Health Innovation Region of Michigan's lower peninsula, our rural geography impacts health in ways that differ substantially from more urban areas. Poverty, unemployment or underemployment, lack of affordable housing, and inadequate transportation make access to health care, behavioral health care, and substance use disorder treatment difficult for residents. In addition, the region lacks the infrastructure necessary to support broadband internet and reliable cellular service which also limits residents' access to telehealth services. These barriers and challenges to accessing healthcare and social services in the region far exceed what any one organization can overcome alone.

The North Central Community Health Innovation Region (NCCHIR) Network endeavors to do together, what cannot be done apart. Comprised of health departments, health systems, community mental health agencies, and Tribal health services, the NCCHIR builds upon the expertise and knowledge of the North West Michigan Community Health Innovation Region. The NCCHIR's robust plans address identified needs that negatively impact health. The development of a unified system of coordinated referrals to community resources is just one avenue the NCCHIR plans to utilize to conquer the basic needs of our communities' most vulnerable residents. These basic needs include access to affordable healthcare, economic security, housing, transportation, and food security. Plans include developing a system of coordinated referrals to community resources to address the basic needs of vulnerable residents in our communities. To foster a true sense of belonging, ownership, and engagement in their communities, the NCCHIR seeks out and encourages resident voice and participation in this work.

Network Development

The North Central Community Health Innovation Region (NCCHIR) Partners have come together to expand the model and the initiatives developed by the North West Community Health Innovation Region (NWCHIR). These initiatives include the expansion of Community Clinical Linkages using the Pathways Hub Model, the completion of the MiThrive 31-county Community Health Needs Assessment and Community Health Improvement Plan, and collective impact and community health impact models.

The NCCHIR Network has formed an Executive Committee, which is using the Governance Model and Charter developed by the NWCHIR. Memorandums of Understanding were developed and signed by all partner agencies. The MOUs established guidance for the NCCHIR Steering Committee members and identified roles and responsibilities of each member as they relate to governance. The Vision of the NCCHIR is: Healthy People in Equitable Communities and the Mission is: Improving health, increasing health equity, and decreasing unnecessary medical costs through planning and partnerships.

The biggest challenge to the development of the NCCHIR Network was a result of the Covid-19 pandemic. The necessary prioritization by the health department and hospital network members of Covid-19 related activities delayed Network planning. In addition, relationships between Network partners from the two local health department jurisdictions needed to be established and strengthened. The unrelenting demands and competing priorities placed on agencies in response to the Covid-19 pandemic plus the limitations of holding network meetings virtually reduced the overall level of engagement in the network planning process and hindered the development of strong relationships among network partners.

To overcome these challenges, the NCCHIR network partnered with a planning consultant from the Northern Michigan Public Health Alliance to lead the network partners in the strategic planning process using the *Technology of Participation.* The ToP strategic planning method consists of a series of workshops, where groups collectively answer a focus question through a variety of activities designed to create a shared understanding of current reality; build consensus on a plan that is realistic, achievable, and easy to monitor; and mobilizes participants to act. The ToP Strategic Planning method adapted well to the virtual platform using MURAL and breakout groups to facilitate the process. This increased engagement of the NCCHIR Network partners and created buy-in and commitment to the Network and the Strategic Plan.

Programmatic Development

The focus of the NCCHIR Network has been to strengthen and expand our Network infrastructure. One programmatic goal of the NCCHIR has been to expand the Community-Clinical Linkages Model to counties in the Central Michigan District Health Department jurisdiction. The NCCHIR Network has developed and distributed a survey to inventory organizations in our region currently offering community health workers and training and to inventory groups currently at work on chronic disease or Social Determinants of Health (SDoH). Network partners are currently in the process of developing a plan to launch additional clinical community linkages hubs in sub-regions.

The challenges facing the NCCHIR program planning have been the competing priorities created by the response needed to the Covid-19 pandemic. Time has been severely limited for Network partners and Network Planning staff to move forward on programmatic development. Monthly Network meetings have focused on strategic planning to determine the programmatic goals and objectives for our Network.

The NCCHIR Network members are committed to gathering input from diverse cross-sector organizations in our region. As a first step in a collaborative effort to expand resource/navigation services based on Social Determinants of Health screenings and align with other organizations in the region doing the same or similar work, we have developed a survey to identify what is already taking place in our region. Survey responses will serve as an environmental scan, which will be used to connect agencies and increase alignment of community clinical linkages between agencies in our North Central Region. Results will be shared with respondents in report format once finalized.

Sustainability

Network partners are committed to maintaining the NCCHIR Network as part of the Northern Michigan Public Health Alliance (NMPHA). Network partners are committed to the Vision and Mission of the CHIR model as part of the 31 county NMPHA region.

The NCCHIR has identified Strategic Directions that will facilitate sustainability:

- Increasing collective impact through partnerships and systems change
- Developing funding strategies to support operations and services of full CHIR model
- Building a shared understanding of health equity needs in the region, including gathering resident voice

- Exploring options for common data elements

The CHIR Charter and Memorandum of Understanding create the model for governance and sustainability of the Network.

Developing a Sustainability Plan is included in the NCCHIR Planning Grant Work Plan and this plan will consist of pursuing potential CHIR funding from Michigan Department of Health and Human Services, alignment of grant-makers' priorities for synergy, securing local, state, and national grants, and educating policy-makers. Legislator education is particularly needed for sustaining the clinical community linkages model. Emerging data from the NWCHIR is documenting both the business case and goodwill case for connecting clients to resources in the community and will be very helpful in justifying funding. Also, there are considerable efforts underway in Michigan for a potential alternative funding model which may provide reimbursement for hub navigation services. Additionally, the NWCHIR received Pathways Community Hub certification of the Community Connections in December 2020 which will align it for potential reimbursement through Medicaid and private insurance. Certification will carry forward into the North Central CHIR subregion.

Region Covered by Network Services

County/State	County/State
Lake County, MI	Gladwin County, MI
Mason County, MI	Isabella County, MI
Mecosta County, MI	Osceola County, MI
Oceana County, MI	Clare County, MI
Newaygo County, MI	Arenac County, MI

Network Partners

Organization	Location	Organization Type
District Health Department #10	Cadillac, MI	Public Health
Central Michigan District Health Department	Mount Pleasant, MI	Public Health
Spectrum Health System	Grand Rapids, MI	Hospital
MidMichigan Health System	Clare, MI and Gladwin, MI	Hospital
West Michigan Community Mental Health	Ludington, MI	Behavioral Health
Community Mental Health for Central Michigan	Mount Pleasant, MI	Behavioral Health
Little River Band of Ottawa Indians	Manistee, MI	Tribal Nation

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Michigan

Health Department of Northwest Michigan
Emmet County Youth Wellness Network

PH10RH37486

Primary Focus Area: Child Health

Other Focus Areas: Behavioral Health
Health Education
Network Organization/Infrastructure Development
School Based Health Services

Network Statement

Emmet County, Michigan is home to charming lakeside communities as well as isolated towns and villages. While many residents are financially secure, our overall population faces many barriers in accessing healthcare services. Rurality, geographic isolation, high rates of uninsured and uninsured, and a shortage of providers often result in drives of up to an hour for our residents to receive needed care.

Recognizing these challenges, a group of school superintendents and parents partnered with the health department and local hospital to form the Emmet County Youth Wellness Network in 2017. Believing that healthy students learn better, and healthy students graduate, we are working to address the health and wellness needs of children and adolescents in rural Northern Michigan. With a focus on behavioral health and telemedicine, we seek to facilitate access to sustainable health services and health education in collaboration with four school districts. Our partnership is growing, and we are committed to enriching the lives of all students in Emmet County schools.

Network Development

In 2017, a group of parents and leaders from the Emmet County school districts, hospital, and local health department was organized with staffing support from the health department. At the time, only one school district—Pellston Public Schools—had school-based health services and the group was focused on securing funding for school-based services at the other districts in the county. Later that year, the group completed an assessment of the need for school-based health services in Alanson, Harbor Springs, and Petoskey. The 2017 Emmet County Schools Exploratory Health Needs Assessment provided justification for school-based health services and over the next three years, several grants were awarded in the county, including funding for ongoing school-based health services in the Harbor Springs and Petoskey school districts. In addition, multiple grants were awarded to implement common health education curricula in all four school districts.

During these early years, the group operated informally, focused on responding to requests-for-proposals and overseeing the launch and implementation of grant-funded projects. Although its members had developed vision and mission statements, they had not had wider discussions to collaboratively determine how the vision and mission would be operationalized. By forming the Emmet County Youth Wellness Network and completing the components for the Network Strategic Plan, the group recognized the need to transition to a formal organizational structure. Over the grant period, members conducted a stakeholder analysis to identify additional sectors, organizations, and/or individuals to recruit; clarified the underlying reasons for, and aspirations of the Network by completing the Network Statement; and scanned trends and identified opportunities and threats at local, state, and national levels for the External Environmental Scan, which informed priorities and strategies for the strategic planning process. The Network Organizational Assessment was very useful in highlighting the need to formalize

group processes through a Memorandum of Understanding; create processes for continually staying abreast of trends that impact the vision and mission; and develop a performance management system.

It was challenging to develop the Strategic Plan components in the midst of the COVID-19 pandemic. There was a steep learning curve to master tools for participatory meetings, such as Mural. All of the Network members experienced severe time constraints to respond to the pandemic; however, they were highly engaged and attendance was high at every meeting. Additionally, one of the health department's team members unexpectedly needed an extended medical leave. Although her leadership and expertise was missed, other staff filled in as needed to continue grant activities.

Programmatic Development

People from rural areas like Emmet County experience significant health disparities, including higher incidence of disease and disability, increased mortality rates, and lower life expectancies when compared with urban areas. Many residents experience risk factors for these health disparities, such as geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, and lack of access to medical care. School-based health services reduce barriers to access to medical care: they are provided at no out-of-pocket cost and eliminate the need for parents to take time off from work and students to be away from school to attend doctors' appointments. One school district remains in the county that does not offer school-based health services and Network members are determined to secure funding in Alanson for primary care and/or behavioral health services in the school.

The Network also recognizes that many residents experience barriers to social determinants of health. The top five reasons clients seek assistance from the health department's certified clinical community linkages model are food insecurity, medical cost/health insurance, behavioral health, utilities assistance, and housing/shelter. Since the onset of the COVID-19 pandemic, residents' need for community resource navigation services has increased markedly. School counselors and social workers are overwhelmed in assisting families—many who are seeking assistance for the first time due to the impact of COVID-19. Network members agree pairing community health workers from the clinical community health linkages model with clinicians from school-based health services is an innovation that will provide valuable service to families while allowing school staff to concentrate on their primary responsibilities.

Over the course of the grant period, Network members also identified a need for assistance with developing or updating school policies related to student health and well-being and included this in their workplan.

Sustainability

The Network's Sustainability Plan consists of a braided funding strategy composed of payments from Medicaid Health Plans and other insurers and cost-based reimbursement, a matching mechanism available to local health departments. By far, the most important factor in sustaining and replicating grant-funded initiatives is collaborations with community partners. For the past 15 years, the health department has provided school-based services without any lapses in funding and now operates them in 11 school districts. Once established, the value of school-based services quickly becomes apparent and grants are secured from local resources like the intermediate school district, school districts, and community foundations. In addition, a pooled community wellness fund is under development in a 10-county region that includes Emmet County to address priorities identified in community health needs assessment, which are healthy food, affordable housing, transportation options, economic stability, behavioral health services, and substance use prevention and treatment.

Region Covered by Network Services

County/State
Emmet County, MI

Network Partners

Organization	Location	Organization Type
Alanson Public Schools	Alanson, MI	School System
Alcona Health Centers	Harbor Springs, MI	Federally Qualified Health Center
Harbor Springs Public Schools	Harbor Springs, MI	School System
Health Department of Northwest Michigan	Harbor Springs, MI	Public Health
McLaren Northern Michigan	Petoskey, MI	Hospital
Pellston Public Schools	Pellston, MI	School System
Public Schools of Petoskey	Petoskey, MI	School System

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Michigan

Northern Michigan University
Northern Michigan Center for Rural Health

P10RH37488

Project Focus Areas: Chronic Disease Management

Other Focus Areas: Emergency Medical Services

Network Statement

The environmental conditions where we are raised, educated, work, and live impact our quality of life and health outcomes. Here in the U. P. of Michigan, our remote location and sparse population often result in challenges for achieving and maintaining good health. In addition to a dearth of primary and specialty health care services, the region has a large low-income population, poor health status indicators, inadequate social support, and major transportation barriers that affect access to health care services.

Partners of the Northern Michigan Center for Rural Health (NMCRH) network have joined forces to take action through the engagement of a wide variety of public, private, and volunteer sectors. We understand that basic needs must be addressed before individuals are empowered to plan and be proactive about their health. Until this is done, efforts to encourage and support preventative and routine healthcare will remain ineffective, and the progression of chronic diseases will persist. As our network continues to grow, we will be guided by our passion and determination to cultivate a sustainable healthcare workforce and create healthy and resilient communities throughout our region.

Network Development

The development of the NMCRH network has been occurring informally since the planning grant start date (July 2020). Core grant partners recognized that to accomplish components of the grant's work plan, two separate subcommittees needed to be formed to focus on the education, prevention and treatment of diabetes and the recruitment and retention of Emergency Management System (EMS) personnel. Subcommittee members consisted of "boots on the ground" type positions that understand how the systems work, historical perspective, current challenges, and on-going developments. The development of the subcommittee provided the opportunity to educate other agencies and individuals about the NMCRH network thus providing a natural progression to expanding the network in a controlled fashion.

Challenges the NMCRH has faced in network development over the past 10 months have included increasing awareness about the network, building and fostering relationships in a traditional sense, and convening and engaging subcommittee members and core grant partners for various meetings. Despite these challenges primarily brought on by COVID19 pandemic developments, NMCRH partners were not deterred and sought alternative approaches to advancing network development.

One example was recognizing what entities were currently overwhelmed and what entities were open to building a relationship. The NMCRH Director brought universities throughout the region together to advance flu vaccination efforts by developing a "Yooper U's Fight the Flu" competition. Universities embraced the opportunity to focus on something other than COVID19 and all universities exceed past vaccination rates. It was a small win and has opened the door to expanding efforts with institutions of higher education in the future. Another example was realizing that instead of creating a platform to increase network awareness, partners could embrace what the pandemic had created…an opportunity to join and engage with other agencies and healthcare entities as efforts to

address pandemic needs became more organized and transparent throughout the region. Recognizing and seizing that opportunity was valuable because the right people were already convening and engaged even if it was only virtually. As coordinated efforts continued, people began to share current situational challenges and that lead to people working together to create short term solutions. The pandemic has reinforced the concept that by working together collectively, a greater impact can be made throughout the region. The hope is that this mentality will only continue in the pandemic aftermath. In essence, it is as though the pandemic has set the table perfectly for advancing network efforts.

One's awareness of current situations, understanding individual's capacities and compromising to advance efforts without sacrificing integrity is key in network development. There is more than one way to move forward and exploring alternative means can lead to new and innovative approaches to advancing efforts.

Programmatic Development

In addition to establishing the Northern Michigan Center for Rural Health (NMCRH) network, other areas of focus included the recruitment and retention of Emergency Medical Services (EMS) personnel and the education, prevention, and treatment of diabetes. Network partners have been adamant about not duplicating or replicating current efforts, but rather expanding successful efforts in new and innovative ways.

One example is exploring the possibility of hiring healthcare professionals such as diabetes educators and registered dietitians who can provide services throughout the region and expand access to care on behalf of the NMCRH via tele-health. This innovative outreach will reduce waiting lists, provide back-up to rural healthcare entities challenged with accommodating professional's time off and serve as a means to continue services in the event there are regional vacancies in these positions. Another example is doing a regional assessment of community member's knowledge of EMS services. One cannot recruit individuals if they do not understand the baseline of knowledge, attitudes, and opinions in existence. It has been the responsibility of individual EMS agencies to fend for themselves with recruitment and retention efforts. By conducting a survey, the NMCRH will provide feedback to EMS agencies throughout the region. Survey results will support further discussion on what is known and unknown and only then can a strategy be developed to create an effective marketing campaign to recruit and retain EMS personnel.

Two primary challenges were identified in relation to these initiatives. The first challenge was that as partners engaged with several "boots on the ground" diabetes professionals, it was determined that the biggest need was simply to get people to change their behavior and lifestyles. Professionals indicated they already have the time, education, and resources to share with patients, what they need is for people to just try to commit to improving their health. As a result, the NMCRH intends to schedule focus groups resulting in a deeper dive with prediabetes and diabetes patients in hopes of further determining how educational efforts might be modified to have a greater impact in the future. Additionally, a diabetes outreach campaign will be developed with the assistance of a professor at Northern Michigan University who specializes in the psychological impact of marketing messages.

The second challenge was understanding the operational structure of EMS agencies in the region. The Upper Peninsula of Michigan does not have healthcare systems that pay individuals to become educated and certified in various EMS levels. Additionally, there is no guarantee for employment for those enrolled in EMS coursework. Furthermore, because of the rural landscape, many agencies rely on paid volunteers who receive minimal compensation for the occasional call. Thus, there is a lack in structure supporting this much needed service and the on-going operations of EMS agencies throughout the region. The NMCRH intends to engage individuals in a larger discussion in hopes of exploring potential solutions. This is more of a systemic challenge that will require input from various entities beyond the region if a sustainable model is to be developed.
When challenges are presented, it is helpful to investigate, identify and understand: 1) what can contribute to short-term and long-term solutions, 2) who should be included in discussions and 3) the reality of how long efforts

may take given unforeseen circumstances. Communities should be encouraged to explore possibilities, engage in conversations, and embrace thinking “outside of the box”.

Sustainability

The Northern Michigan Center for Rural Health (NMCRH) will continue to expand beyond the Network Planning grant. Partners are committed to network growth and implementing plans that impact the health and well-being of residents throughout the Upper Peninsula of Michigan. In June 2021, an Advisory Council will be formed to assist with guidance and on-going network focus and development. A formalized approach to recruiting new network partners will ensue and meeting schedules will be developed and disseminated for upcoming Advisory Council and Network Partner meetings. The strategic plan will provide guidance and all efforts will be measured and evaluated on an annual basis. Revisions to timelines and activities will be considered and implemented as necessary and will continue to support the integrity of the network.

Northern Michigan University is committed to the on-going development of the NMCRH. The State Office of Rural Health (the Michigan Center for Rural Health) is committed to the on-going partnership and efforts will continue using the World Health Organization (WHO) framework for collaborating centers. Current work will continue and will be expanded as time, efforts, and resources permit. Funding opportunities will continue to be explored and, when possible, leveraged as to maximize opportunities for advancing activities.

As a result of receiving HRSA network planning grant funds, the NMCRH network has been well positioned to move forward with long-term sustainability in mind. The relevant tools, guidance and support that HRSA continues to provide combined with the development of a strategic plan will greatly assist in creating a thoughtful and deliberate future map for success. These elements combined with the wisdom and oversight of the advisory council and the on-going enthusiasm and commitment from partners for a solid foundation for future sustainability.

Region Covered by Network Services

County/State	County/State
Alger, MI	Keweenaw, MI
Baraga, MI	Luce, MI
Chippewa, MI	Mackinac, MI
Delta, MI	Marquette, MI
Dickinson, MI	Menominee, MI
Gogebic, MI	Ontonagon, MI
Houghton, MI	Schoolcraft, MI
Iron, MI	

Network Partners

Organization	Location	Organization Type
Bay Ambulance Inc.	Baraga, MI	EMS
Bay Mills Indian Community	Bay Mills, MI	Tribal Nation
District 10 Lions Clubs	Entire Upper Peninsula, MI	Non-Profit
Finlandia University	Hancock, MI	College/University
Lac Vieux Desert Band of Lake Superior Chippewa Tribe	Watersmeet, MI	Non-Profit
Lac Vieux Desert Health Center	Watersmeet, MI	Tribal Clinic
Lake Superior State University	Sault Ste. Marie, MI	College/University
Marquette County Senior Provider Network	Marquette, MI	Collaborative
Michigamme Spurr First Responders	Michigamme, MI	Emergency Medical Services (EMS)
Michigan Center for Rural Health	Lansing, MI	Non-Profit
Michigan Rural EMS Network	Caro, MI	EMS
Michigan Technological University	Houghton, MI	College/University
NorthCare Network, Inc.	Marquette, MI	Medicaid Managed Care Organization
Northern Michigan University	Marquette, MI	College/University
Region 8 Healthcare Coalition	Marquette, MI	Non-Profit
Region 8 Trauma Network	Marquette, MI	Collaborative
Upper Peninsula Diabetes Outreach Network	Marquette, MI	Non-Profit
U.P. Health System EMS	Marquette, MI	EMS
Upper Great Lakes Family Health Center	Houghton, MI	Federally Qualified Health Center (FQHC)

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Minnesota

St. Joseph's Medical Center
Central Minnesota Network

P10RH40106

Project Focus Areas: Substance Abuse/Addition - Opioid

Other Focus Areas: Behavioral Health
Care Coordination
Emergency Medical Services
Network Organization/Infrastructure Development

Network Statement

Rural communities across the country have been disproportionately affected by the opioid epidemic and the rise in use of other substances. In 2020, the Central Minnesota Network was formed to help our community support people who have experienced substance use disorder to not only recover, but to fulfill their potential and lead healthy lives. The network includes partners from primary healthcare providers, behavioral health organizations, local law enforcement agencies, educators, social services, the recovery community, and prevention services. The partners recognize the need to address the impact of substance use on families and provide them with early intervention to improve their health outcomes. The Central Minnesota Network is committed to taking this aligned action together to lift central Minnesota out of the opioid crisis for a healthier future.

Network Development

The Network for the Central Minnesota Substance Use Prevention, Intervention, and Long-Term Recovery Planning Project began September 2020, upon receipt of this Rural Health Network Development Planning Grant. The network was formed to reduce substance use disorders, with a focus on opioid use disorders, by building sustainable relationships and support within the community, gathering resources, and working together for all affected by substance use disorders. The Network so far has accomplished meeting together monthly, adding new members, pursuing additional community partners, meeting together for a 4-hour strategic planning session, and completing all required products for the grant.

One challenge the network faced was a misunderstanding between two partners at a network meeting. After one member missed two meetings, the Project Director directly approached the person and talked it through with this individual. Then she reached out to the other partner, so the two organizations could share information. Both organizations are now attending network meetings and the strategic planning meeting.

COVID was a large challenge for this grant year, with busy work and personal schedules, in addition to meetings being held remotely. For instance, clinic staff were sometimes called away from a meeting briefly to provide vaccinations to people who dropped in. However, the group remained committed each month and joined monthly team calls. We were able to do a hybrid meeting for our strategic planning day on with most participants participating in person. St. Joseph's Medical Center facilities provided the means for us to also meet with members virtually. Virtual meetings provided an easy way to quickly meet, without travel time, and have everyone engaged.

Our next steps for network development are to continue to identify and recruit additional organizations, which would add resources and fill gaps within the network, i.e., jail staff. One helpful strategy we adopted to manage

the project was weekly virtual meetings between the project manager in one clinic; the operations manager, RN care manager, and physicians in a second clinic; and the two evaluators in two other distant locations. It kept us on track and moving forward in the face of amazing challenges, especially for clinic staff, during COVID.

Programmatic Development

As a planning grant, we did not conduct any direct services. Network members have enhanced community and partner relationships, promoted engagement and participation in the network, and planned for substance use prevention, treatment, and recovery. The evidence-based strategies included integration of behavioral health in primary care, focusing on Opioid Use Disorders (OPD) and other Substance Use Disorders (SUD), with medication for opioid use disorder (MOUD) treatment provided by physicians, nurse practitioners, and physician assistants. We also are planning for more systematic care facilitation with referrals to treatment for SUD and recovery programming. We are working towards close collaboration among network members from various organizations, including co-located services in the clinic, where, for example, a co-located partner then refers to other partners.

Since the proposal for this grant was written, the Baxter clinic has added a Registered Nurse care manager to focus on medications for opioid use disorder (MOUD). She has also worked with the St. Joseph's Hospital Emergency Department staff in Brainerd to begin initial treatment in the Emergency Department, with referral to the primary care clinic for follow-up and ongoing treatment. Additionally, during this grant period, the RN Care Navigator created a learning collaborative throughout Essentia Health to collaborate with other RN's whose focus is MOUD.

Progress was also made through networking at monthly meetings. One partner would communicate a need within their organization and, after the need was shared, a different partner in the network would offer assistance to meet the need, or the group would brainstorm solutions and resources together. Following these conversations, as resources were shared or needs were presented, patient referrals were created.

The network's next step is to establish workgroups, based on work at the strategic planning meeting. Important themes emerged, specifically, the need for harm reduction strategies such as increasing access to NARCAN. As the group decides on goals and objectives, workgroups will be established to implement projects.

Sustainability

The network partners are in the initial phases of establishing themselves as a group and are committed to continuing to collaborate. Each partner has signed a memorandum of understanding. The largest barrier to continuing the network is funding for facilitation of the group. In the short run, that role will be funded by a state opioid response grant. In the long run, the group will create a formal method for ongoing network support, perhaps by partnering with other existing groups.

St. Joseph's Medical Center applied for and successfully received a State Opioid Response grant. This grant will assist in sustaining services of SUD treatment, adding a care facilitator within the Baxter Clinic, and continuing the work of the RN care navigator. The purpose of this project is to expand access to office-based opioid treatment and treatment for other SUDs in rural Minnesota communities through evidence-based strategies. The strategies include: 1) integration of behavioral health (mental health and substance use disorders) in primary care, 2) increased number of prescribers available to provide MOUD, 3) integrating care facilitation to coordinate referrals to treatment and recovery programs and to community organizations addressing social determinants of health, 4) RN care management into the rural primary care team; and 5) development of pathways for transitions between clinics and other community organizations. The project includes individuals living in Cass, Crow Wing and Hubbard Counties.
Other partners will continue their positive work to increase success through collaboration. For instance, the certified community behavioral health clinic is an active partner, providing treatment and recovery services. Their services will continue, with the Network facilitating their connections to other organizations such as public schools.

Region Covered by Network Services

County/State	County/State
Cass County, MN	Morrison County, MN
Crow Wing County, MN	

Network Partners

Organization	Location	Organization Type
St. Joseph's Medical Center	Brainerd, MN	Hospital
Crosby Ironton School District	Crosby, MN	School System
Northern Pines Mental Health	Brainerd, MN	Behavioral Health
Crow Wing County Sheriff's department	Brainerd, MN	Law Enforcement
Crow Wing County Social Services	Brainerd, MN	Social Services Agency

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Missouri

Freeman Neosho Hospital
Southwest Missouri School Health Network

P10RH37479

Primary Focus Area: Care Coordination

Other Focus Areas: Integrated Health Services
School Based Health Services

Network Statement

With some of the worst health outcomes in Missouri, McDonald County is a place in need. But it is also a resilient place where community leaders work together, bringing their resources and influence to form the Southwest Missouri School Health Network with a shared vision of an improved culture of health for children and families through school health programs.

There are significant barriers to accessing medical and behavioral care in the county. Every day, bus drivers for the school district travel 4,125 miles picking up and returning students to their homes (more miles than a round-trip journey from Washington DC to Yellowstone National Park). Along with transportation barriers, limited access to health providers and the threat of loss of employment directly impact access to medical and behavioral health services. Through our approach of telemedicine in the schools, we seek to reduce or eliminate these barriers to care. The Southwest Missouri School Health Network community partners are working together to improve health outcomes, reduce costs, ensure access, and promote innovative approaches.

Network Development

The Southwest Missouri School Health Network (SWMOSHN) partners clearly recognize this is the right time to launch the Network, due in part to government funding of telemedicine and broadband capabilities in rural areas. The Network partner organizations are committed to the Network goals, with a clear desire for these goals to succeed. Working diligently through the grant process to identify the strengths and weaknesses, using the External Environmental Scan, developing the Network Statement, and completing the Organizational Assessment allowed the Network to develop organically.

Each step from writing the Network Statement to the External Scan and the Organizational Assessment has built upon prior steps, ensuring clear recognition of weaknesses and a consensus among partners. Working through the potentially difficult conversations and clearly identifying the needs, has allowed the partners to fully address each need in the strategic planning for the Network. The partners have frank and clear conversations, which enhances the sustainability of the Network, allowing them to deal with any conflicts or challenges as they arise.

The realization that rebuilding relationships among secondary level staff was needed to ensure their participation was successfully addressed through site visits, increased relationship building efforts, and consistently asking questions of all potential stakeholders instead of presenting previously identified solutions. Going forward, all partner agencies will need to ensure we communicate and celebrate the successes of this endeavor, intentionally aligning messaging/marketing to support the mission. Having a strong foundation, as demonstrated by the commitment shown by each partner organization, is key to the sustainability and future growth of the Network and will allow the Network to take full advantage of the current external environment.

Programmatic Development

Telemedicine offered in the schools takes advantage of the higher technological capabilities of the school sites. The SWMOSHN partnership specifically benefits from the nature of the McDonald County School District as the centralized communal and infrastructure hub in the community. As Network partners worked to build relationships across the county, continued fact-finding identified additional opportunities the Network could address, such as providing pharmacy delivery to further reduce the effect of the barrier of the lack of transportation in the population.

Supported by extensive testing, strong technological support is key to establishing a program dependent upon technology. In parallel to the technological development, Network partners recognize supporting in-person services are needed and have laid the foundation for this need, including seeking to bolster development of the behavioral health employee pipeline in the county through outreach efforts to regional universities and community members.

Sustainability

SWMOSHN partners have agreed to continue organic network development, determining the baseline requirements for future partners, while formalizing governance when the need arises. The strategy is to establish a strong, successful foundation before expanding into additional service endeavors where additional partners would be beneficial.

As part of the sustainability planning, Network partners will apply for grants to fund the infrastructure needed for the telemedicine program and overall Network growth with the intent to launch telemedicine in a minimum of one school this coming school year. Network partners fully intend to sustain and expand all programs into the future.

Region Covered by Network Services

County/State
McDonald County, MO

Network Partners

Organization	Location	Organization Type
Freeman Neosho Hospital	Neosho, MO	Critical Access Hospital (CAH)
Ozark Center	Joplin, MO	Behavioral Health
McDonald County R-1 School District	Anderson, MO	School System

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Montana

Central Montana Medical Center (CMMC)
Rural Healthcare Emergency Transport (RHET) Program

P10RH37475

Project Focus Areas: Emergency Medical Services

Other Focus Areas: Care Transitions
Health Education

Network Statement

In central, northeastern Montana, emergency medical services (EMS) are an essential component of a comprehensive frontier health care system. Rural residents and those traveling through this sparsely populated area rely on EMS for treatment and transport in the event of an injury or other health emergency. Many rural communities in this region are too small to support a full-time paid EMS service, so volunteers are the mainstay of pre-hospital emergency care. The need for this project stems from a critical lack of ground EMS transport access in frontier central, northeastern Montana. Due to the nature of frontier areas of Montana, EMS systems are required to travel farther or navigate difficult terrain when responding to a call to transport a patient to the hospital. Adverse weather conditions, when coupled with longer distances and geographical obstacles, can significantly affect response or transport times.

Three rural hospitals (Central Montana Medical Center in Lewistown, Phillips County Hospital in Malta, and Wheatland Memorial Hospital in Harlowton) – who provide the majority of medical services in this area – partnered to develop the *Rural Healthcare Emergency Transport (RHET) Network,* which builds upon a shared recognition of the need to improve access to – and reduce the cost of – non-emergent care for patients needing inter-facility transfer. Access to EMS is critical for the frontier residents served by the RHET program, but providing EMS can be challenging, where volunteer teams who have full time job responsibilities – in addition to their volunteer duties – provide many EMS services. The RHET Network Partners are addressing this issue through the development of a comprehensive regional ground transport system. The three rural health partners in this grant are dedicated to providing the best care possible to the patients we serve in the communities and surrounding areas. In order to do that, we recognize as community-based healthcare that innovative ways to deliver patient care need to be explored. We have sought input from our volunteer emergency transport system as well as leaders in our community in developing this approach to providing care in extremely rural communities. As we continue to pursue the coordination of the regional flow of patient care, we will build upon the programs developed by our community volunteer and regional healthcare system.

Network Development

All organizations incorporated within the RHET network are members of the Montana Hospital Association (MHA) as a Critical Access Hospital (CAH) and worked together to develop current missions and goals prior to beginning of grant program. Each partner is unique in their region's needs and strengths to serve rural Montana residents across the central Montana corridor. Along with these CAH is the EMS professionals that serve this broad geographic area. Relationships with these vital EMS providers is foundational for the RHET network, as without them critically injured and ill patients do not get

transported for treatment and stabilization. The RHET network development thrived on collaborative conversations between all parties for the best interest in serving residents and visitors of the area.

Our network experienced challenges with consistent administration in several facilities. Which resulted in delays in the decision-making process and progression of our program. Ultimately all positions were filled with professionals who were invested in the best interests of their facilities and the population they serve.

Programmatic Development

Network partners were able to collaboratively develop an interfacility transport process model. Through a centralized dispatch center ambulances would be assigned transfer as needed based on the patient's acuity. Consistent medical services would be provided across all networks with interchangeable equipment and network wide education standards. When interfacility transfer is required over extensive distances multiple ambulances would be dispatched in a daisy chain fashion to eliminate provider fatigue and improve in patient care. Consistent availability of advanced licensure EMS staff and ambulance will help to eliminate unnecessary air medical transport resulting in more affordable healthcare for rural MT residence while preserving critical care availability for patients who truly need it.

Analysis of needs from network partners for education and equipment resulted in extensive startup and maintenance expenses. Also, reimbursement for ground ambulance transfers is minimal despite saving the consumer and insurances companies thousands upon thousands of dollars in expenses. Continued work is needed by the network to collaborate with local and government officials and potentially contract with insurance companies to overcome this issue.

Sustainability

The RHET network's sustainability is directly impacted by financial reimbursement. Cost analysis of our program requires a high reimbursement rate, grant funding, or philanthropic donations to ensure sustainability. Network partners are driven and dedicated to solving the need for EMS personnel and equipment in creating an interfacility transport network. We will continue to communicate and work together to strategize and aid each other in transporting patients to higher levels of definitive care. The relationships formed in this network organizational process will forever be sustainable and beneficial to each other.

Region Covered by Network Services

County/State	County/State
Fergus County, MT	Wheatland County, MT
Judith Basin County, MT	Phillips County, MT
Petroleum County, MT	Golden Valley County, MT
Musselshell County, MT	Blaine County, MT

Network Partners

Organization	Location	Organization Type
Phillip's County Hospital	Malta, MT	Hospital
Wheatland Memorial Hospital	Harlowtown, MT	Hospital
Central Montana Medical Center	Lewistown, MT	Hospital

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Montana

Montana State University
Montana Regional Initiatives in Dental Education Network

P10RH37485

Primary Focus Areas: Oral Health

Other Focus Areas: Health Education
Workforce Development

Network Statement

Oral health impacts more than the mouth. Good oral health is important to healthy pregnancies, healthy kids, people suffering from chronic disease. In addition, oral health is related to behavioral health issues and affects our well-being. People with lost teeth, damaged teeth, or dental pain can find it difficult to flourish in their professional and personal lives, and lack of a dental home can lead to expensive and inefficient ER visits.

Montanans concerned with access to oral health services in frontier and underserved communities of our state found a partner in the University of Washington School of Dentistry (UW SOD) and their Regional Initiatives in Dental Education. Montana State University (MSU) College of Nursing, the Montana/UW WWAMI Medical School, the Montana State University Division of Health Sciences, and the Montana Office of Rural Health/AHEC have been working with state and local partners, including the Montana Department of Public Health and Human Services, Montana Oral Health Partners, and the Rocky Mountain Tribal Leaders Council, to expand dental care to Tribal, rural/frontier and underserved sites. Placing UW dental students in rotations, developing interprofessional education, and building towards a collaborative UW/MSU School of Dentistry combine to increase access to dental care and collaborative models of oral health. We are excited about expanding opportunities for dental students to work with other health professionals to bring improved oral health to our communities in greatest need.

Network Development

In 2020, the Montana Office of Rural Health/Area Health Education Center (MORH/AHEC) partnered with University of Washington School of Dentistry (UW SOD), the Rocky Mountain Tribal Epidemiology Center (RMTEC), MT WWAMI Medical School, MSU Division of Health Sciences (MSU-DHS), the Montana Department of Public Health and Human Services (DPHHS), and rural/Tribal/underserved communities to increase the number of dentists in rural and underserved communities in Montana. The MT RIDE network envisions educating a progressive oral health workforce and developing community collaborations to better serve Montanans with the expanded access to oral healthcare. Our collective mission is to create a network to address the severe shortage of adequately trained oral health professionals in rural and underserved communities and to aid in the improvement of health outcomes for residents. The shared governance of the MT RIDE Network establishes a collaborative decision-making process, which includes the participation of all network members.

Our network has been successful in formalizing by memorandum of understanding, due to the participation and commitment by the network members. Our members' dedication to attending monthly meetings and participating at a high level has been both impressive and appreciated. Most of our members work in a university setting and have taken on additional workloads since the COVID-19 pandemic began, but their collective dedication to the goals of MT RIDE is evident. Our team is very thankful to be collaborating with a group of individuals that truly want to increase the access to oral healthcare in Montana. By having regularly scheduled meetings and a mapped out quarterly plan, our network was able to focus on building, securing, and sustaining our network to successfully

accomplish our project goals. All meeting and programmatic activities of the network are coordinated by the staff of the MORH/AHEC.

Recruiting and retaining dentists in our rural, frontier, underserved and tribal sites remains a challenge in Montana. Our network focused early efforts in creating a coordinated plan for training, recruiting, and supporting the UW SOD dental students completing rotations in Montana. We continue to work toward expanding clinical sites across the state and seeking available dentists to serve as preceptors in our most isolated communities. The Rocky Mountain Tribal Leaders Council staff continues to work on the Tribal dental site capacity and interest assessment, preceptor engagement plans, and evaluating housing options. As expected, COVID-19 presented various challenges during this last year. Setting up the clinical experiences for the UW SOD RIDE dental students was an ongoing challenge as new regulations, quarantine rules, testing protocols, and housing arrangements were made. However, even though this was a challenging process, we consider the outcomes a success. UW SOD was very considerate in sending their students to Montana and followed a thorough preparation process to ensure that students would not be bringing the COVID-19 virus to Montana communities. We have appreciated UW SOD's efforts and thoughtfulness in keeping both their students and Montanans as safe as possible while still allowing for valuable training opportunities. The MT RIDE network also continues to develop an operational plan for supporting the MT RIDE program and will use this plan for guidance during the next legislative session.

Programmatic Development

The last year has taught our network how to be adaptable during a time of uncertainty and change. While our network was unsure of what clinical rotations would look like in Fall 2020 due to COVID-19, we were pleased that we were able to host clinicals for all the UW RIDE dental students that had expressed interest in coming to Montana. The UW SOD RIDE team worked very closely with their students to ensure that they would be safe and that they would not put Montanans at risk. While not all the tribal sites were able to take students over the fall semester due to COVID-19 restrictions, other sites in Montana stepped up to take more than one student. This helped lead to successful clinical experiences during Spring 2021 as well. The network placed 14 UW SOD dental students in 6 Montana clinical sites during the Fall 2020 and Spring 2021 semesters.

Our network shifted our originally planned in-person educational trainings to online formats. The interprofessional education (IPE) trainings that have been offered have also been successful. The first training session focused on Pediatric Oral Health and this presentation also highlighted oral health statistics in Montana, focusing on access challenges specifically in rural and frontier Montana. We believe that we may be able to include more students in IPE trainings by offering them virtually rather than in-person. To reduce screen fatigue, our next IPE training sessions were shortened to one hour in length each. Additional sessions focused on how dental care is integrated into primary care. UW SOD dental faculty discussed what other health professionals should know pediatric dental care, mandatory reporting, and how the mouth ties medically to the rest of the body. We also offered a Veterans' health IPE training and two fluoride application (virtual hands on) trainings in the Spring 2021. Health professions students from various backgrounds attended all our trainings and will continue to be invited to future IPE trainings with the UW SOD dental students and faculty members. Our network also integrated the Smiles for Life oral health training program into the MORH/AHEC's CHW curriculum, consisting of eight sixty-minute modules. The curriculum is offered online and is actively being utilized by current CHW cohorts in Montana.

Sustainability

Our network members are committed to forming a sustainable network to create a comprehensive approach to educating and training dentists and other oral health professionals, along with nurses and physicians who can address the oral health needs in tribal sites, rural/frontier communities, community health centers, and in collaboration with rural health clinics.

Network members continue to contribute their expertise and resources to build upon developing relationships and sustain the network partnership collaboration. While it is too early to determine if rural and Tribal community members have experienced increased access to and utilization of oral health services through new rural and Tribal dentists, both dental students and nursing students have participated in clinical rotations at such sites, providing additional oral health services to these communities. With increased and continued clinical experiences in rural and Tribal communities, we are better preparing health professions students to eventually practice in these locations, ultimately reducing both the recruitment and retention costs for healthcare facilities. We will continue to monitor and track outcomes tied to both short term and long-term goals of this project.

Our network is also finalizing our sustainability plan which includes a review of sources of funding from state, federal, local, and philanthropic sources available to support workforce development and oral health services by creating a "braided funding" model of potential funding sources. We will continue to engage with statewide partners and stakeholders in sustainability discussions by attending state conferences, holding regional listening sessions, webinars, websites, surveys, and other methods of gathering input. We also are discussing how partner dues could be used to support our network's operations. Our network is also looking at how we can include tele-dentistry in potential educational trainings or clinical experiences. The UW SOD has provided multiple sites in Montana with tele-dentistry carts (through their funds), and we would like to continue to work with these sites to build clinical training manuals for tele-dentistry. Because the use of telehealth is expanding so rapidly, both students and preceptors would greatly benefit from learning about tele-dentistry, and this may be an area to explore funding support for our network.

Region Covered by Network Services

County/State
All 56 Counties, MT (Statewide Program)

Network Partners

Organization	Location	Organization Type
Rocky Mountain Tribal Leaders Council, Epidemiology Center	Billings, MT	Other
University of Washington School of Dentistry	Seattle, WA	College/University
Montana WWAMI Medical Education Program	Bozeman, MT	College/University
Montana State University Division of Health Sciences (DHS)	Bozeman, MT	College/University
Montana Department of Public Health and Human Services	Helena, MT	Public Health

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New Hampshire

Bi-State Primary Care Association
Food & Health Network
P10RH37474

Project Focus Areas: Population Health/Social Determinants of Health.

Other Focus Areas: Care Coordination
Chronic Disease Management
Increase Health System Efficiencies
Reimbursement for Health Services

Network Statement

The quality of our daily diet is closely linked to good health. Health care professionals, patients, policy makers – many people recognize this connection. How to *act* on the link between food and health is a much trickier question. Anyone who has ever vowed to 'eat right' knows how challenging it can be to move from good intention to sustained action.

The Food and Health Network partners want food and access to a healthy diet to become a fully integrated component of health care in Vermont. Vermont has many great assets around food and health care. We have a strong agricultural community, high general awareness of food's importance in health, innovative prevention programs, good working relationships between health care practices and community organizations, and dozens of pilot projects across every region of the state. The Food in Health Care Network works collaboratively to identify strategic initiatives that can bring this work to the next level – going beyond special projects and pilots to sustained, fully integrated, far-reaching programs that will become foundational to our health care system.

Our Network is currently focused on building capacity to fine-tune policy, secure project funding, and directly support the transformation of food's role in health care at the local and statewide levels. We believe that our collaborative efforts will result in better health outcomes for all rural Vermont residents.

Network Development

The Food in Health Network is a new initiative, and our first year of planning focused on building relationships between health care organizations and food-focused organizations. A lot of work has happened at the hyper-local level for these types of partnerships - for example between a primary care clinic site and their neighborhood food shelf. Our goal is to build a statewide perspective and be able to scale up impact.

Due to COVID-19 disruptions, we were not able to implement our original plans, which revolved around bringing statewide partners to communities to learn in detail about the work in progress locally and then build from there to statewide implications and next steps. These disruptions also limited the ability for statewide partners to spend extended time becoming familiar with each other's work. We managed these disruptions in several ways. We held regular virtual meetings between partners to keep in connection. We replaced in-community meetings with interviews with different organizations about their approaches, which were then edited into podcast episodes to cover a range of topics within Food and Health Care. This format allowed us to get into detail and explore specific community examples without visiting communities in-person and will set the foundation for stronger community work when COVID-19 restrictions ease. We also held several larger stakeholder virtual meetings on specific topics, in particular Connecting with Community Food Resources and Medically Tailored Meals.

Some elements of our original work plan were less impacted by COVID-19, and therefore received more detailed attention than originally planned. More time went into research / literature review and sharing written resources, which were made available online at VTFoodInHealth.net. The transition to virtual work also made it comparatively easier to connect with colleagues in other states and attend their workshops, webinars, and meetings. We appreciate the input received through these connections.

Although Network Development did not proceed in the form we had originally anticipated, the activities undertaken over the last year provide a strong foundation for returning to in-person collaboration in the near future.

Programmatic Development

The topic area of food in health care is broad. We managed this by combining the general research and background work described above in Network Development, with a deeper review of a particular model: Medically Tailored Meals (MTMs). We contracted with Marydale DeBor of Fresh Advantage LLC to assess options for supporting the development of MTM programs in Vermont. A broad group of stakeholders had a pre-existing interest in this topic area, and several pilots had been attempted. Additionally, the national Medically Tailored Meals (MTM) community had started to work on ways to support emerging programs in regions without MTMs, including launching a Food is Medicine accelerator program.

Our project determined that Vermont does not have the necessary starting blocks for a full MTM program. However, in the process of examining our options in detail, we determined a list of areas where additional investment could position us to launch MTMs in the future while simultaneously supporting other types of food-based clinical interventions. These areas included centralized production capacity for meals, sharing registered dietitian resources for nutrition counseling, managing IT structures for patient referrals between health care practices and community-based organizations, instituting widespread screening for food insecurity, and increased collaboration with Meals on Wheels programs. We had previously identified meal delivery systems as being a major barrier to bringing the existing program model to a rural region. Based on our research we have broadened the framing of that challenge to a focus on 'removing transportation as a barrier to food access' as a high priority.

Our work over the last year outlined many possible next steps. The Network is currently reviewing our options. Bi-State Primary Care Association recently received an Outreach Grant that will help us pilot projects in three FQHCs, informed by our 2020-2021 work that will increase our experience with food prescriptions, prepared meals, and healthy retail options.

Sustainability

We were not able to engage in detailed sustainability conversations during this year of strategic planning. All the Network partners are membership-based organizations, and we were deeply engaged in managing our core programs and supporting our members through the challenges experienced during COVID-19. We recognize that this last year has also led to new experiments in the area of food and health, along with highlighting the number of Vermonters who either experience food insecurity or are at risk of food insecurity. For this reason, we anticipate there will be a sustained need for a Food in Health Network in some form. However, the timing was not right for designing the long-term format for our Network during a pandemic response. Our next steps in this regard will be to develop a formal plan for the Medically Tailored Meals stakeholder group (see Programmatic Development above), engage the Network Partners' membership in reviewing the strategic plan and providing additional input on their role, and engaging with other Networks that have goals similar to ours in discussing future collaboration. In Summer, 2021, Bi-State Primary Care Association will be hiring a project manager to focus on pilot projects related to food and FQHCs. We anticipate that strengthening our programming, informed by previous work on Network development and the partnerships explored through this planning grant, will position us to return to the Network building and sustainable Network questions in the future.

Region Covered by Network Services

County/State	County/State
Addison, VT	Bennington, VT
Caledonia, VT	Essex, VT
Lamoille, VT	Orange, VT
Orleans, VT	Rutland, VT
Washington, VT	Windham, VT
Windsor, VT	

Network Partners

Organization	Location	Organization Type
Bi-State Primary Care Association	Montpelier, VT	Non-Profit
Hunger Free Vermont	S. Burlington, VT	Non-Profit
Northeast Organic Farming Association	Richmond, VT	Non-Profit
Vermont Foodbank	Barre, VT	Food Bank

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New Mexico

Miners' Colfax Medical Center (MCMC)
Western United States Miners' Disease Mortality Hotspots Network

P10RH37484

Project Focus Areas: Health Education

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

Network Statement

The recent re-emergence of pneumoconiosis in the Western US, coupled with a concomitant decline in expertise in the care of those with pneumoconiosis, has created a unique challenge in the multidisciplinary care of miners and nuclear weapons workers. To get these workers access to health care and medical and compensation benefits, there is a need to educate and mentor multidisciplinary teams of professionals in the pneumoconiosis mortality hotspots in the Western US. These professionals include lawyers, benefits counselors, respiratory therapists, home health professionals, and clinicians.

Partners of our Network came together in 2016 to create a multidisciplinary virtual community of practice to support, educate and mentor multidisciplinary professionals caring for the health and well-being of miners and nuclear weapons workers. We have embarked on this mission by establishing bi-weekly 75-minute sessions to present a didactic followed by a case discussion in an interactive virtual format.

The short-term impact of this program is to help create, mentor, and sustain rural multidisciplinary team-based expertise to improve the lives of those at risk for or affected by pneumoconiosis. The long-term impact is to combat the emerging epidemic of pneumoconiosis in the Western US.

Network Development

The planning grant period has provided our Western United States Miners' Disease Mortality Hotspots Network the opportunity to further formalize our network via a memorandum of understanding and to advance our plans and focus areas. We have been able to develop a broad range of subjects and adapt our curriculum to new focus areas as needed by the spoke participants. We have also used this time to address identified challenges, such as boosting attendance by implementing a recognition award for high attenders and by creating a glossary of terms so that new spoke participants have a resource to better understand any common vernacular used in sessions. In addition, we started advertising the recording of sessions so spoke participants can review when they have scheduling conflicts with live sessions.

A beneficial innovation that has helped our Network sustain and grow is that it is made up of two parts. We have our committee members who make up the Hub Team who make decisions for the full Network based on regularly gathered feedback. Then we have our spoke participants who attend TeleECHO sessions and participate in case discussions, providing their feedback through bi-monthly post-session surveys. This two-prong approach allows our Network to include a wide range of stakeholders, forming an inclusive Network.

Programmatic Development

The progress we have made to develop the direct services to provide stakeholders has been successful in the telehealth sector. While the last year has presented challenges due to the disruption of the pandemic, our Western United States Miners' Disease Mortality Hotspots Network has overcome them through regular committee meetings following each of our larger TeleECHO sessions with the full Network. It is through these collaborative interactions that we have been able to keep our programmatic development on track.

Our Western United States Miners' Disease Mortality Hotspots Network is centered on the ECHO Model which drives an all-teach-all-learn environment that encourages a large amount of hub and spoke participation. It is this model that has differentiated our Network from webinars and other online opportunities that have become so widely available during the pandemic. The Network also includes a diverse multidisciplinary team of doctors, respiratory therapists, home health professionals, benefits counselors, and attorneys. By engaging such a wide range of professionals, our Network can develop several academic disciplines and professional specializations in approaching miners' health.

Sustainability

Our Western United States Miners' Disease Mortality Hotspots Network is fortunate to have a dedicated membership and it will function past the planning grant period through input and collaboration from the current partners. The services of the Network will continue, in full, through either donated time from grant partners or alternative grant funding that is currently being perused.

Region Covered by Network Services

State	State
NM	MT
WY	UT

Network Partners

Organization	Location	Organization Type
Miners Colfax Medical Center (MCMC)	Raton, NM	Rural Health Center
University of New Mexico (UNM) ECHO Institute	Albuquerque, NM	College/University
Northwest Community Action Program (NWCAP)	Sheridan, WY	Community Development Organization
Critical Nurse Staffing LLC. (CNS)	Grand Junction, CO	Home Health

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North Dakota

Coal Country Community Health Center
Energy Capital Health Network

P10RH37478

Project Focus Areas: Network Organization/Infrastructure Development

Other Focus Areas: Increase Health System Efficiencies
Population Health/Social Determinants of Health

Network Statement

The Energy Capital Health Network (ECHN), located in the West Central region of the state of North Dakota, believes that organizations working together can have a positive impact on the health outcomes of the communities in which they serve. Since 2011, our organizations, through such aligned efforts, have completed many projects together and continue to have a proven track record of success. Building upon that success, the ECHN partners, consisting of a Federally Qualified Health Center, Critical Access Hospital, Skilled Nursing Facility and Public Health, in 2020 decided to formalize the existing relationship between the organizations and to build on its collaborative accomplishments. Bolstered by this deeper commitment, the network sees a future where healthier communities can be realized through collaboration and innovation between network partners.

Network Development

The primary focus of the network for this grant period was to formalize the existing relationship between the organizations and to develop a strategic plan that would aid the organizations to ensure that the collaborative and innovative efforts of the past would continue. This formalization was achieved through a memorandum of understanding signed by each of the four organizations.

The funding from this grant was used to hold strategic planning meetings to develop a formal strategic plan that will be used to guide the work efforts of the network for the foreseeable future. The strategic planning sessions were held in February 2021 and the final strategic plan document will be completed in June 2021. Four committees were formed because of the strategic planning process to address specific areas of need for the network: Network Structure, External Forces, Workforce, and Services.

Operating a network organization during the pandemic proved to be the biggest challenge to our network development. All meetings were held via Zoom, including the Strategic Planning sessions. To address this challenge, we consulted with other local organizations as to how to do meetings effectively in a virtual environment. We wanted all participants to be engaged and feel that their comments and thoughts were heard by the group. We then used as much as possible the small group breakouts, white board, chat, and notifications features to enhance the meeting experience. Another focus was to provide ample feedback to the group and ongoing review of the prior successes of the network to help motivate participants to engage.

Programmatic Development

Since the primary focus for the network for this grant period is strategic planning, ECHN developed four main goals for the network for the future:

1. Develop, attract, recruit, and retain a talented, committed, and innovative workforce.
2. Develop programs to address unmet community needs, increase market share growth, and improve the quality of life of all persons served.
3. Create a network structure that fosters open communication, trust, equity, and innovation in achieving unified goals.
4. Proactively respond to external forces that will impact the sustainability of network member organizations.

Each of these goals were assigned to a separate committee. Goal #1 was assigned to Workforce; Goal #2 to Services; Goal #3 to Network Structure; and Goal #4 to External Forces. Each committee was tasked with developing a work plan that identified the specific objectives and initiatives, with target dates, needed to achieve the goals set. The work plans will be reviewed by the Network Board of Directors and included with the formal Strategic Plan that will be submitted in June 2021.

Additional time was needed by the committees to complete the work plans. Partners' resources have been stretched due to the roll out of the COVID 19 vaccinations and to the increased use of virtual meeting formats. Often, what could be achieved in one in-person meeting would require 2 or 3 virtual meetings to complete. To ensure that the work plans were complete and meaningful, a request for an extension of the due date to submit the strategic plan was submitted and then approved by HRSA and FORHP. This extension allowed the committees the additional time needed. The result will be a dynamic Strategic Plan that has buy-in from all network members.

Sustainability

Prior to 2019, the network operated informally and achieved many objectives by using funding from grants, member investments, patient service revenues, 340B savings, ACO shared savings, private donations, and private industry contributions. The network members understand the importance of having a diverse financial portfolio to support the work of the network and to achieve the goals set.

The network is still working through the strategic plan goals, objectives, and initiatives. Many of the initiatives can be achieved through voluntary participation and work effort expended by the individual members. Other initiatives will require additional financial support and the network will use a variety of the funding to support those initiatives. The duties of the Network Director and Project Director positions, once the grant expires, will be handled by staff from the member organizations on a rotating basis. The existing Population Health committee will monitor the progress of the network toward meeting its goals and will report back to the Network Board and each individual organization's board.

Region Covered by Network Services

County/State	County/State
Mercer County, ND	Dunn County, ND
Oliver County, ND	McKenzie County, ND (southern portion)

Network Partners

Organization	Location	Organization Type
Coal Country Community Health Center	Beulah, ND	Federally Qualified Health Center (FQHC)
Sakakawea Medical Center	Hazen, ND	Critical Access Hospital (CAH)
Knife River Care Center	Beulah, ND	Skilled Nursing Facility
Custer Health	Mandan, ND	Public Health

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Oklahoma

Rural Health Network of Oklahoma
Rural OK Collaborative for Health Information Technology (ROC-HIT)

P10RH37490

Project Focus Areas: Health Information Technology

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

Network Statement

Health Information Technology (HIT) standards have been in place for over a decade outlining regulations and requirements for interoperability, patient engagement and quality reporting. Certified Electronic Health Record Technology (CEHRT) and other HIT tools can create an environment that improves care coordination and makes vital health information more accessible to both providers and patients. However, this rapidly advancing industry has created increasing security threats surrounding an enormous amount of electronic health data and places an undue strain on the rural healthcare workforce tasked with collecting, maintaining, and sharing this protected health information. Lack of broadband connectivity, limited workforce capacity and advancement opportunities, and financial constraints for technology infrastructure are all barriers that negatively impact these rural providers treating highly vulnerable populations.

The Rural OK Collaborative for Health Information Technology (ROC-HIT) developed in 2020 provides a network platform to enhance the capabilities of rural healthcare systems and improve access to health information for all Oklahomans. We have engaged in this mission to improve healthcare quality and outcomes through advancements in technology by creating a diverse collaborative to enhance electronic processes and care coordination for unique rural populations. Our support continues to grow as public health emergencies and modernizing regulations transform healthcare delivery and virtual engagement becomes a necessity instead of an amenity. We welcome the opportunity to develop healthcare communities that are accessible, efficient, and interoperable throughout the state.

Network Development

ROC-HIT is currently comprised of 3 organizations joined by a memorandum of understanding: Rural Health Network of Oklahoma (RHNOK), Oklahoma Foundation for Medical Quality (OFMQ) and the Oklahoma State University Center for Health Systems Innovation (CHSI). To evaluate the Health Information Technology (HIT) and IT infrastructure needs of rural OK providers, our member organizations engaged additional stakeholders in network activities, including rural hospitals, CAHs, RHCs, and additional rural health care providers. Participants from 36 different OK counties engaged in needs assessment and gap analysis activities. Additionally, we have had over 125 registrants for our quarterly educational and round-table sessions.
Our network has experienced some difficulties resulting from the COVID-19 pandemic related to consortium recruitment and engagement. We had to adapt from planned onsite events to virtual environments. We have utilized various virtual platforms for educational sessions to introduce new technology for polling or breakout groups to keep members and stakeholders engaged. As a network, we continue to advocate for rural health at the state level to improve opportunities for funding streams and access to services.

Programmatic Development

ROC-HIT serves as a hub for education, tools and resources regarding HIT, IT security and risk management, telehealth, and Value-Based Care (VBC). We have hosted various sessions providing education and outreach to the rural workforce on health care regulations pertaining to interoperability, patient access, telehealth during the COVID-19 pandemic, and quality reporting programs. Our network aims to provide education and resources that are applicable within rural communities and rural health care systems. Identified gaps and needs of network stakeholders include HIE connectivity, regulatory compliance, IT staffing and infrastructure.

Challenges to our network include competing programs and priorities as well as vendor accountability. Providers and other healthcare workers have experience burn-out due to the pandemic and constantly changing healthcare regulations. Our network helps to support rural providers by analyzing regulations and identifying best practices and innovative strategies to implement within rural healthcare settings and maintain regulatory compliance. Furthermore, our network has developed a trusted relationship with physician offices and hospitals to examine technology (i.e., EHR systems, HIEs, telehealth systems) and provide educated feedback and resources on options for rural providers. Additional challenges that currently impact our network include the development and expansion of a state-based Health Information Exchange and other activities impacted by public health and Medicaid Expansion.

Sustainability

ROC-HIT will utilize various strategies to continue the momentum created by network planning and ensure sustainability of services throughout the target population. Our network is creating continuing education and workforce training programs to enhance the knowledge and skills of HIT and IT professionals operating in rural health care. Additionally, our network is in the process of identifying subpopulations or regions within the state to implement QI programs focused on enhancing processes related to electronic care coordination, patient & family engagement, and security of PHI. Another sustainability focus of the network will be to enhance IT infrastructure within rural communities. This includes expanding access to broadband internet, telehealth, and other IT infrastructure to expand access to care among populations of focus. ROC-HIT will offer consultation, education, and other resources, such as group purchasing options for infrastructure and technology, to ensure that health care is accessible and affordable in the most rural areas of the state.

ROC-HIT will resource the ongoing convening and programming by continuing to work with current members of the Rural Health Network of Oklahoma and clients of the Oklahoma Foundation for Quality. These two organizations will work with Oklahoma State University for Health Systems Innovation's physician network to provide the above services throughout Oklahoma. As these services grow, the revenue will help sustain the growth and opportunity to hire more staff to fill the needs for HIT and IT professionals that operate in rural health care.

Region Covered by Network Services

County/State	County/State
Atoka, OK	Jackson, OK
Beaver, OK	Kiowa, OK
Beckham, OK	LeFLore, OK
Blaine, OK	Lincoln, OK
Caddo, OK	Major, OK
Choctaw, OK	McCurtain, OK
Coal, OK	Osage, OK
Custer, OK	Pittsburg, OK
Dewey, OK	Pushmataha, OK
Grady, OK	Roger Mills, OK
Greer, OK	Washita, OK
Harmon, OK	Woods, OK
Harper, OK	

Network Partners

Organization	Location	Organization Type
Rural Health Network of Oklahoma	Hugo, OK	Non-Profit
Oklahoma Foundation for Medical Quality	Oklahoma City, OK	Non-Profit
Oklahoma State University Center for Health Systems Innovation	Tulsa, OK	College/University

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Oklahoma

Rural Health Projects, Inc./NwAHEC HOME Network

P10RH37491

Project Focus Areas: Network Organization/Infrastructure Development

Other Focus Areas: Care Coordination
Health Information Technology
Increase Health System Efficiencies

Network Statement

Our community is one that embodies the true meaning of caring for one another, and that is why the HOME Network was established. Here in Garfield County live over 2,800 individuals from the Marshall Islands, who are a vibrant and vital part of our community. Unfortunately, they face a unique set of challenges that hinder their full inclusion in community life. Language and cultural differences, combined with lack of awareness about health care and community resources and little access to transportation and insurance, present barriers that result in poor health outcomes for the Marshallese population.

The Health Outreach to the Marshallese in Enid (HOME) Network is working to create a bridge between local healthcare and human service providers and the Marshallese community. A Community Health Worker has found initial success in providing that connection, but more work must be done to improve health outcomes and quality of care. We are committed to mitigating language barriers, improving the community's health outcomes, and educating the community as a whole on the importance of the inclusion and diversity of the Marshallese culture. We are confident that we will achieve our goal of inclusion through the connections provided by the HOME Network.

Network Development

The HOME Network (Health Outreach to the Marshallese in Enid) has formalized the partnerships of the Network members. This funding has provided a format to create formal partnerships from what had been informal, incomplete, and sporadic conversations and meetings to address the needs of the Marshallese community in Enid, OK. The HOME Network has and continues to add partners to the original group. All partners have either signed MOUs or are in the process of reviewing the MOU to sign. The newest partner, INTEGRIS Health Bass Baptist Health Center, has a new Hospital Administrator who has agreed to join the network. To see the only two hospital systems in the community now working together, with high-level executives representing their organizations, both rewarding and promising for the continued success of this network. All partners are dedicated to reducing barriers for the Marshallese population and all potential programs are centered around that goal.
The biggest challenge to the partnership, as with many collaborative efforts, is consistent attendance at meetings. Some of this might be blamed on the pandemic; however, this has been a persistent problem with other previous and current projects. Staff believe that while virtual meetings have been a barrier to creating good personal connections among partners, they have helped with meeting attendance, as attendees can easily move from meetings at their facilities to meetings for the HOME Network without travel time included. Another challenge has been participation in some of the important grant-required activities. It is difficult, especially during a pandemic, for hospital and clinic staff to take time from their day to work out elements to what will eventually be the strategic plan. Many of the partner representatives are "doers" and some of these high-level conversations feel

like low priority items when, especially now, they work in high-performance positions. Staff has tried to impress upon the group the importance of everyone's participation and the need for everyone to have a voice.

The innovations to network development are small but have helped with time restraints for the network members. The AccessMeCare™ developer, HEUDIA, has been able to create online documents, such as the MOU, which enable the partners to sign electronically through a link. Additionally, HEUDIA staff have made put some of the Network Planning documents for HRSA deliverables into a web format, enabling easy input and requiring no printing or reformatting.

Programmatic Development

The HOME Network (Health Outreach to the Marshallese in Enid) has made progress in the last 10 months despite being in the middle of a pandemic. Partners have contracted with Heudia to create a site on their AccessMeCare™ platform in order to create a robust and self- or patient/client-selectable, online resource directory, and we gathered information and recruited organizational input for the site. Staff held three focus groups to determine what the Marshallese see as barriers to accessing care. Staff and partners are finalizing a community health needs assessment to ask our Marshallese community members what their healthcare needs are. Monthly and as-needed HOME Network partner meetings and Steering Committee meetings have been held. Janet Cordell, RN, has begun mentoring Joelynn Karben, the Community Health Worker, to work with the clinicians and help recruit them to the project.

Throughout the Planning grant year, the HOME Network has faced challenges related to the COVID-19 pandemic. Staff and partners have met virtually to accommodate restrictions and prevent the spread of COVID-19. Although this method is less conducive to the flow of conversation, staff believes the convenience of virtual meetings allows for better participation due to travel time and time restrictions of some of the partners. Staff has delayed visits to clinician, social workers, care managers, etc. and meetings with the Marshallese community due to COVID-19. This has delayed the workplan, but staff is working hard to ensure the activities are accomplished. Staff is requesting a No Cost Extension to finalize some of the activities and to allow for additional outreach to occur. This necessary delay has the benefit of allowing time for the AccessMeCare™ site to be developed, and staff will be able to showcase that platform when making visits and holding meetings.

An innovation from the HOME Network is the partnership and product being developed through the AccessMeCare™ site. Network partners hope the site will solve the problem of the paper forms of resource directories that become obsolete or outdated sometimes by the time they are printed. The AccessMeCare™ site allows for real-time updating and places some of the onus on updates on the service provider. This specific site is being built with and for a specific population, utilizing colors and themes familiar to the population, and will be available in the language native to the population as well as English. Network members hope this will increase the utilization of services and helps both the population and those managing their care overcome barriers to accessing appropriate services.

Sustainability

The HOME Network will continue to function beyond the Network Planning grant. Partners continue to be added, and the timing is right to ensure that the health of this important group of community members is addressed appropriately and effectively. The forward momentum of legislation that allows the Marshallese to access Medicaid, plus Oklahoma's statewide legislative petition that allowed voters to expand Medicaid mean that many in this population will have access to insurance previously denied. Members of this population will continue to need assistance in learning what is appropriate care, including when and why to see a primary care physician. This information and other resources can be accessed and utilized through the AccessMeCare™ platform that is being developed with this funding. Partners continue to look for funding to sustain the program, and have already applied for appropriations funding from an Appropriations Committee in Congress. The partners hope that continued funding will sustain all the current services and will expand services to include telehealth options for providing primary care services by Dr. Riklon, a Marshallese physician working in the Springdale, AR community.

Region Covered by Network Services

County/State
Garfield County, OK

Network Partners

Organization	Location	Organization Type
Great Salt Plains Health Center	Enid, OK	Federally Qualified Health Center (FQHC)
St. Mary's Regional Medical Center	Enid, OK	Hospital
INTEGRIS Health Bass Baptist Health Center	Enid, OK	Hospital
Enid Community Clinic	Enid, OK	Physicians' Clinic
Garfield County Health Department	Enid, OK	Government
Rural Health Projects, Inc./NwAHEC	Enid, OK	Non-Profit

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Oregon

Greater Oregon Behavioral Health Inc.
Substance Use Disorder Network (SUD-NET)

P10RH37480

Project Focus Areas: Substance Abuse/Addiction

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

Network Statement

Oregon ranks 12th out of 51 for the most challenged states in the nation for substance use, while at the same time ranking among the worst states for access and engagement in services and care. These disparities are even worse in our rural and frontier communities across Eastern Oregon that are severely affected by alcohol and other substance use disorders (SUD).

Most agree that improving access to services and care for people with SUD requires a systematic change. For the first time, Eastern Oregon providers from four counties are coming together to evaluate how to collaborate as a network. The focus of the network will be to build connections, share resources, and explore funding opportunities that will broaden access to care for people with SUD.

We envision reducing the overall impact of substance use among all families across Oregon. Our hope is that one day, all our communities will have a global awareness about SUD services and feel empowered to use them. We also hope there will be sufficient evidence-based treatment available to facilitate recovery, especially for those involved with the justice system in our rural communities. We believe by coming together, we can make a difference in the lives of people suffering from the effects of SUD and help them and their families thrive in a life of recovery.

Network Development

In July of 2020, Lifeways, Inc., Center for Human Development, New Directions Northwest, Eastern Oregon Recovery Center, and Umatilla Alcohol and Drug Program signed memorandums of understanding with Greater Oregon Behavioral Health, Inc. (GOBHI), committing to participate in the Substance Use Disorder Network (SUD-NET) grant activities as a committee. The overall formalization of an Eastern Oregon SUD-NET has come a long way over the past year. Lines of communication have opened between the five agencies. For example, discussions are occurring between Wallowa, Union, and Baker Counties to develop a peer support project to increase outreach, in-reach, and support to those affected with SUD. Additionally, Eastern Oregon Recovery Center/Eastern Oregon Detox Center (EORC/EODC) and Umatilla County Alcohol and Drug are also in discussion to increase share Certified Recovery Mentors (CRMs). The primary goal of the project is to ensure that a minimum of three CRMs will provide support, lived experience, and an understanding of the real-life situations often experienced by individuals with SUD. This opportunity has also allowed time for these organizations to build trust and truly see each other as partners rather than competition.

Programmatic Development

Since the start of this planning grant, there have been several major changes that greatly impact the way SUD services will be delivered in Oregon. In the Fall 2020, Oregon passed Ballot Measure 110 which decriminalizes the personal possession of small amounts of illicit drugs, including cocaine, heroin, Oxycodone, and methamphetamine. It also reduces the penalties for possessing larger amounts of drugs. A few weeks ago, the first request for funding proposal was released which gave the SUD-NET committee as well as other counties an opportunity to discuss collaboration efforts. As a result of previous planning grant efforts, Umatilla County and Eastern Oregon Recovery Center went in on an application to increase capacity for peer services and share staff between their organizations. Additionally, they requested funds for respite beds for those in between detox and residential treatment to ensure individuals have better support for recovery.

Center for Human Development, New Directions Northwest and Wallowa Valley Wellness Center also collaborated with each other to put in an application to increase capacity for peer services across their three counties. They will work together to support the hiring of nine peers.

Lastly, all twelve Eastern Oregon counties supported the Greater Oregon Behavioral Health, Inc. application to request funds for safe and supportive housing, harm reduction interventions, and professional development for peers across all of Eastern Oregon. This level of support, collaboration, and strong communication between each other has come from the trust built over the past several months through these planning grant efforts.

Sustainability

Eastern Oregon communities are significantly under-resourced to effectively deliver SUD services to all those in need of treatment. However, the SUD-NET committee has identified possible solutions to help address the gaps such as sharing workforce development opportunities among each other and collaborating on future funding initiatives as previously discussed with the Ballot Measure 110 collaboration efforts. The committee also agreed to continue meeting to review data and exchange new information. In fact, GOBHI's CEO has invited all five committee members to meet monthly, to which they all agreed. Additionally, the members agreed to advance strategic planning around alternative payment methodologies, the Ballot Measure 110 initiative, and the SUD 1115 Waiver.

The Centers for Medicare and Medicaid Services (CMS) approved Oregon's application for a five-year Medicaid 1115 SUD Demonstration Waiver, which will increase access to treatment services for people with substance use disorders who are covered by the Oregon Health Plan. Prior to the approval of the 1115 SUD waiver, any Institutions for Mental Disease (IMD) could not bill services to Medicaid. IMDs are settings of more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. The waiver now allows federal funds to match state funds for substance use treatment for Medicaid members in an IMD. While the additional covered services will help more Oregonians, the state's application to support people with ongoing, post-treatment, and peer recovery services with Medicaid funding was not approved. Eastern Oregon SUD providers will continue to find other ways to fund this crucial component of effective treatment.

Region Covered by Network Services

County/State	County/State
Baker County, OR	Umatilla County, OR
Malheur County, OR	Union County, OR

Network Partners

Organization	Location	Organization Type
Center for Human Development	La Grande, OR	Behavioral Health
Eastern Oregon Recovery Center	La Grande, OR	Other
Lifeways Inc.	Burns, OR	Behavioral Health
New Directions Northwest	Baker City, OR	Behavioral Health
Umatilla Alcohol and Drug Program	La Grande, OR	Behavioral Health

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South Dakota

Rosebud Sioux Tribe Health Administration
Rosebud Connected Care Initiative

P10RH40104

Project Focus Areas: Network Organization/Infrastructure Development

Other Focus Areas: Care Coordination
Health Information Technology
Integrated Health Services
Population Health/Social Determinants of Health

Network Statement

Our mission is to reform our health care delivery system by establishing a relative focused, culturally adaptive, and easily accessible comprehensive health care system whose foundation is built on sacred Lakota virtues:

Unsiiciyapi (Humility), Wowacintanka (Perseverance), Wawoohola (Respect), Wayounihan (Honor), Cantognake (Love), Icicupi (Sacrafice), Wowicake (Truth), Wansilapi (Compassion), Woohitike (Bravery), Cantewasake (Fortitude), Canteyuke (Generosity), Woksape (Wisdom).

Each relative will be afforded opportunities to access quality health care in his/her own community. We will partner with allies from a variety of backgrounds who share our same dream. We will strengthen our identity and become healthy, self-sufficient people. We will walk together with one heart, one mind, one voice, one action. One day we will help other nations as other nations have graciously helped ours. We will continually strive to improve the physical, mental, emotional, and spiritual health of our relatives. We will build on each other's strengths and strengthen each other's weakness.

Network Development

The Rosebud Connected Care Initiative is a framework for interorganizational collaboration coordinated through the Rosebud Sioux Tribe Health Administration, which is the backbone organization for the network. The network initially consisted of the major health delivery sites on the Rosebud Indian Reservation: Indian Health Service Rosebud Service Unit, Rosebud Sioux Tribe Health Administration, and the Veterans Administration Black Hills Healthcare System. The service areas of these three delivery sites heavily overlap and, together, serve the entirety of the Rosebud Indian Reservation. Once the network has become successful and sustainable, the partners will pursue expansion to include other healthcare delivery sites as partners (e.g., Cherry County Critical Access Hospital, Winner Regional Critical Access Hospital, Avera Health System, Sanford Health System).

The Indian Health Service will function as a non-governing network partner. Two additional prospective network partners, both located on the Rosebud Reservation, have been engaged during the project period first year: 1) White River Nursing Home and 2) Sinte Gleska University. The nursing home engagement is around better coordination of elder care services across the population, and the university focus is around providing better health promotion/education/outreach as well as providing direct health services to students.

Programmatic Development

The network partners are collaborating and working towards a common agenda built around shared values. Governing network partners plan to operationalize a common agenda by forming up to five interorganizational working groups, each addressing one of five key focus areas: 1) population health informatics and analytics, 2) care coordination between healthcare delivery sites, 3) value-based healthcare, 4) stakeholder and community engagement; and 5) tribal research capacity development. A comprehensive strategy for integrating service delivery and ensuring mutually reinforcing activities between partner organizations is being will further developed by key network leadership working and sharing knowledge across these areas of focus

Initial planning and strategy development for the Rosebud Connected Care Initiative network included stakeholder analysis and stakeholder outreach by the Rosebud Sioux Tribe Health Administration. Next planned steps include community engagement through qualitative inquiry and outreach activities, including surveys, interviews, focus groups, community events, and social media analysis. Continued stakeholder outreach and engagement is planned to occur through more involved activities, including participatory model building workshops and other convening activities that stimulate discussion between organizations

The primary endpoint to the network planning grant is to function as a network consisting of membership from each network partner as well as from the community itself, operating under a jointly drafted Memorandum of Understanding which outlines network mission, goals, and strategy.

Sustainability

Sustainability of the Rosebud Connected Care Initiative network focuses on strengthening network connections, both social and information networks. The strengthening of social networks has focused on building and strengthening the relationships between network member leadership and staff and is now planned to expand its focus towards building relationships with the community. A coordinated, consensus-based community outreach strategy that is developed by network leaders who have built strong relationships is expected to lead to a more meaningful relationship with the community itself.

The strengthening of the information network is going forward with continued expansion of broadband accessibility and quality in the Rosebud community, which also allows for installation and connection of telehealth access points across the reservation. This is further supported through investments from the American Rescue Plan Act. These information technology upgrades and modernizations make it easier for stakeholders to stay in communication with each other and share data to better coordinate care and manage patient cases.

Region Covered by Network Services

County/State	County/State
Todd, SD	Gregory, SD
Tripp, SD	Mellette, SD

Network Partners

Organization	Location	Organization Type
Rosebud Sioux Tribe Health Administration	Rosebud, SD	Tribal Health Clinic
VA Black Hills Healthcare System	Hot Springs, SD	Veterans Administration Clinic
Indian Health Service Rosebud Service Unit	Rosebud, SD	Hospital
(Prospective) White River Nursing Home	White River, SD	Other
(Prospective) Sinte Gleska University	Mission, SD	College/University

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Vermont

Copley Professional Services Group dba Lamoille Health Partners Lamoille Health Collaborative

P10RH37477

Project Focus Areas: Network Organization/Infrastructure Development

Other Focus Areas: Care Coordination
Increase Health System Efficiencies

Network Statement

Living in Vermont comes with many advantages and pleasures, including the state's natural beauty and access to the outdoors. Yet living in rural Vermont presents some challenges. Making and keeping connections can be difficult. Many people lack reliable transportation, lack adequate access to the internet, and find it confusing to locate and coordinate needed services among often siloed community service organizations. These barriers can lead to isolation, missed opportunities, and a lack of information and resources at important life milestones, particularly for pregnant women.

All pregnant women deserve to know about the resources that are available from the moment of discovery to delivery. "What is the closest hospital for delivery?" "How will I get to my appointments?" "Am I eligible for extra dental care through Medicaid during my pregnancy?" It's a matter of equity. All providers of medical care and human services should know about the needs of pregnant women in their community, especially those with complex needs. "What are the mental health needs of pregnant women in the Lamoille Valley?" "What percentage of pregnant women in our community smoke or misuse substances?" "What have birth weights looked like over the past five years?" It's a matter of the right care at the right time.

Building off of decades of coordination and collaboration, health and human service providers came together in 2020 to form the Lamoille Health Collaborative (LHC). The LHC is focused on connecting pregnant women to resources, sharing key patient information across the system, and integrating care for pregnant women. The work of the LHC is informed by the powerful voices of pregnant women, experiences of community providers, and concrete health data. The purpose of the Collaborative is to create a pathway for more accessible and integrated care for pregnant women. LHC's goal is to improve the health care and health outcomes for pregnant women and their babies. We are convinced that improved care during these nine months will reap benefits that will last a lifetime, not only for mothers and babies but also for their providers and the community as a whole.

Network Development

Progress
Lamoille Health Collaborative has experienced success with full participation of ten community partners over its first year. The Collaborative meets monthly and has successfully developed and submitted required HRSA documents and processes. The Collaborative discovered that it could be very efficient and effective by dividing into two working groups to tackle the two primary focus areas of governance and care coordination.

Challenges
Due to COVID's arrival a few months before the start of the planning process, the Collaborative was forced to conduct its work through remote meetings. Leaders had to obtain the necessary technological tools and help their staff get comfortable with remote work. In addition to keeping their organizations running, organizational leaders were tasked with responding to the plethora of challenges and impacts of COVID in the community.

Innovations
Lamoille Health Collaborative (LHC) deliberately focused on relationship building. LHC used the beginning of monthly meetings as time for connecting, as well as arranging one-on-one meetings for members who were new to the community. LHC also used a full array of Zoom functions (breakout rooms, chat responses to prompts, polls) to engage members. Partners were offered opportunities to contribute individually to HRSA forms and also to participate in group processes between meetings and most partners engaged. LHC also created a special care coordination team to dive into the status of our teamwork and to identify specific actions the region and its organizations could take to improve outcomes for pregnant women. This team, with representatives from all 10 partner agencies and the local Ob/Gyn practice, met for a total of six hours to conduct this work.

Programmatic Development

Progress
As mentioned above, LHC brought together a team of direct care staff and managers who looked deeply at the current system of care and where improvements could be made regarding care coordination. The group assessed some of the tools and processes currently used by the partners. The review and analysis included inventorying all the risk and need screening and assessment tools the partners use; where formal relationships exist and where additional formal linkages would strengthen the system; and identification of future actions that would improve the system and strengthen care coordination for pregnant women.

Challenges
The primary challenge LHC faced was accessing, analyzing, and reporting data. Very little data are available for the target population. The initial vision for this work was holding six monthly meetings for the care coordination team. Due to bandwidth challenges, the group met for three times, and the goals and objectives were consolidated and narrower.

Innovations
LHC was fortunate to have the services of two college student interns who added tremendous value to the work. The first student was informatics and analytics graduate student. She helped LHC obtain essential data and she provided some helpful data visualization for the group. The undergraduate student focused on oral health care, and she conducted local research among the dental practices in the region. Another innovation is the potential for the Self Sufficiency Matrix to be a shared information tool for both patients/clients and for providers. The tool is user friendly and can inform case planning and assessment of progress.

Sustainability

Network
The network members are committed to maintaining monthly meetings into the future. The group plans to assess if/how its unique composition and goals fit with other existing collaboratives that bring health care, human services, and education partners together. There is a recognition that funding is needed to support group facilitation and planning. A larger community effort is underway to figure out if there are efficiencies to be gained by consolidating or linking LHC and/or other collaboratives with one another. The grantee, Lamoille Health Partners, is committed to funding LHC facilitation for several months while this community assessment process moves forward.

Program
No new services were created as a result of this planning effort. Both low/no-cost and medium/high-cost ideas to improve care coordination for pregnant women were generated through the planning process. There is palpable enthusiasm to move forward, especially with the low and no-cost ideas. The higher cost ideas that require collaboration across the members will be considered for inclusion in the group's strategic plan. Full group buy-in is necessary for these aspirations to become reality.

Region Covered by Network Services

County/State
Lamoille, VT

Network Partners

Organization	Location	Organization Type
Capstone Community Action	Morrisville, VT	Social Services Agency
Clarina Howard Nichols Center	Morrisville, VT	Social Services Agency
Copley Hospital	Morrisville, VT	Hospital
Lamoille County Mental Health	Morrisville, VT	Behavioral Health
Lamoille Family Center	Morrisville, VT	Social Services Agency
Lamoille Health Partners	Morrisville, VT	Federally Qualified Health Center (FQHC)
Lamoille Home Health & Hospice	Morrisville, VT	Home Health
Lamoille Restorative Center	Hyde Park, VT	Social Services Agency
North Central Vermont Recovery Center	Morrisville, VT	Social Services Agency
Vermont Department of Health	Morrisville, VT	Public Health

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Virginia

Virginia Rural Health Association
The Pride of Rural Virginia

P10RH40107

Project Focus Areas: Population Health/Social Determinants of Health

Other Focus Areas: Network Organization/Infrastructure Development

Network Statement

LGBTQ+ people face the same challenges that others in rural America face: limited access to healthcare, housing shortages, a growing opioid epidemic and job loss. However, being LGBTQ+ can make those challenges more difficult. LGBTQ+ people face higher rates of discrimination, and the impact of discrimination is more acute for essential needs such as employment, housing, and especially healthcare.

Healthcare professionals interact with people at their most vulnerable, and their training and expertise gives them incredible power over patients. The advice they provide—or refuse to provide—to an LGBTQ+ patient can influence the treatment that person seeks. It can make that individual less likely to seek primary care or identify themselves as LGBTQ+ in healthcare settings, which can lead to the failure to screen, diagnose, or treat important medical issues.

The Pride of Rural Virginia is a statewide network created for the purpose of addressing rural health priorities for the LGBTQ+ community. We are intent on providing educational and community opportunities to increase knowledge of LGBTQ+ issues among healthcare providers and community stakeholders; hosting interactive discussions on the community level to determine what barriers to healthcare exist for LGBTQ+ community members and creating and disseminating tools to determine the future needs for addressing health for LGBTQ+ persons in rural Virginia.

Network Development

The Pride of Rural Virginia hosted a statewide kickoff meeting June 12th which included a broad mix of stakeholders: people who identify as LGBTQ+, community allies, and healthcare providers. Of the 85 registrants, 9% were healthcare providers who are also LGBTQ+.

The kickoff event was the lead-in to the five community-level conversations that will be held in the upcoming months. This will provide an opportunity to hear directly from community members and refine our project approach. The information gathered during those conversations will inform our next steps.

Two of the five events have been hosted with positive results. A highlight was a participant finding better options for hormone replacement therapy closer to home through the connections she made at the community conversation.

Programmatic Development

We have identified community-level partners for the next phase of the project in 4 of the 5 target communities (Farmville Pride, Collidescope, Shenandoah LGBTQ+ Resource Center, WRCNRV Inclusion Council) and are exploring options for the fifth.

We had a small setback from the consultant who we had intended to provide the LGBTQ+ cultural competency training to healthcare providers, having to step down. However, the connections we made hosting the statewide kickoff provided a solution.

At the recommendation of the Leadership Team, the network has added a healthcare provider recommendation component to the project. Previously, persons identifying as LGBTQ+ had to rely on word of mouth to find affirming providers. The network will create an on-line portal that will identify healthcare providers who have completed the cultural competency training and/or are recommended by a member of the community.

Sustainability

The network will continue to function as a program under the umbrella of the Virginia Rural Health Association. The network activities and partner meetings will be led by VRHA staff.

The network is working with the healthcare systems based in Virginia (Valley Health, Carilion Clinic, etc.) on an agreement for covering the cost of the LGBTQ+ cultural competency training for their employees, greatly reducing the in-house expenses of the network.

Network leadership has applied to Virginia Tech's "Vibrant Virginia" program for funds to expand the program into five additional communities and add an evaluation component.

Region Covered by Network Services

County/State	County/State
Pulaski, VA	Shenandoah, VA
Prince Edward, VA	Martinsville, VA
Danville, VA	

Network Partners

Organization	Location	Organization Type
Virginia Rural Health Association	Luray, VA	Non-Profit
Community Health Center of the New River Valley	Pulaski, VA	Federally Qualified Health Center (FQHC)
Page Memorial Hospital	Luray, VA	Critical Access Hospital (CAH)
Shenandoah Memorial Hospital	Woodstock, VA	Critical Access Hospital (CAH)
Virginia State Office of Rural Health	Richmond, VA	Government
LewisGale Pulaski Hospital	Pulaski, VA	Hospital
Office of the Governor	Richmond, VA	Government
Unite Virginia	Richmond, VA	Other
James Madison University	Harrisonburg, VA	College/University
Planned Parenthood South Atlantic	Roanoke, VA	Non-Profit

Farmville Pride	Farmville, VA	Non-Profit
Equality Virginia	Richmond, VA	Non-Profit
Women's Resource Center of the New River Valley	Pulaski, VA	Non-Profit

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Washington State

San Juan County Public Hospital District No 1
San Juan County Community Based Long Term Care Network

P10RH40105

Project Focus Areas: Network Organization/Infrastructure Development

Other Focus Areas: Care Coordination
Chronic Disease Management
Reimbursement for Health Services
Workforce Development

Network Statement

With nearly 6,000 full-time residents over the age of 65 (33% of the total population), San Juan County is one of the oldest counties in Washington State. As the percentage of islanders in their 80s and 90s is expected to increase dramatically, the lack of affordable long-term home care, home health care, and residential care in San Juan County becomes a crisis. The high costs and limited availability of housing combined with geographic barriers make it difficult to develop and sustain the workforce needed to support elders as their need's intensify. As a result, aging safely at home is not possible for the majority of seniors. When combined with a lack of facility-based options, our most vulnerable residents are often forced to leave their community at the end of their lives.

Planning is underway to create the San Juan County Community-Based Long-Term Care Network (*the Network*). Entities involved in this endeavor come from health care, Emergency Management Services and agencies providing social supports and services across the three major ferry served islands. Together, the group is working to establish a formal Network that will ensure there is the infrastructure needed to support and sustain a county-wide system of long-term care services and social supports. While a segment of critical components is established (e.g., medical clinics, emergency services, senior services), others lack resources, capacity and coordination. Most of the services beyond prevention, primary care and emergency services aren't provided by organizations based in the County, leaving islanders vulnerable to decisions and policies outside of local control. The Network seeks to establish and/or contract for the full continuum of services while balancing access, quality and cost in the interest of both care givers and clients.

Islanders are good at helping neighbors, but the need has outgrown what volunteers and informal coordination can consistently and effectively provide. Through a robust planning process, the Network will engage providers and other stakeholders in strong, formalized contracts assuring capacity and accountability. These formal alliances will leverage our collective purchasing power and help provide a more uniform standard of care throughout the County. They will also offer each island community the flexibility to respond to diverse local needs and maximize limited resources. The Network will serve as a vehicle to advocate for policy or legislative changes needed. Most importantly, the Network will ensure all islanders have access to the full spectrum of long-term care services and social supports needed to preserve a high quality of life and health while they age safely in place, as long as possible. Everyone will need long-term care someday. We hope you will join us on this important journey!

Network Development

The Network has defined both immediate and emerging needs, and the members are fully in agreement about the magnitude of the problem based on our demographics. Network members also share a common vision of the need for long-term care integration especially in our multi-island environment, and while the Network is united on the "what" we are still actively engaged—and in fact have differing opinions--- about "how." Early in the process, the issue of workforce was identified, and while we were aware of the shortage, the magnitude and the need to solve the issue has proven to be a top priority. Because of the high cost of living in the County, we must address housing, childcare, wage rates and other economic issues if we are to address the needs for our growing elderly population.

In terms of the future role of the Network, there is increasing alignment that the Network should not be a provider of direct services. Future purpose is likely to include advocacy, convening, communication, and setting standards for the measurement, collecting and reporting of data. We also want to be a catalyst to encourage existing organizations to increase and expand capacity to address identified service gaps.

There is not yet consensus in terms of the Network role, or ultimate structure. In terms of role, there has been significant discussion about using an inter-local agreement that would include the County's three public hospital districts and the County's Public Health Department. Others do not want another "governmental entity" and prefer to see a 501(c)(3) or a public/private partnership. We continue to work this through and need to address the value of creating a new entity focused on immediate needs versus creating a system for addressing long-term or emerging problems. All members acknowledge that it is important to not limit the scope to LTC services, but also to the spectrum of care services and workforce needed to make efforts successful.

We are aware that the ability to even consider partnerships with foundations is a real benefit to us. There are a number of island-based foundations that have expressed strong interest in our work and have offered meaningful support to help move the Network forward.

Our challenges include needing to reach consensus and confirm the explicit direction and strategies. As was the goal of the grant, getting entities to work together who haven't in the past takes time. While significant progress was made to establish a strong foundation of trust and mutual respect, the old patterns of retreating to a more siloed approach surface on occasion and it will be necessary to continue to work towards a new model where everyone feels valued and comfortable.

Programmatic Development

We have determined that being able to bill Medicare is a key to sustainability, and to do so requires that billing entities be a "provider" within the Medicare program. Additionally, in Washington our Rural Health Clinics can file "change of scope" applications to Medicaid to add services. For this reason, we are looking to capitalize on our existing Rural Health Clinics to offer some of the needed services. For services with no or limited reimbursements, we have determined that the best course is the local foundations; but to do so we are preparing to have an ongoing process for data collection, analysis and reporting so that we can demonstrate outcomes, patient satisfaction and cost savings. We see this function as an ongoing role for the Network.

We do know that we still have action steps to implement so that we can more fully understand the needed resources, both in terms of resources to maintain the Network after the grant period and resources to support specific strategies. We also need to confirm the long-term financial commitment of the members and other financial strategies for sustainability, as well as how we will staff any new entity.

Finally, this process has "shone the light" on the magnitude of the workforce recruitment, retention and development needs in the County. We are actively partnering with existing providers, funders and with the County's Economic Development Council to address head on. Through our work, solutions are already being

deployed to grow the existing workforce; and that has been a wonderful example of the power the Network could bring to our community.

Sustainability

The functioning of the Network beyond the grant is still in flux (see above). Our intent is to have all of the service needs we define to be sustainable as described in the Programmatic Development section of the Source Book.

Region Covered by Network Services

County/State
San Juan County, WA

Network Partners

Organization	Location	Organization Type
PeaceHealth, Peace Island Medical Center	Friday Harbor, San Juan Island, WA	Critical Access Hospital (CAH)
Inter Island Health Foundation	San Juan Island, WA	Philanthropy/Foundation
San Juan County Public Hospital District No. 2	Lopez Island, WA	Hospital
San Juan County Public Hospital District No. 1	San Juan Island, WA	Hospital

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Wisconsin

Marshfield Clinic Health System
Western Wisconsin Rural Behavioral Health Network

P10RH40103

Project Focus Areas: Mental Illness/Mental Health Services

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

Network Statement

The health outcomes of our rural Wisconsin agricultural communities are indicators of the effectiveness of our community health strategies.
As an occupation, agriculture is one of the most stressful occupations and experiences higher rates of suicides. In the past couple of years, stressors caused by economic and political pressures, as well as the COVID-19 pandemic and its impacts led to an increased need for mental health access in the state. The Wisconsin department of agriculture reported that the number of requests for counselling vouchers almost doubled between Spring 2019 and Spring 2020. Despite the increasing need for behavioral health services, challenges associated with accessibility, availability, and affordability in rural areas hinder rural communities from seeking or receiving the help they need. The Western Wisconsin Rural Behavioral Health Network, which serves four counties (Rusk, Taylor, Clark, Chippewa) will be instrumental in helping increase access to services by creating a more efficient line of communication, and in developing a Community Health Worker (CHW) model that is adaptive and targeted towards our farming and agricultural population.
The Social Determinants of Health are characteristics in the environments where people live and work that effect a variety of health outcomes (CDC, 2021). While mental health challenges in agriculture are not new, they are expected to become more acute as the social determinants of health in rural communities pose risks and challenges to farmers, agricultural workers, Plain communities and their families in the post-pandemic world.
By taking a collective approach to the need for behavioral health services among the agricultural population, we can better understand the factors that influence mental health outcomes, draw from supportive resource options, and build effective strategies to make mental health care accessible for underserved communities in the four-county region.

Network Development

The partners have developed a formalized Network of roughly 20 individuals from different organizations across the state of Wisconsin in pursuit of a collective goal. The Network represents a diversity of organizations, such as the University of Wisconsin Extension, county health departments, Area Health Education Centers, health systems, wellness centers, agricultural health and safety, and social service providers. Network members have expertise in many different arenas, such as community health worker programs, higher education, social work, public health, agricultural population mental health, and community organizing. Given that the network project specifically addresses the mental health needs of three hard-to-reach target populations (farmers, Hispanic migrant workers and the plain community), the partners have pulled together individuals who have experience working with these communities in a culturally responsive manner to help guide the work to form a community health worker model that reflects the Network's values of culturally adaptive and person-centered care.

Partners faced two major challenges in the first ten months of the planning grant. First, COVID-19 changed the trajectory of the project considerably. Building trust is integral to creating a strong, cohesive Network, and requires a considerable amount of time. The inability to meet face-to-face extended the amount of time needed to create sustainable and strong relationships with Network members. A second challenge is connected to challenges around connecting with the hard-to-reach populations, as they may be distrusting of programs like those of the Network and/or face stigma talking about mental health. Incorporating direct representation from the Hispanic community and from the plain communities has been difficult but the partners have identified gatekeepers for each of these communities who have committed to creating connections with the farm populations.

The project champions group, alongside with the project director and full-time health educator, agreed on the importance of building the network around a foundation of storytelling and authentic human connection. Partners have created space for one-to-one conversations between Network members and team leadership to further build trust and bolster the strength of collective group work and Network buy-in. Partners have encouraged the meshing of different types of participants, whether that means a breadth of organizational representation or inviting gatekeepers to the three sub-populations to provide guidance to the Network on culturally sensitive methodologies. This furthered team building and showed that the Network can uphold its collective values. The Network also opened the floor to different levels of participation on a sliding scale, meaning that members could participate formally by signing the memorandum of understanding (MOU) or they could provide their time, expertise and energy in-kind as often as they could. This has allowed the Network to create space for knowledgeable experts in mental health and community health worker programs to share what they know who would otherwise decline invitations due to time constraints.

Programmatic Development

The Network has brought together a diverse team of Network members who have collectively painted a picture of the mental health needs of the target populations in rural Wisconsin. Using these needs assessments as a guide, partners are now moving into the process of integrating Network members into the process of choosing an appropriate community health worker model and developing plans for training and recruitment plans and outcome measures. To leverage existing knowledge and further develop the network, partners are collaborating with successful community health worker programs in the region.

The main challenge to programmatic development is associated with the delayed hiring of the full-time health educator, who came on seven months into the grant. This was mostly due to the short time window between the funding announcement and project start coupled with organizational procedures to hire a new grant-funded position. The delays in the hiring pushed the timeline forward and the Network will be applying for a no-cost extension to complete the development of the community health worker model.

A truly participatory process where all Network members are actively developing the community health worker model material together would be ideal. However, work priorities and workloads likely prevent members from extensive engagement. During an upcoming Network meeting on the development of the community health worker model, the health educator will propose a hybrid participatory model. In this type of model, the health educator would gather and synthesize information from the peer-reviewed literature, conversations with network members, and interactions with regional community health workers programs. She would then bring the synthesized information and a menu of options to the network for group discussions and decisions.

Sustainability

Continued attendance to monthly meetings and the signature of the MOU by organizations that represent three of the four counties are example of the Network's commitment to continue to participate in Network activities and to share the work towards collective visions and goals. This process itself should be limited in terms of resource required with anticipated continued in-kind donations of network members' time.
Partners will be looking to identify funding to conduct a pilot project for the implementation and evaluation of the behavioral health community health worker model. Should pilot data sufficiently illustrate the importance and value of the behavioral community health worker model, the Network would use the data to have conversations with its members to work towards internal and sustained funding of the model. Seeking funding for pilot projects will be pursued earnestly and success is not guaranteed. As such, partners will work to identity funding opportunities at the federal and state government levels as well as through philanthropic organizations.

Region Covered by Network Services

County/State	County/State
Clark County, WI	Rusk County, WI
Taylor County, WI	Chippewa County, WI

Network Partners

Organization	Location	Organization Type
National Farm Medicine Center	Marshfield, WI	Non-Profit
Clark County Health Department	Neillsville, WI	Public Health
Marshfield Clinic Health System	Marshfield, WI	Federally Qualified Health Center (FQHC)
Chippewa County Health Department	Chippewa Falls, WI	Public Health
Rusk County Health and Human Services Dept.	Ladysmith, WI	Public Health
Professional Dairy Producers of Wisconsin	Juneau, WI	Other/Professional Development
Clark County Community Services	Neillsville, WI	Community Development Organization
Clark County UW Extension	Neillsville, WI	College/University/Social Services
Western Wisconsin Public Health Readiness Consortium	Eau Claire, WI	Public Health
Well Badger Resource Center	Wisconsin - Statewide	Social Services
Child and Youth with Special Health Care Needs Network	Chippewa Falls, WI	Social Services
Wisconsin Well Woman Program	Wisconsin - Statewide	Public Health
Recovery and Wellness Consortium	Chippewa Falls, WI	Social Services
UW-Madison School of Medicine	Madison, WI	University
UW- Extension Taylor County	Medford, WI	University/Social Services
Area Health Education Centers (AHEC)	Milwaukee, WI	Area Health Education Center

Taylor County Human Services	Medford, WI	Social Services
Family Health Center- MCHS	Marshfield, WI	Social Services
Wisconsin Title V Maternal Child Health Program	WI - Statewide	Social Services
Migrant Clinician Network	Austin, TX	Non-Profit

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