Rural Health Network Development Planning Program

2023 Grantee Directory

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

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Introduction

Over 60 million people live in geographically isolated rural and tribal communities in the United States. Residents of these areas often face barriers to accessing comprehensive and affordable health care services, including long travel distances, limited public transportation, lack of specialty care, and higher rates of uninsurance, and the accelerating pace of hospital closures in rural communities means that health care is often inaccessible.[1]

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. As the U.S. health care payers and key stakeholders seek to achieve better population outcomes and cost reductions through a shift toward value-based payment, the need for strong networks has become even more apparent.[2]

The Federal Office of Rural Health Policy (FORHP) of the Health Resources and Services Administration administers grant programs designed to build health care capacity and improve health outcomes for rural residents. Through its community-based programs, FORHP supports evidence-based, innovative programs that encourage network development among rural health care providers. FORHP's Rural Health Network Development Planning Program brings together key parts of a rural health care delivery system, particularly to establish and improve local capacity and coordination of care. The program promotes the planning and development of health care networks to (1) achieve efficiencies; (2) expand access to, coordinate, and improve the quality of essential health care services; and (3) strengthen the rural health care system. The program supports one year of planning with the primary goal of networks creating a foundation for their infrastructure and focusing member efforts to address important regional or local community health needs.
The funded partnerships use their planning year for two purposes:

- Program planning to assess and more fully understand the gaps and the unmet health needs in their communities and within their health care systems, and to explore best practices and strategies to address unmet needs
- Infrastructure development to explore leadership, governance, policies, and procedures that will support a sustainable rural health network

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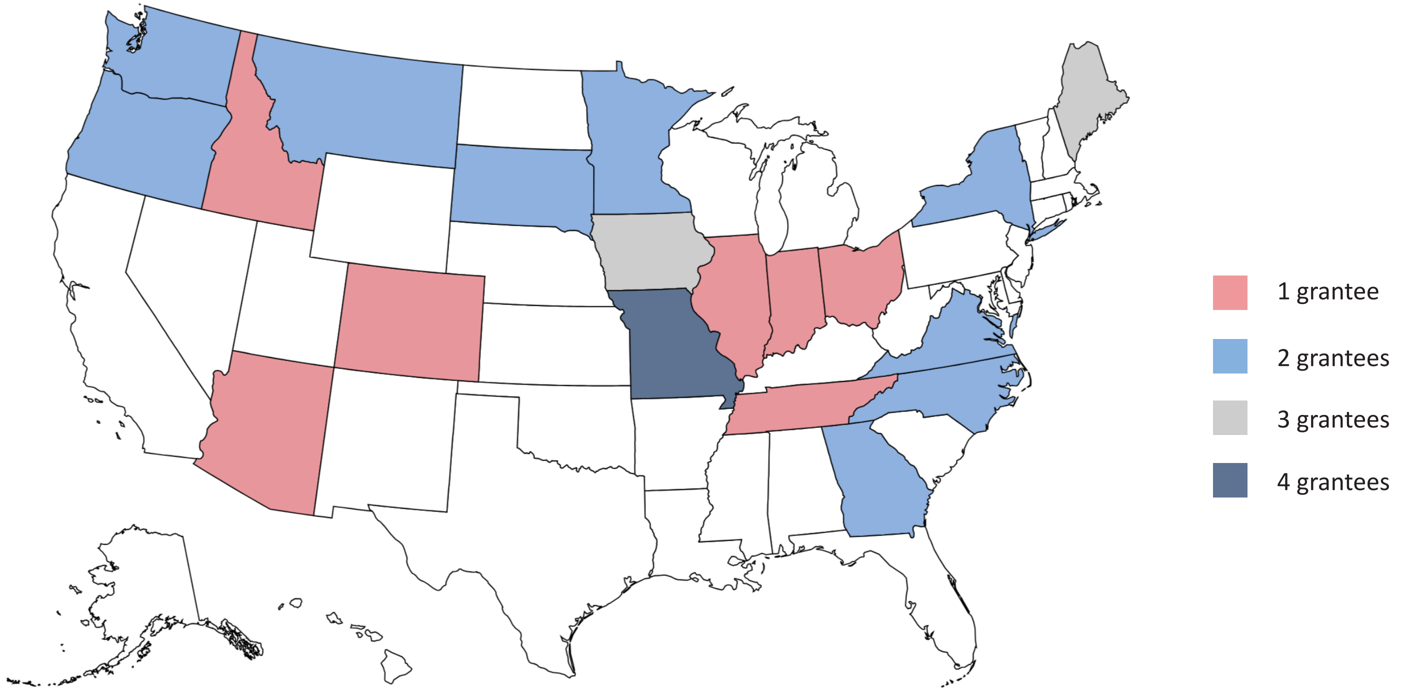
[1] Centers for Medicare & Medicaid Services. (2022). *CMS framework for advancing health care in rural, tribal, and geographically isolated communities*. Accessed at https://www.cms.gov/files/document/cms-geographic-framework.pdf

[2] Henning-Smith, C., & Story-Tuttle, M. (2021). *Evaluating the rural health network development planning program*. University of Minnesota Rural Health Research Center. Available at: https://www.ruralhealthresearch.org/projects/100002508

Cohort Snapshot

With funding provided by the fiscal year 2023 Rural Health Network Development Planning Program, 36 grantees in 19 states are addressing these challenges by bringing together a broad range of partners to form rural health networks.

Grantee Location Map



Lead organizations represent a range of health care providers and other health-related organizations.

Grantee Organization Type

Grantee Organization	501(c)(3) Collaborative	Critical Access Hospital	Emergency Medical Service	Federally Qualified Health Center	Government	Home and Community Based Service Provider	Hospital	Nonprofit	Nonprofit Acute Care Hospital	Primary Care Association	State Office of Rural Health	University
Affiliated Services Providers of Indiana								•				
Appalachian State University												•
Banner Wyoming Medical Center							•					
Colorado Rural Health Center											•	
Council for a Healthy Dent County								•				
FISH								•				
Gibson Area Hospital		•										
Healthy Ferry County Coalition	•											
Hospital Authority of Monroe County		•										
James Madison University												•
Mary Imogene Bassett Hospital							•					
Medical Care Development								•				
Missouri Coalition For Primary Health Care								•				
Montana Health Research and Education Foundation								•				
Montana State University												•
Mosaic Medical Center							•					
North Carolina Community Health Center Association										•		
Northwest Hospital Alliance								•				
Pike County Memorial Hospital								•				
Rural Health Development								•				
South Dakota Association of Healthcare Organizations Healthcare, Research, Education and Trust								•				

Grantee Organization	501(c)(3) Collaborative	Critical Access Hospital	Emergency Medical Service	Federally Qualified Health Center	Government	Home and Community Based Service Provider	Hospital	Nonprofit	Nonprofit Acute Care Hospital	Primary Care Association	State Office of Rural Health	University
St. Joseph Hospital		•	•									
St. Louis County					•							
Share Health Southeast Georgia								•				
Tennessee Technology University												•
Third Street Community Clinic				•								
Tillamook County Health Department					•							
Tri-Area Community Health					•							
Trivium Life Services						•						
Upper Peninsula Health Care Solutions								•				
Van Buren County Hospital		•										
Wabanaki Public Health and Wellness								•				
West River Area Health Education Center								•				
Westchester County Health Care Corporation									•			
Western Lane Fire and EMS Authority			•									
Windom Area Hospital		•										

The funded networks have identified a focus area around which they are conducting their assessment and planning efforts. The table below summarizes the primary focus areas identified by the grantees.

Grantee Primary Focus Area

Grantee Organization	Care Coordination	Chronic Disease Prevention/Management	Elder Care	Health Equity	Mental/Behavioral Health	Network Organization/ Infrastructure Development	Palliative Care/Hospice	Social Determinants of Health	Telehealth	Workforce Development
Affiliated Services Providers of Indiana						•				
Appalachian State University				•						
Banner Wyoming Medical Center									•	
Colorado Rural Health Center										•
Council for a Healthy Dent County						•				
FISH						•				
Gibson Area Hospital						•				
Healthy Ferry County Coalition						•				
Hospital Authority of Monroe County				•						
James Madison University					•					
Mary Imogene Bassett Hospital			•							
Medical Care Development									•	
Missouri Coalition For Primary Health Care						•				
Montana Health Research and Education Foundation				•						
Montana State University						•				
Mosaic Medical Center					•					
North Carolina Community Health Center Association						•				
Northwest Hospital Alliance								•		
Pike County Memorial Hospital						•				
Rural Health Development					•					
South Dakota Association of Healthcare Organizations Healthcare, Research, Education and Trust							•			

Grantee Organization	Care Coordination	Chronic Disease Prevention/Management	Elder Care	Health Equity	Mental/Behavioral Health	Network Organization/ Infrastructure Development	Palliative Care/Hospice	Social Determinants of Health	Telehealth	Workforce Development
St. Joseph Hospital									•	
St. Louis County						•				
Share Health Southeast Georgia		•								
Tennessee Technology University				•						
Third Street Community Clinic						•				
Tillamook County Health Department						•				
Tri-Area Community Health						•				
Trivium Life Services					•					
Upper Peninsula Health Care Solutions						•				
Van Buren County Hospital						•				
Wabanaki Public Health and Wellness					•					
West River Area Health Education Center					•					
Westchester County Health Care Corporation					•					
Western Lane Fire and EMS Authority	•									
Windom Area Hospital					•					

The 2023 Rural Health Network Development Planning Grantee Directory

This *Directory* provides a description of geographic coverage area and target populations for the network, network planning activities, goals for the planning year, and network partners.

Affiliated Service Providers of Indiana (ASPIN)

ASPIN TeleSalud Network

P10RH49205

Primary focus area:
Network Organization/Infrastructure Development

Other focus areas:
Increase Health System Efficiencies
Mental/Behavioral Health
Telehealth

Grantee Contact Information

Grantee Contact: Karissa Morris, MSW, LSW, CCHW-CT
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Organization Type: Nonprofit
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Program Description

The TeleSalud Network aims to serve Spanish-speaking rural residents in northern Indiana counties: Kosciusko, Marshall, and Noble. These counties were selected as they represent 16,527 Hispanic and Latino individuals in the state, of whom 3,040 (16.8%) of those individuals potentially are impacted by mental illness.

The TeleSalud Network's activities include (1) conducting a needs assessment of the most critical mental health needs of the Hispanic and Latino community in rural northern Indiana; (2) developing the network's operations, strategic, and sustainability plans; and (3) developing a Spanish-speaking mental health and primary care worker advisory committee. With input from both the governance board and advisory committee, the TeleSalud Network will implement a community-driven approach to developing mental health services tailored to the Spanish-speaking community. Input from these community members and organizations will inform the best or promising practice models chosen by the network.

Network Description

The TeleSalud Network was formed in 2023 to address health disparities and a lack of access to mental health care for the Spanish-speaking population in rural, northern Indiana. The TeleSalud Network aims to develop innovative approaches to engaging Hispanic and Latino individuals in mental health care while addressing

existing policies, procedures, and reimbursement models that may pose a barrier to accessing quality health care.

Network members include the Affiliated Service Providers of Indiana (ASPIN), the Bowen Center, and the East Coast Migrant Head Start Project (ECMHSP). ASPIN has expertise in grant management, telemedicine network development, recruitment, marketing, and community outreach. The Bowen Center is the largest community mental health center in Indiana, with locations throughout the state, and provides subject matter expertise on mental health. ECMHSP is a Head Start program for farmworkers and migrant families, with a concentration of locations in northern Indiana. As a subject matter expert on the rural Indiana Spanish-speaking community, ECMHSP can provide valuable input on the needs of families served by their programming.

ASPIN has existing relationships with both network member organizations. The Bowen Center has been a member of the ASPIN network since its inception in 1995 and has a seat on the board of directors. The Bowen Center has also successfully partnered with ASPIN on numerous grants. Additionally, ASPIN has previously collaborated with ECMHSP and has trained five of its employees as certified community health workers.

Network Partners

Organization	Location	Organization Type
ASPIN	Warsaw, IN	Nonprofit
Bowen Center	Warsaw, IN	Rural Health Center
East Coast Migrant Head Start Project	Lakeville, IN	Nonprofit

Populations Served

- Hispanic/Latinx

Region Covered

- Kosciusko County, IN
- Marshall County, IN
- Noble County, IN

North Carolina

Appalachian State University

Supporting Health Equity and Quality Improvement Through Engagement Network

P10RH50522

Primary focus area:
Health Equity

Other focus areas:
Care Coordination
Quality Improvement
Social Determinants of Health

Grantee Contact Information

Grantee Contact: Sydeena Isaacs, PhD, RD, LDN
Contact Title: Project Director
Organization: SHEQuITE Network
Organization Type: University
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Website: None

Program Description

The programmatic focus of the Supporting Health Equity and Quality Improvement Through Engagement (SHEQuITE) Network is health equity. All communities in the target service area of the SHEQuITE rural health network are in the Appalachian region of the United States. These communities are characterized by a number of health disparities, including higher incidence of chronic diseases and disabilities, higher mortality rates, and lower life expectancies compared to the national averages. Furthermore, capacity around chronic care management, behavioral health, and patient pain management is low and critically needed in the region.

The SHEQuITE Network is working to create a bidirectional rural health network composed of primary care clinics and interdisciplinary researchers to engage the health care community through collaborative assessment, data sharing, and quality improvement project development. The team is currently in the midst of organizing and hosting a meet-and-greet event to provide an opportunity for initial engagement and rapport building among all network members. During the initial meeting, the research team will share primary goals and objectives of the project and ask for feedback and input about other potential urgent needs and priorities among network members. Throughout the project planning period, the research team will complete bimonthly network member check-ins to engage each organization, provide updates on current project planning efforts and progress to date, and ask for additional feedback and input. Additionally, the research team will conduct network strategic planning meetings every other month to collect and analyze survey results, develop reports, and identify quality improvement projects around referrals for SDOH.

Depending on the needs of the partners, the team plans to distribute a content-validated survey to network partners with the purpose of gauging providers' confidence in making referrals based off of SDOH. Data will be collected in Qualtrics and measured by the number of organizations, employees, and stakeholders engaged in the network, and by the number of accreditation-fulfilling reports. Using data collected from network partners, the team will monitor progress by generating monthly reports on the measures and sharing this information with project staff and stakeholders.

Network Description

The Supporting Health Equity (SHE) Collaborative was formed in August 2021 to work as an interdisciplinary team to conduct collaborative scholarship, both practice and research, to support health equity. From August 2021 to December 2022, the collaborative developed and validated a Primary Care Engagement Survey to assess engagement and burnout, referral practices, and self-efficacy and confidence in making referrals based on social determinants of health (SDOH) among primary care providers and clinic staff in Appalachian North Carolina. In December 2022, the SHE Collaborative expanded to form the SHEQuITE Network, which includes five additional partners: University of North Carolina (UNC) Health Appalachian, Blue Cross North Carolina Institute for Health and Human Services (IHHS) and the affiliated IHHS Interprofessional Clinic, the Community Care Clinic, High Country Community Health, and Appalachian Healthcare Training and Consulting.

The SHEQuITE Network aims to increase and strengthen referrals from primary care providers around SDOH by exploring why and how referrals in the health care setting happen in rural Appalachian communities, in the context of a global pandemic. The greater goal of this network is to provide the opportunity to further develop collective impact initiatives to reduce morbidity and mortality, improve health outcomes, and enhance overall health in Northwest North Carolina. To provide comprehensive and equitable representation of the community at large, network members were selected based on diversity of services provided, population groups served, previous track record of collaboration with other community partners, and capacity to be a sustainable member of the rural health network.

Network Partners

Organization	Location	Organization Type
Appalachian Healthcare Training and Consulting	Boone, NC	Consultant
Blue Cross NC Institute for Health and Human Services	Boone, NC	Other
Blue Cross NC Institute for Health and Human Services–Interprofessional Clinic	Boone, NC	Other
Community Care Clinic	Boone, NC	Nonprofit
High Country Community Health	Boone, NC	Federally Qualified Health Center
UNC Health Appalachian	Boone, NC	Hospital

Populations Served

- Children/Adolescents
- Hispanic/Latinx
- LGBTQIA+
- Older adults
- Persons adversely affected by persistent poverty
- Persons with disabilities
- Pregnant people

Region Covered

- Ashe County, NC
- Avery County, NC
- Burke County, NC
- Surrey County, NC
- Watauga County, NC

Banner Wyoming Medical Center

TeleStroke Wyoming

P10RH50523

Primary focus area:
Telehealth

Other focus areas:
Increase Health System Efficiencies
Network Organization/Infrastructure Development
Quality Improvement

Grantee Contact Information

Grantee Contact: Sara Kemper
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Organization Type: Hospital
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Program Description

TeleStroke Wyoming connects emergency room physicians at partner sites with neurologists to collaboratively devise the best treatment plans for stroke patients in real time. Banner Wyoming Medical Center's (BWYMC's) TeleStroke partners are equipped with VeeOne as their telehealth platform and TeleKarts at no cost to the hospitals. The TeleKart is a scalable, mobile cart system that can be rolled into any patient room. Remotely, neurologists can examine and speak with patients and emergency room physicians at spoke sites through the high-definition cameras and display monitors. The neurologists have direct access to patient electronic medical records that contain patient history, vital signs, and other data in real time for consultation with the on-site physician. This physician-to-physician consultation helps guide the on-site team's treatment of these patients and helps determine if a patient is in need of thrombolytics or transfer for higher level of intervention. The TeleStroke program ensures that a qualified neurologist can actively participate in patient care and decision-making from the moment the patient arrives at their local hospital.

Network Description

The TeleStroke Wyoming network reaches nine of the state's 23 counties and serves nine of its 16 Critical Access Hospitals. All nine of the participating hospitals are in rural areas in the state. The TeleStroke program ensures that expert, lifesaving, highly specialized stroke care is available 24/7 in Wyoming patients' own rural

communities. This time-sensitive care is particularly important, as every minute of delayed care worsens patients' prognoses. The TeleStroke program gives rural patients access to health information technology and digital medical innovation. BWYMC's TeleStroke partners are equipped with VeeOne as their telehealth platform and TeleKarts, the best in telehealth technology. Further, participating in the American Heart Association's Get with the Guidelines Stroke Patient Management Tool and following its evidence-based guidelines improves outcomes for Wyoming residents. Thus, rural underserved stroke patients receive the same, cutting-edge advanced care that patients in metropolitan areas receive.

Network Partners

Organization	Location	Organization Type
Johnson County Healthcare Center	Buffalo, WY	Critical Access Hospital
Memorial Hospital of Carbon County	Rawlings, WY	Critical Access Hospital
Memorial Hospital of Converse County	Douglas, WY	Critical Access Hospital
SageWest Lander	Lander, WY	Critical Access Hospital
SageWest Riverton	Riverton, WY	Critical Access Hospital
Sheridan Memorial Hospital	Sheridan, WY	Critical Access Hospital
West Park Hospital	Cody, WY	Critical Access Hospital
Weston County Health Services	Newcastle, WY	Critical Access Hospital

Populations Served

- Asian American or Pacific Islanders
- American Indian
- Black or African American
- Hispanic/Latinx
- Older adults
- Persons adversely affected by persistent poverty
- Persons with Disabilities

Region Covered

- Carbon County, WY (spoke site)
- Converse County, WY (spoke site)
- Fremont County, WY (spoke site)
- Hot Springs County, WY (spoke site)
- Johnson County, WY (spoke site)
- Natrona County, WY (hub site)
- Park County, WY (spoke site)
- Sheridan County, WY (spoke site)
- Weston County, WY (spoke site)

Colorado Rural Health Center

Network for Strengthening the Clinical Support Staff Workforce

P10RH50524

Primary focus area:
Workforce Development

Other focus areas:
Health Education
Network Organization/Infrastructure Development

Grantee Contact Information

Grantee Contact: Michelle Mills
Contact Title: Chief Executive Officer
Organization: Colorado Rural Health Center
Organization Type: State Office of Rural Health
Address: 3033 S. Parker Road, Aurora, CO 80014
Telephone Number: 303-407-0410
Email: mm@coruralhealth.org
Website: www.Coruralhealth.org

Program Description

The network seeks to identify and address opportunities and barriers in the engagement of health professions education and training (HPET) efforts within rural communities. The Colorado Rural Health Center (CRHC), Colorado Community Health Network (CCHN), and network partners created this plan as a response to a high need for primary medical, dental, and behavioral health–based providers located in rural and frontier Colorado. A shortage of primary care providers and clinical support staff in these underserved and vulnerable communities results in poorer health outcomes for those residents.

The network will conduct a landscape assessment with partners and conduct key informant interviews with partners and community members to gain a better understanding of the facilitators and barriers of HPET efforts. A collaborative network of local and statewide educational entities will be formed with whom CRHC, CCHN, and partners will share data analyses, develop strategic goals, and be equipped with tools and resources needed to successfully implement HPET initiatives and other student opportunities within rural clinics.

Network Description

CRHC is Colorado's nonprofit State Office of Rural Health. CRHC works with federal, state, and local partners to offer services and resources to rural health care providers, facilities, and communities. CCHN is the Primary

Care Association for the 20 Colorado Community Health Centers (Community Health Centers or Federally Qualified Health Centers [FQHCs]). CCHN strives to educate policymakers and stakeholders about the unique needs of CHCs and their patients, provide resources to ensure that CHCs are strong organizations, and supports CHCs in maintaining the highest quality of care. Under the umbrella Network for Strengthening the Clinical Support Staff Workforce, the network will identify and address opportunities and barriers in engaging in HPET efforts within rural communities.

Current partners of the Network for Strengthening the Clinical Support Staff Workforce include two Area Health Education Centers (AHECs), Southwestern Colorado AHEC and Western Colorado AHEC; three rural health clinics, Delta Health, Pediatric Associates Prof LLC, and Southwest Health Systems; and two FQHCs, Axis Health Systems and River Valley Family Health Center. Their partners span 10 counties in southwestern Colorado: Archuleta, Delta, Dolores, Hinsdale, La Plata, Montrose, Montezuma, Ouray, San Juan, and San Miguel. The identified network partners are included due to their Health Professional Shortage Area status and vast knowledge of rural-based health professions as well as their willingness to contribute to planning and building of resources across the state. These partners have worked together in both formal and informal collaborations to support workforce, policy, and health outcomes and to increase health care access in rural areas of Colorado. The network partners have had numerous accomplishments including building collaborations, bolstering recruitment and retention of clinicians and support staff, and advancing team-based care in their clinic. All have in common bringing high-quality, equitable, and accessible health care to their rural communities.

Network Partners

Organization	Location	Organization Type
Axis Health Systems	Durango, CO	Federally Qualified Health Center
Colorado Community Health Network	Denver, CO	Nonprofit
Delta Health	Delta, CO	Rural Health Center
Pediatric Associates Prof, LLC	Montrose, CO	Rural Health Center
River Valley Family Health Center	Olathe, CO	Federally Qualified Health Center
Southwest Health System	Cortez, CO	Rural Health Center
Southwestern Colorado AHEC	Durango, CO	Area Health Education Center
Western Colorado AHEC	Grand Junction, CO	Area Health Education Center

Region Covered

- Archuleta, CO
- Delta, CO
- Dolores, CO
- Hinsdale, CO
- La Plata, CO
- Montrose, CO
- Montezuma, CO
- Ouray, CO
- San Juan, CO
- San Miguel, CO

Council for a Healthy Dent County

Primary focus area:
Network Organization/Infrastructure Development

Other focus areas:
Chronic Disease Prevention/Management
Community Paramedicine
Increase Health System Efficiencies

Dent County Health Improvement Network

P10RH50525

Grantee Contact Information

Grantee Contact: Jackie Sisco
Contact Title: Program Director
Organization: Council for a Healthy Dent County
Organization Type: Nonprofit
Address: 1200 W. Rolla Road, Salem, MO 65560
Telephone Number: 573-729-8163
Email: jackie@salemcommunitycenter.org
Website: www.healthydentcounty.org

Program Description

The purpose of this planning grant is to develop an integrated health care network in Dent County to achieve efficiencies; expand access to, coordinate, and improve the quality of basic health care services and associated health outcomes; and strengthen the rural health care system.

The main goal of this planning grant is to have a comprehensive plan to improve the overall health care system in the rural underserved community of Dent County at the end of the one-year project. To meet the goal and outcome, network members will:

1. Complete a comprehensive analysis examining the strengths, resources, and gaps in care for the community, including an assessment of Salem Memorial District Hospital (SMDH) maintaining Critical Access Hospital status. Community engagement in these discussions is paramount; the planning grant will ensure all avenues are explored.
2. Complete an analysis of Mobile Integrated Healthcare (MIH) as an enhancement to the existing care delivery system. Missouri has an emerging national model for MIH, and the Dent County Health Improvement Network will engage their leadership as part of its exploration of new models of care for its service area. This model, through funding from both HRSA and the Centers for Disease Control and Prevention, uses a community paramedicine approach, together with community health workers, taking care to patients' homes in lieu of ambulance transport, connecting patients to care and community-based services to help them maintain their health at home.

3. Develop a plan that will achieve efficiencies; expand access to, coordinate, and improve the quality and sustainability of essential health care services in Dent County.
4. Based on the results of the planned community health needs assessment, additional data assessments, network member planning meetings, and expert technical assistance, the Dent County Health Improvement Network will complete three plans — strategic, business, and sustainability plans — to propel the work forward at the conclusion of the planning year.

Network Description

The Dent County Health Improvement Network is a newly established partnership comprising organizations representing the health care system in Dent County, Mo. The network is an informal organization (not incorporated or holding an independent tax identification number from network members) formed to research, design, and implement new and improved evidence-based models of care and service delivery to meet the health care needs of its rural population more effectively and efficiently. All network members serve as community leaders, serve the community, and understand the unique challenges of the rural Dent County service area. The members will focus on leveraging limited resources, providers, and facilities with an emphasis on the rural underserved population.

Dent County is an isolated community where the potential for a hospital closure is real. Because of its isolation and limited financial resources, any damage to the current health care system will severely limit access, cause direct harm to individuals, and have a negative impact on the economy of the community. In today's environment, no single health care entity can address systemic health care needs in a rural community, and the network members recognize that collaboration and sharing resources are the only pathway to meeting local needs and helping to maintain the hospital's future in the community and strengthen the community's health care system.

Network Partners

Organization	Location	Organization Type
Council for a Healthy Dent County	Salem, MO	Nonprofit
Dent County Health Center	Salem, MO	Rural Health Center
Salem Memorial Hospital	Salem, MO	Hospital

Populations Served

- Older adults
- Persons adversely affected by persistent poverty
- Underserved and uninsured population

Region Covered

- Dent County, MO

FISH

Central Washington Food is Medicine Network

P10RH50526

Primary focus area:
Network Organization/Infrastructure Development

Other focus areas:
Health Education

Grantee Contact Information

Grantee Contact: Peggy Morache
Contact Title: President/CEO
Organization: FISH Community Food Bank, Food Pantries, Open Table Meal Service
Organization Type: Not-for-Profit Charity — Food Resource
Address: 804 Elmview Road, Ellensburg, WA 98926
Telephone Number: 509-925-5990
Email: peggy@kvfish.org
Website: www.kvfish.org

Program Description

The Central Washington Food is Medicine Network is addressing nutrition insecurity, social determinants of health associated with nutrition insecurity, and chronic disease in central Washington by providing medically tailored meals, medical nutrition therapy, and social determinants of health screening and referral for clients with cardiovascular conditions, chronic kidney disease, and diabetes. Research has shown the medically tailored meals are one of the most effective and inexpensive interventions for patients with chronic health conditions.

The network's aim is to expand access to medically tailored meals in central Washington and improve health outcomes for some of the most at-risk patients in Washington.

Network Description

The Central Washington Food is Medicine Network was formed in 2019-20 and consists of representatives from LINC Food Hub, Central Washington University, Community Health of Central Washington, the Kittitas County Public Health Department, a registered dietician, nutritionists, and representatives from FISH Community Food Bank's operations and meal service departments. The goals of the network are to improve the capacity to sustain food-is-medicine services in Kittitas County, Wash., and to improve capacity to scale food-is-medicine services across Central Washington. Food-is-medicine refers to the integration of specific

food and nutrition services in, or closely coordinated with, the health care system. Services include medically tailored meals (which typically include individualized nutrition counseling), medically tailored groceries, and produce prescriptions. The expected outcomes of the program are to improve communication, collaboration, and sustainability of services; improve action planning for services; and improve measurement of activities.

Network Partners

Organization	Location	Organization Type
Central Washington University	Ellensburg, WA	College/University
Community Health of Central Washington	Ellensburg and Yakima, WA	Federally Qualified Health Center
FISH and Healthy Table	Ellensburg, WA	Food Bank
Kittitas County Health Network	Ellensburg, WA	College/University
Kittitas County Public Health	Ellensburg, WA	Public Health
LINC Food Hub	Spokane, WA	Other

Populations Served

- Persons with chronic diseases

Region Covered

- Kittitas County, WA

Gibson Area Hospital and Health Services

East Central Illinois Rural Consortium

P0RH49207

Primary focus area:
Network Organization/ Infrastructure Development

Other focus areas:
Social Determinants of Health
Substance Abuse Prevention and/or Treatment

Grantee Contact Information

Grantee Contact: Amanda McKeon
Contact Title: Director, Grants Administration
Organization: Gibson Area Hospital and Health Services
Organization Type: Critical Access Hospital
Address: 1120 N. Melvin Street, Gibson City, IL 60936
Telephone Number: 217-784-2567
Email: Amanda_mckeon@gibsonhospital.org
Website: www.Gibsonhospital.org

Program Description

The East Central Illinois Rural Healthcare Consortium (ECIRHC) will focus on promoting the resources offered by social service agencies in the area to expand access to care. Coordinated efforts by interdisciplinary and interagency agreements will increase referrals to community agencies. Consortium members will reach out to other social, community, legal, and educational organizations in the service areas to join with ECIRHC in working to reduce and eliminate barriers to health care.

The primary goal of this planning project is to expand services through collaborating within the membership and adding three new community members. Much of the focus for ECIRHC's planning project will be addressing substance use disorder, opioid use disorder, alcohol use disorder, and behavioral health issues within the target populations. Consortium efforts will target those with substance use disorder/opioid use disorder and those who are not currently accessing basic health care services, including COVID vaccinations and boosters, as needed.

Network Description

ECIRHC was established in 2014 to address pressing health challenges in specific rural areas of Illinois, including Ford, Iroquois, and Livingston counties. Each of these counties is recognized as a Medically Underserved Area

for primary care and mental health services. They are also recognized as Health Professional Shortage Areas for primary care and mental health providers. Under the leadership of Gibson Area Hospital and Health Services, the consortium was organized for the purpose of addressing issues of access to care and the underlying social determinants of health. All members are independent community organizations that understand the needs of their respective rural communities.

Examining social determinants of health data helps ECIRHC members to understand the environments where people live, learn, work, play, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. By focusing on these determinants in rural areas like Ford, Iroquois, and Livingston counties, the consortium aims to understand and potentially improve factors of clinical and nonclinical care that can lead to health disparities. These include addressing circumstances such as socioeconomic status, education, neighborhood and physical environment, employment, housing, and social support networks, as well as access to health care. Each of these areas of interest has representation in the consortium. This planning grant will allow the East Central Illinois Rural Healthcare Consortium to add three additional community representatives.

Network Partners

Organization	Location	Organization Type
Community Resource Counseling Center	Paxton, IL	Behavioral Health
Ford County Public Health Department	Paxton, IL	Nonprofit
Gibson Area Hospital and Health Services	Gibson City, IL	Hospital
Illinois Critical Access Network	Princeton, IL	Other

Populations Served

- Children/Adolescents
- Justice-involved
- Older adults

Region Covered

- Ford County, IL
- Iroquois County, IL
- Livingston County, IL

Healthy Ferry County Coalition

Ferry County Rural Mobile Integrated Health Network

P1049208

Primary focus area:
Network Organization/
Infrastructure Development

Other focus areas:
Community Paramedicine
Mobile Integrated Health

Grantee Contact Information

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Organization Type: 501(c)(3) collaborative/coalition
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Website: www.healthyferrycountycoalition.org

Program Description

With the HRSA FORHP Rural Network Planning Grant Funding Award, the network is looking to build upon previous research by developing a plan to start a sustainable rural mobile integrated health network within Ferry County. The goal is to develop a plan for launching the Ferry County Rural Mobile Integrated Health Network (FCRMIHN) as a sustainable, growable, and duplicable multiagency model for the frontier, low-density population and economically stressed rural areas.

The network initially considered a rural paramedicine model but determined that a rural mobile integrated health network was more appropriate for Ferry County, given that other rural counties like Ferry County were not able to sustain paramedic employment within volunteer rural emergency medical services and fire districts. The network plans to use the Rural Health Network Development Planning Program grant to investigate network structures, including HUB, hybrid, or others, in forming the network model for FCRMIHN.

Network Description

The Healthy Ferry County Coalition (HFCC) is a 501(c)(3) serving the county by providing a forum for organizations and individuals to work collaboratively in more efficient use of scarce resources for improving the health and socioeconomic determinants of health for all Ferry County citizens. As a coalition, HFCC uses

networks within that community to achieve its mission to coordinate the development of opportunities for economic growth, strong health and social service systems, and a healthy population toward achieving the vision that Ferry County is consistently among the top 10 healthiest counties in Washington state.

Network Partners

Organization	Location	Organization Type
Better Health Together	Spokane, WA	Nonprofit
Ferry County EMS District 1 (Republic EMS)	Republic, WA	Emergency Medical Services
Ferry County Health	Republic, WA	Critical Access Hospital
Healthy Ferry County Coalition	Spokane, WA	Collaborative
Lake Roosevelt Community Health Centers	Inchelium and Keller, WA on Colville Confederated Tribes Reservation	Federally Qualified Health Center
Northeast Tri County Health District	Colville, Newport; Republic, WA	Public health
Northeastern Washington Alliance Counseling Services	Chewelah, Colville, Davenport, Republic, WA	Behavioral Health
Rural Resources Community Action	Chewelah, Clarkston, Colville, Davenport, Grand Coulee, Inchelium, Ione, Kennewick, Kettle Falls, Moses Lake, Newport, Pullman, Republic, WA	Social Services Agency

Populations Served

- General population

Region Covered

- Ferry County, WA

Hospital Authority of Monroe County

Monroe County Hospital Network

P1049208

Primary focus area:
Health Equity

Other focus areas:
Care Coordination
Network Organization/Infrastructure Development
Social Determinants of Health

Grantee Contact Information

Grantee Contact: Katherine Tucker
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Program Description

Utilizing this planning grant, the network will explore opportunities to address nutritional deficits and food insecurity currently affecting older people living in Monroe, Butts, Lamar, Upson, Crawford, and Jasper counties. The region's food insecurity rate is 12.68% collectively, and 12.2% and 13.4% in Monroe and Crawford counties respectively. Further, Monroe County Hospital data reveals that a considerable percentage of patients are older, have been diagnosed with having at least one disability, and are categorized as being a minority based on their race or ethnicity. The network will explore the feasibility of instituting a new service at Monroe County Hospital that would offer additional nutritional services to discharged patients, inclusive of providing nutritional counseling and offering medically and nutritionally tailored meals to provide support in helping these patients maintain healthy and nutritious eating habits to support their dietary needs.

The Monroe County Hospital Network will also revisit the current relationship between Morrison Healthcare and the Monroe County (80% minority population) and Crawford County (65% minority population) senior centers to expand their current meal service agreement to include providing additional meals for their older adults to take home on Fridays to ensure they have healthy meals over the weekend. This population is very similar to the hospital's discharged patients. Thus, the network sees value in working with both audiences. The expansion of these new and existing services will ultimately provide post-discharge continuity of care.

Network Description

Based on Monroe County's 2022 community health needs assessment, there were three priorities that were identified as a part of a suggested implementation plan: nutrition, health education and promotion, and exploring external funding opportunities to support Monroe County Hospital's efforts within the region. Three existing partners came together in 2022 to develop the Monroe County Hospital Network to begin addressing these priority areas. The Monroe County Hospital Network founding members are Monroe County Hospital, a Critical Access Hospital; Morrison Healthcare, a food service provider; and Food Fitness First Inc., a nutritional counseling service that provides medically sound nutritional coaching and guidance.

Morrison Healthcare has been the contracted food service provider for Monroe County Hospital for the past six years and oversees all kitchen operations at the hospital, along with providing meals to both senior centers in Monroe and Crawford counties. Food Fitness First is an arm of the dietitian services utilized by Monroe County Hospital. Monroe County Hospital has been in partnership with Food Fitness First Inc.'s parent company, Instructional Dietetics Associates Inc., for 17 years. The existing network members have a successful history of working together and serving this rural region within Central Georgia. Through this funding opportunity, the three partner organizations are committed to combining their resources to expand opportunities to meet the needs of senior adults residing within the target service area who are experiencing food insecurity, especially those who are a part of racial and ethnic marginalized groups and living with disabilities.

Through this funding opportunity, the network added two new additional partners, Monroe County Senior Center and the Crawford County Senior Center, based on their experience and proven track record of working with older adults from various racial and ethnic backgrounds and living with disabilities. Both centers are managed by the Middle Georgia Community Action Agency. The network has also extended an invitation to the Area Agency on Aging to be a part of the network due to their extensive background in working with older adults and those living with disabilities that have diverse racial and ethnic backgrounds.

Network Partners

Organization	Location	Organization Type
Food Fitness First Inc.	Vidalia, GA	Collaborative
Middle Georgia Community Action Agency/Area Agency on Aging	Macon, GA	Senior Center
Monroe County Hospital	Forsyth, GA	Critical Access Hospital
Morrison Healthcare	Forsyth, GA	Other

Populations Served

- Older adults
- Racial and ethnic marginalized groups
- People with disabilities
- People experiencing homelessness

Region Covered

- Butts County, GA
- Crawford County, GA
- Jasper County, GA
- Lamar County, GA
- Monroe County, GA
- Upson County, GA

James Madison University

Reaching Out and Being There

P10RH49210

Primary focus area:
Mental/Behavioral Health

Other focus areas:
Housing
Substance Abuse Prevention and/or Treatment
Transportation

Grantee Contact Information

Grantee Contact: Yvonne Frazier
Contact Title: Project Director
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Organization Type: University
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Program Description

The focus areas of the Reaching Out and Being There planning grant are mental and behavioral health, substance use prevention and treatment, affordable housing, and transportation. These areas were initially identified as part of community listening sessions and local needs assessments completed prior to and in conjunction with the grant application. As new members have joined the network, these continue to be identified as the highest needs for the community, with deepening discussion of the integral connection that exists between these needs. Network members brought attention to the fact that the need for local mental and behavioral health services is not limited to adults but is being increasingly seen in preschool and elementary age children, many of whom have parents suffering from mental health issues or substance use disorders or who are or have been incarcerated. With the inclusion of the public schools in network planning, the sharp increase in significant mental and behavioral needs of young children, particularly since COVID, added urgency to this focus area. Others identified these needs for incarcerated clients preparing for re-entry and medication-assisted treatment counseling. Network members recognize the hierarchical need for safe housing and transportation to access medical and mental health services as equally important for individuals as the need for more mental and behavioral health and substance use services.

The network will add nontraditional members and previously unrepresented groups to enhance planning and creative strategies in a tiered approach to increase local mental and behavioral health services. The network will determine short-term and long-term collaborative approaches, including working with neighboring rural

counties, to address the need for dependable, sustainable transportation and housing support. The network will employ best practice approaches that have proven effective in rural communities, most importantly making sure where and how the services are delivered meet the expectations of the members of this rural community. This will require identifying and creating safe and trusted locations, including mobile, to equitably serve the entire county. By engaging multiple, diverse stakeholders, rich insight, input, and investments will make this a truly collaborative and effective project. Utilizing their diverse skills, experiences, and relationships, network members will pursue sustainable funding options to continue to address complex needs in this community.

Network Description

James Madison University's (JMU's) Institute for Innovation in Health and Human Services (IIHHS) opened The Health Place (THP) in 2000 as an IIHHS satellite location in Stanley (Page County) Va., to respond to community-identified needs, with unduplicated services, by partnering with faculty, students, and community partners to develop innovative, interprofessional services and programs that advance the quality of life in this rural, mountainous community.

Over the next 20 years, THP's mental and behavioral health and maternal and child service providers became increasingly aware of the need for greater intentional collaboration with others in the community to better understand and overcome the nuanced barriers to accessible health care and health-related services in Page County. In 2019 the Rural Engagement and Capacity-building Hub (REACH) was formed to connect agencies, students, institutions, and community members to build capacity in reaching rural community goals for health and well-being. REACH began by holding local listening sessions to determine community-identified priority needs and assets. In addition to gaining important input, the sessions led to increased interest from other groups to collaborate to address local needs and ultimately a receipt of the Rural Health Network Development Planning Grant.

The momentum for creative, inclusive, and goal-driven collaborative work, coupled with the needs identified, guided network development to include a diverse group of stakeholders and decision-makers who could facilitate change. The Reaching Out and Being There Rural Health Network Development Planning Program team currently includes 14 different organizations and agencies. Some groups have more than one individual participating to help ensure more equitable and diverse representation. The members were invited to participate largely based on their connection to and targeted work within Page County around the project's focus areas, with an emphasis on gaining involvement from previously under-, or unrepresented, groups. Network members continue to meet individually with potential members to build relationships to ensure the development of a comprehensive network that will effectively address rural health care and related needs in Page County, Va.

Network Partners

Organization	Location	Organization Type
Career Support Services	Luray, VA	Other
James Madison University	Harrisonburg, VA	College/University
Living Legacy	Luray, VA	Nonprofit
Luray Family Medicine	Luray, VA	Rural Health Center

Northwestern Community Services Board	Woodstock, VA	Behavioral Health
Page Alliance for Community Action	Luray, VA	Nonprofit
Page County Department of Social Services	Stanley, VA	Social Services Agency
Page County Public Schools	Luray, VA	School System
Page County Sherriff's Department	Luray, VA	Law Enforcement
Page Free Clinic	Luray, VA	Nonprofit
People Inc.	Woodstock, VA	Community Development Organization
The Health Place/CAPS	Stanley, VA	Behavioral Health
Unite Page VA	Luray, VA	Nonprofit
Valley Health System–Page Memorial Hospital	Luray, VA	Critical Access Hospital
Virginia Department of Health	Winchester, VA (regional office)	Public Health
Virginia Poverty Law Center–Enroll Virginia	Staunton, VA (local representative)	Other

Populations Served

- Children/Adolescents
- Hispanic/Latinx
- Justice-involved
- LGBTQIA+
- Low-income families and individuals
- Older adults

Region Covered

- Page County, VA

Mary Imogene Bassett Hospital

Northern Catskills Aging in Place Continuum of Care

P10RH50527

Primary focus area:
Elder Care

Other focus areas:
Care Coordination
Long-Term Care
Network Organization/Infrastructure Development

Grantee Contact Information

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Program Description

The focus of the Network Planning Grant activities is to form a structured and sustainable continuum of care across the three counties that addresses the needs and challenges of aging in place in a rural community. The network is actively recruiting agencies that address social care needs, such as faith-based organizations, civic and governmental agencies, and community-based agencies that serve older adults. The network is compiling a compendium of all services as part of a greater gap analysis to reduce duplication of services and enhance cross-sector collaboration to sustain a complete continuum of care for older adults.

The network is dedicated to advancing best practices and ensuring a seamless patient experience across the different agencies and counties. The challenges of rural care necessitate the need for deep and meaningful collaboration and bidirectional communication and data sharing. To achieve this, the network is reviewing continuum of care models across the United States for best practices, innovation, and sustainability actions that can be incorporated into the network model.

Network Description

New York has one of the fastest-growing older adult populations in the United States, with rural areas uniquely affected by this trend. Harsh winters, deteriorating housing stock, lack of transportation services, generational poverty, and severe staffing shortages in all sectors have converged to create a health crisis for older adults.

This multifaceted crisis has led to social consequences such as isolation, which is detrimental to safe and healthy aging in place.

The Northern Catskills Aging in Place Continuum of Care comprises six community partners with a long history of collaborating for improved health outcomes. Network partners are aligning to provide the foundation for a vigorous aging-in-place care network that addresses health care and the social determinants of health that will lead to the development of a robust continuum of care network. Network partners include Otsego County Office for the Aging, Schoharie County Office for the Aging, Bassett Healthcare Network, Helios Care, Leatherstocking Collaborative Health Partners, and At Home Care. Efforts to create a more formal and structured network among these partners began in 2022.

The Schoharie County Office for the Aging and Otsego County Office for the Aging provide a myriad of services to older adults and their caregivers in the counties. Helios Care is the only agency in the region to provide hospice care and palliative care services. At Home Care provides in-home nursing and rehabilitation services. Bassett Healthcare Network is the largest health care organization in the three counties. Leatherstocking Collaborative Health Partners is a network focused on health systems management and community health initiatives. These partners serve Otsego, Schoharie, and Delaware counties in New York. All partners have extensive experience providing services to older adults and their families in rural areas.

Network Partners

Organization	Location	Organization Type
At Home Care Inc.	Oneonta, NY	Home Health
Bassett Healthcare Network	Cooperstown, NY	Hospital
Helios Care	Oneonta, NY	Hospice
Leatherstocking Collaborative Health Partners	Oneonta, NY	Collaborative
Otsego County Office for the Aging	Cooperstown, NY	Area Agency on Aging
Schoharie County Office for the Aging	Schoharie, NY	Area Agency on Aging

Populations Served

- Older adults

Region Covered

- Delaware County, NY
- Otsego County, NY
- Schoharie County, NY

MCD Global Health and Maine Seacoast Mission

Virtual Healthcare Bridge

P10RH50528

Primary focus area:
Telehealth

Other focus areas:
Chronic Disease Prevention/Management
Network Organization/Infrastructure Development
Social Determinants of Health

Grantee Contact Information

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Program Description

Along rugged, coastal Maine, unbridged island communities face significant barriers to health care access, including travel time, availability of travel, and other social determinants. The Maine Virtual Healthcare Bridge (VHB) network intends to promote the planning and development of an integrated rural health care network to serve unbridged island communities through telehealth technology. The VHB will focus efforts along the Midcoast and Downeast regions of Maine.

Co-led by the Maine Seacoast Mission (MSM) and MCD Global Health (MCD), the VHB facilitates strategic planning to:

1. Engage coastal health care providers and island communities to develop a comprehensive understanding of local resources, needs, trends, and opportunities through an external environmental scan;
2. Identify opportunities to improve access to health care for islanders through telehealth while considering community needs, existing resources, and operational challenges;
3. Develop a comprehensive assessment to outline a collaborative approach to increasing access to health care for Maine's unbridged island communities;
4. Develop a two-year strategic plan to formalize, mobilize, and sustain the VHB network; and
5. Support health care providers in developing implementation and sustainability plans to serve island communities through the network using telehealth.

Network Description

The VHB is facilitated by MCD and the MSM. The initiative is supported by statewide partners, advisers, and service providers, including three health systems that provide most primary care services to coastal Maine.

VHB network members include Mount Desert Island Hospital, a Critical Access Hospital with three health center locations on Mount Desert Island that provides primary care services to many residents of island communities; MaineHealth, an integrated health system with Pen Bay Medical Center and Waldo County General Hospital serving Midcoast Maine islands, and which operates the largest medical center in Maine; and Northern Light Health, an integrated health system and home to the primary medical center for Downeast Maine. Network partners also include Hospice of Hancock County and Hallowell Family Practice, an independent primary care practice, which shares a long history of supporting the Maine Seacoast Mission and island communities.

MCD is a Maine-based, global public health nonprofit and member of the National Network of Public Health Institutes. It has as its mission to improve the health and well-being of people through enduring, high-quality, cost-effective, and universally accessible public health solutions. MCD serves as the lead applicant for the VHB and has demonstrated success in rural health and telehealth strategic planning and network development, including serving as the HRSA-funded Northeast Telehealth Resource Center.

The MSM is rooted in a history of compassionate service and mutual trust to strengthen Maine's coastal and island communities by promoting and enabling good health, among other community outreach services. Their boat, the Sunbeam, is a mainstay on the islands of Matinicus, Monhegan, Isle au Haut, Frenchboro, Swan's Island, Great Cranberry, and Islesford and offers some services for Vinalhaven, North Haven, Islesboro, and the Casco Bay islands. Without the mission's Island Health Program, island residents make difficult, expensive, and lengthy trips to the mainland for health care services.

Network partners have collaborated and supported each other for many years, but through the Rural Health Planning Grant, an assessment and strategic planning process aims to formalize a telehealth-enabled service delivery network.

Network Partners

Organization	Location	Organization Type
Hallowell Family Practice	Hallowell, ME	Physicians' Clinic
Hospice Volunteers of Hancock County	Ellsworth, ME	Home Health
MaineHealth	Portland, ME	Hospital
Maine Island Eldercare Network	Northeast Harbor, ME	Other
Maine Seacoast Mission	Northeast Harbor, ME	Nonprofit
MCD Global Health	Hallowell, ME	Nonprofit
Mount Desert Island Hospital	Bar Harbor, ME	Critical Access Hospital
Northern Light Health	Brewer, ME	Hospital

Populations Served

- Persons adversely affected by persistent poverty

Region Covered

- Cumberland County, ME
- Hancock County, ME
- Knox County, ME
- Lincoln County, ME
- Waldo County, ME
- Washington County, ME

Missouri Coalition for Primary Health Care

Missouri Rural Health Coalition

P1049208

Primary focus area:
Network Organization/
Infrastructure Development

Other focus areas:
Health Equity
Population Health
Social Determinants of Health

Grantee Contact Information

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Organization Type: Nonprofit
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Program Description

During the Missouri Primary Care Association's (MPCA's) strategic-planning process, leadership from member Federally Qualified Health Centers (FQHCs) identified "establishing a rural health initiatives group" as one of the key areas to address population health, social determinants of health, and health equity. Missouri's rural FQHCs are faced with unique challenges including but not limited to workforce shortages, insufficient broadband access, limited transportation, limited behavioral health services, and ongoing stigmas that health centers are unable to address individually. However, as a network, they can achieve efficiencies working together to improve the quality of basic health care services and associated health outcomes, as well as strengthen the rural health care system.

The main goals of this planning grant will focus on engaging with other rural health care affiliations and entities to enhance efficiencies and capacity by developing a sustainable network for Missouri's rural FQHCs through exploring rural broadband programs, addressing barriers to service, determining workforce and staffing needs, and evaluating population health tools. The network will use social determinants of health data to improve care service delivery, address behavioral risk factors impacting rural areas, address negative stigmas, and improve access to community resources. MRHC recommends using the standardized PRAPARE tool to screen for social determinants of health and using population health data to guide decision-making. Throughout the planning process, the 14 FQHCs will provide input and participate in determining the goals and objectives for the network's movement forward.

Network Description

The Missouri Rural Health Coalition (MRHC) will be a newly formed network of FQHCs comprising the MPCA and 14 FQHCs operating rural clinics throughout the state. The focus will be on providing access to affordable medical, dental, and behavioral health services. These FQHCs operate a total of 159 clinic sites throughout rural areas in Missouri, including 45 medical, 15 dental, 37 medical and dental combined, 16 mobile, and 46 school-based sites. Collectively, these FQHCs serve nearly 300,000 unique patients. The population served are rural residents and include underserved populations who have historically suffered from poorer health outcomes, health disparities, and other inequities such as low socioeconomic status, being uninsured or underinsured, and being minority populations. These FQHCs bring a level of expertise based on their respective communities and have a substantial history of serving underserved and vulnerable populations in rural Missouri. They are committed to working together to develop a sustainable network.

MRHC network members have a proven track record of success. They have collaborated on initiatives to address COVID-19, including testing, vaccination, and treatment. During the COVID-19 pandemic, vaccine hesitancy impacted rural areas in Missouri. Through a collaborative effort, member FQHCs provided educational health messaging and connected residents to vaccines to improve safety and health outcomes of Missourians.

Network Partners

Organization	Location	Organization Type
Access Family Care	Neosho, MO	Federally Qualified Health Center
Central Ozarks Medical Center	Richland, MO	Federally Qualified Health Center
Clarity Healthcare	Hannibal, MO	Federally Qualified Health Center
Community Health Center of Central Missouri	Jefferson City, MO	Federally Qualified Health Center
Compass Health	Wentzville, MO	Federally Qualified Health Center
Great Mines Health Center	Potosi, MO	Federally Qualified Health Center
HCC Network	Lexington, MO	Federally Qualified Health Center
Katy Trail Community Health	Sedalia, MO	Federally Qualified Health Center
Missouri Highlands Health Care	Ellington, MO	Federally Qualified Health Center
Missouri Ozarks Community Health Center	Ava, MO	Federally Qualified Health Center
Northeast Missouri Health Council	Kirksville, MO	Federally Qualified Health Center
Ozarks Community Health Center	Hermitage, MO	Federally Qualified Health Center
Southeast Missouri Health Network	Benton, MO	Federally Qualified Health Center
Southern Missouri Community Health Center	Howell, MO	Federally Qualified Health Center

Populations Served

- Alaska Native
- American Indian
- Children/Adolescents
- Hispanic/Latinx
- Justice-involved
- LGBTQIA+
- Older adults
- Pregnant people

Region Covered

- 69 counties across rural Missouri

Montana Health Research and Education Foundation

Montana Health Equity Network

P10RH49212

Primary focus area:
Health Equity

Other focus areas:
Increase Health System Efficiencies
Network Organization/Infrastructure Development
Social Determinants of Health

Grantee Contact Information

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Program Description

The Montana Health Equity Network will focus on developing a learning collaborative to support hospitals and community organizations in building proficiency in addressing the social determinants of health throughout the spectrum of health and community services. This program area has been selected due to identified gaps in services and education and associated health inequities, and due to an ongoing desire to improve rural and frontier capacity for addressing social determinants of health.

The programs developed by the network will follow quality improvement methods and are based on ZIP code–level data for each network partner. Following an analysis of the data, network partners will convene to collaborate on interventions specific to their community and best practices related to these interventions. This collaborative will be implemented through an online learning platform and monthly educational meetings centered on peer-to-peer communication.

Network Description

The Montana Health Equity Network was founded in 2023 to address inequities in the health care system and develop a learning collaborative centered around best practices for improving health equity in rural and frontier settings. The Montana Health Equity Network seeks to build connections among health care providers

and community-serving organizations to increase access to and the quality of care across settings. The Montana Health Equity Network is a statewide network made up of Montana Health Research and Education Foundation, the Montana Office of Rural Health, Beartooth Billings Clinic, and Frances Mahon Deaconess Hospital. This network includes two Critical Access Hospitals, the state office of rural health, and a leading statewide technical and program support organization. These partners were selected due to their expertise in rural and frontier health care and commitment to advancing health equity. The Montana Health Equity Network continues to expand to other health care facilities and community organizations outside of the health care system.

Network Partners

Organization	Location	Organization Type
Beartooth Billings Clinic	Red Lodge, MT	Critical Access Hospital
Frances Mahon Deaconess Hospital	Glasgow, MT	Critical Access Hospital
Montana Health Research and Education Foundation	Helena, MT	Nonprofit
Montana Office of Rural Health	Bozeman, MT	Other

Populations Served

- American Indian
- Rural/Frontier

Region Covered

- All rural and frontier counties in Montana

Montana Office of Rural Health

Montana Rural Health Clinic Network

P10RH50529

Primary focus area:
Network Organization/ Infrastructure Development

Other focus areas:
Health Equity
Increase Health System Efficiencies

Grantee Contact Information

Grantee Contact: Kailyn Mock
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Program Description

The Montana Rural Health Clinic (RHC) Network will focus on developing collaborative, strategic approaches to strengthening RHC operations and quality in rural Montana. The Montana RHC Network will conduct assessment and planning activities resulting in a network plan to address RHC-prioritized challenges related to financial, operational, and service delivery efficiencies. The Montana RHC Network will develop and implement strategies to ensure its sustainability through stakeholder engagement and network expansion, formal organizational and sustainability policies and procedures, and continual evaluation of network performance.

The most significant gap the Montana RHC Network is addressing is moving sparingly resourced rural and frontier Montana RHCs to a networked community that leverages resources and expertise to create sustainable performance and health outcome improvement. Inclusive and data-driven approaches are utilized to implement strategies and best practices. The Montana RHC Network's outcomes are sustainability of member RHCs, quality of care improvements, and responsiveness to community health needs.

Network Description

The Montana RHC Network started with the initiation of the Practice Operations National Database (POND), a web-based rural health clinic data and analytics system, in 2020. In 2022, Montana RHC Network partners — Montana Office of Rural Health (MORH), Montana Health Research and Education Foundation (MHREF),

and Montana Health Network (MHN) — developed a plan to address efficiencies, sustainability, and technical assistance based on feedback from RHCs and an assessment of RHC needs. MORH/AHEC, MHREF, and MHN began jointly planning a framework for network development and reached out to solicit commitment from RHCs. To date, six RHCs have committed to network leadership roles in collaboration with MORH, MHREF, and MHN. Another 13 RHCs have committed to network participation.

The Montana RHC Network strives to ease RHC challenges to being responsive to community health needs, maintaining operational and financial sustainability, and improving the health of their communities. Each RHC does not have the financial, human, or knowledge capital resources to do it alone. RHCs play critical health and economic roles in Montana's rural and frontier communities. As hospital and clinic closures negatively impact rural communities across the country, the health of Montana's RHCs is essential to serving the state's 55 rural and frontier counties. Stated inclusivity goals include expanding the RHC network board to include a minimum of 10 RHCs and engaging at least 30-31 RHCs (50%) in the RHC Network Council.

Network Partners

Organization	Location	Organization Type
Dahl Memorial Hospital	Ekalaka, MT	Rural Health Center
Fallon Medical Complex	Baker, MT	Other
Logan Health Primary Care Clinic	Whitefish, MT	Rural Health Center
Montana Health Network	Miles City, MT	Nonprofit
Montana Health Research & Education Foundation	Helena, MT	Nonprofit
Montana Office of Rural Health	Bozeman, MT	College/University
Prairie County Hospital	Terry, MT	Rural Health Center
Ravalli Family Medicine	Hamilton, MT	Rural Health Center
Roosevelt Memorial Medical Center	Culbertson, MT	Rural Health Center

Populations Served

- Rural and frontier populations

Region Covered

- All rural and frontier counties (55), Montana

Mosaic Medical Center–Maryville

Rural Northwest Missouri Behavioral Health Consortium

P10RH50530

Primary focus area:
Mental/Behavioral Health

Other focus areas:
Care Coordination
Child Health

Grantee Contact Information

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Program Description

The consortium chose this project based on an assessment of the population, firsthand experience, and data that demonstrates a need to address pediatric mental health in rural northwest Missouri. The purpose of this project is to conduct planning activities that will achieve efficiencies across mental health and non–mental health network partners. The goals are to create an infrastructure for optimizing resource usage and to create a regional behavioral health network strategic plan to address pediatric mental health. The consortium's focus area is care coordination. Research and experience in other areas of health care demonstrate care coordination as a best practice for improved access to care, increased efficiency, and improved communication.
Planning activities will include:

- Creating agreements, establishing guiding principles, and building social capital within and between network partners;
- Conducting outreach to organizations most likely to encounter young people with mental health indicators to prepare those organizations to receive and respond to the needs assessment;
- Creating an inventory of existing mental health services;
- Conducting a comprehensive pediatric mental health needs assessment across six counties in northwest Missouri to determine service, geographic, or age gaps;

- Identifying and developing a plan to address gaps in the workforce pipeline to provide these services; and
- Coordinating services within and outside the network.

Network Description

The Rural Northwest Missouri Behavioral Health Consortium identified the growing pediatric mental health crisis in rural northwest Missouri as its focus. The primary partners in this network consist of two hospitals in the target area (Mosaic Medical Center–Maryville and Mosaic Medical Center–Albany); Family Guidance Center, the only Certified Community Behavioral Health Center in the community; Northwest Missouri State University, a regional public university that provides a broad array of wellness services to college students, including peer and professional counseling; and New Beginnings Counseling Group, which provides behavioral health services for youth 12 and older. Network members were selected based on their geographic location and coverage area, the services that they provide, their credentials and accreditation to provide such services, experience and knowledge of working with the target population, and ability to engage community partners.

The network is in the formative phase of its development and has been meeting informally for over a year. However, members have collaborated previously on various initiatives. For example, some network partners provide qualified mental health providers to local schools within the target area and provide mental health coverage in the local emergency rooms. Mosaic Medical Center–Maryville, Family Guidance Center, and Northwest Missouri State University collaborate to provide wellness services to students at the university. Additionally, all network partners work closely with the 4th Judicial Circuit Court to provide services and resources to those individuals with mental health diagnoses to minimize incarceration when appropriate.

Network Partners

Organization	Location	Organization Type
Family Guidance Center	St. Joseph, MO	Behavioral Health
Mosaic Medical Center–Maryville	Maryville, MO	Hospital
Mosaic Medical Center–Albany	Albany, MO	Critical Access Hospital
New Beginnings Counseling Center	Maryville, MO	Behavioral Health
Northwest Missouri State University	Maryville, MO	College/University

Populations Served

- Children/Adolescents

Region Covered

- Andrew County, MO
- Atchison County, MO
- Gentry County, MO
- Holt County, MO
- Nodaway County, MO
- Worth County, MO

North Carolina Community Health Center Association

Northwest North Carolina Rural Health Network

P10RH49213

Primary focus area:
Network Organization/ Infrastructure Development

Other focus areas:
Mental/Behavioral Health

Grantee Contact Information

Grantee Contact: Justin Oyler
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Program Description

Increasing access to behavioral health services is crucial to supporting the identified needs and gaps in care within rural northwest North Carolina. The Federally Qualified Health Centers (FQHCs) in the region have limited capacity to provide care to all the behavioral health patients seeking services. Even more so, their behavioral health approach is short-term and unable to meet the demand nor the medical necessity for patients who need access to specialized, long-term clinical therapies. CareNet has a regional presence and has the capacity and expertise in providing specialty mental health care for a broad range of ages, mental health illnesses, and evidence-based interventions. CareNet can accept direct referrals from the FQHC partners as part of an effort to improve coordination of care for patients who require support to navigate a complex health system, while engaging patients in a way that facilitates change and provides support when the patient is ready and willing, with “no wrong door” to access behavioral health treatment.

There is no current formal partnership, contractual or otherwise, between any of the network partner organizations. As such, this planning and development grant will focus on establishing a governing board. The board will include community members and persons with lived experience who will help steer the direction of the rural health network in their respective communities. The network will also focus on developing formal pathways (e.g., contracts, memoranda of understanding) between the entities, including identifying a referral management software system that will be the centralized hub of information for all network partners. Finally, part of this planning grant approach is for the governing board to strategize on a model of sustainability

beyond the grant period that includes alternative funding sources as well as expansion of service area/region, partner organizations, and so on.

Network Description

This rural health network has no previous history as a formal consortium, but partners are independent practices that have had incidental patient encounters and referrals to and from one another. This Rural Health Network Development Planning Program grant is the first time all partners will come together to mutually serve one another with shared patients. The initial work to convene potential partners and information on localities begun in January 2022. The North Carolina Community Health Center Association (NCCHCA) held a series of conversations to determine the best approach and strategy for success. To date, the accomplishments shared as a consortium have been six meetings with the network partners to plan a response to the notice of award, the finalized project narrative, feedback on necessary changes, and group confirmation/buy-in on geography and service intent.

As the northwest region of North Carolina is the identified target of serving the rural patient population with behavioral health support, four primary network partners located in that region emerged as the best and most reasonable pilot sites for this planning grant. NCCHCA is the federally designated Primary Care Association for North Carolina and serves as the state association representing 43 community health centers that serve underserved and uninsured patients at more than 400 service sites. NCCHCA supports network collaboration and encourages community health centers to participate in collaborative activities with other primary care safety net providers named in state statutes. CareNet Counseling has been providing behavioral health counseling for all ages across North Carolina for 50 years. CareNet's expertise, compassion, and delivery of spiritually integrated care has resulted in serving clients in more than 80 North Carolina counties, including the four counties identified in this planning grant service area of northwest North Carolina. AppHealthCare is a fully accredited district health department serving Alleghany, Ashe, and Watauga counties and a FQHC serving Alleghany and Ashe counties. High Country Community Health is a community health center providing quality care to patients from birth to age 18. Services at the clinic are being expanded to include health and social services for adults. The clinic is part of the High Country Community Health network, which provides health care services in Avery, Burke, Surry, and Watauga counties and has entered into a memorandum of understanding with AppHealthCare for maternal health services.

Network Partners

Organization	Location	Organization Type
AppHealthCare	Sparta, NC	Federally Qualified Health Center
CareNet Counseling Northwest Region	North Wilkesboro, NC	Behavioral Health Provider
High Country Community Health	Elkin, NC	Federally Qualified Health Center
North Carolina Community Health Center Association	Raleigh, NC	Primary Care Association

Populations Served

- General population

Region Covered

- Alleghany County, NC
- Ashe County, NC
- Surry County, NC
- Wilkes County, NC

Northwest Hospital Alliance

Northwest Hospital Alliance North Idaho Connections Network

P10RH49214

Primary focus area:
Social Determinants of Health

Other focus areas:
Care Coordination

Grantee Contact Information

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Program Description

The Northwest Hospital Alliance-North Idaho Connections (NWHA-NIC) partners are planning to expand NIC from Kootenai County to the rural communities of Benewah, Bonner, Boundary, Clearwater, Latah, Lewis, Idaho, Nez Perce, and Shoshone counties to expand access to and improve the quality of health care and social service resources throughout rural northern Idaho. NIC is a robust social service database on the Findhelp platform that houses detailed information to connect patients and the public to health care and social services that improve social determinants of health.

Residents in the target area transition between their rural Critical Access Hospital or clinic to the regional medical center at Kootenai Health in Kootenai County for a higher level of care than their community hospital can provide. Once discharged, it is important for all health partners and social service organizations in the region to have access to and use the closed-loop referral system. This allows health care providers and staff to refer patients directly to organizations that can provide needed resources related to social determinants of health to help in their care management. NIC also hosts a public-facing site for community members to search for services they need.

Network Description

The NWHA-NIC Network is a new network under the umbrella of Northwest Hospital Alliance Inc. and formed

to provide a structure for the hospitals in the panhandle of Idaho to collaborate in providing a cooperative regional approach to the delivery of rural health care. NWHA began serving the five northern counties of Idaho in 1991. In 2019, NWHA expanded the service area to include the 10 northern counties of Idaho.

In addition to the hospital members of the NWHA, joining the new NWHA-NIC Network are Panhandle Health District — the public health agency for the five northern counties of Idaho, and Heritage Health, a Federally Qualified Health Center providing rural health care services in two of the region's rural counties. Both of these organizations are aligned with the goal of providing patients with wraparound care via the North Idaho Connections (NIC) closed-loop referral system. Rural communities will also have representation from participating discharge planners from NWHA-NIC Network member hospitals, who will act as project "champions" to promote NIC. The network plans to establish a steering committee comprising community-based organizations, hospital leaders, community leaders, and project champions to discuss training, marketing plans, database usage, service access trends, and long-term usage strategies. All NWHA-NIC Network members are well connected with social service agencies in the communities they serve and the primary population North Idaho Connections serves.

Network Partners

Organization	Location	Organization Type
Benewah Community Hospital	St. Maries, ID	Hospital
Bonner General Health	Sandpoint, ID	Hospital
Boundary Community Hospital	Bonners Ferry, ID	Hospital
Clearwater Valley Health	Orofino, ID	Hospital
Heritage Health	Coeur d'Alene, ID	Federally Qualified Health Center
Kootenai Health	Coeur d'Alene, ID	Hospital
Panhandle Health District	Hayden, ID	Public Health
Shoshone Medical Center	Kellogg, ID	Hospital
St. Mary's Health	Cottonwood, ID	Hospital
Syringa Hospital and Clinics	Grangeville, ID	Hospital

Populations Served

- General population

Region Covered

- Benewah County, ID
- Bonner County, ID
- Boundary County, ID
- Clearwater County, ID
- Idaho County, ID
- Kootenai County, ID
- Latah County, ID
- Lewis County, ID
- Nez Perce County, ID
- Shoshone County, ID

Pike County Memorial Hospital

Pike County Health Improvement Network

P10RH49215

Primary focus area:
Network Organization/ Infrastructure Development

Other focus areas:
Substance Abuse Prevention and/or Treatment

Grantee Contact Information

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Program Description

The evidence-based Readiness and Emergency Management for Schools (REMS) and the related *Guide for Developing High-Quality Emergency Operations Plans* will be utilized in developing the Pike County Schools Emergency Operations Plan. The five missions of the REMS guide include prevention, protection, mitigation, response, and recovery, all of which will be covered in the emergency operations plan. Proposed activities include:

- Forming a planning committee consisting of representatives from all network partners.
- Identifying threats and hazards to the school community using a variety of assessment tools.
- Developing goals and objectives and action plans to achieve best outcomes for before (prevention), during (protection and mitigation), and after (response and recovery) substance use disorder/opioid use disorder incidents.
- Training school and hospital staff.

Network Description

Members of the Pike County Health Improvement Network include Pike County Memorial Hospital (Critical Access Hospital), Louisiana RII School District (K–12), Bowling Green RI School District (K–12), Pike County RII School District–Clopton Schools (K–12), and BONCL School (K–8). All members are located in Pike County, an

HRSA-designated rural area. Network partners have signed a letter of commitment indicating their willingness to integrate functions, to the degree possible, and to share clinical and administrative resources.

The Pike County Health Improvement Network is an outgrowth of Health Resources and Services Administration Rural Communities Opioid Resource Program Planning grant awarded in 2019 that examined opioid use disorder in Pike County. With this Rural Health Network Development Planning grant, the network will delve further into substance use disorder/opioid use disorder issues within the identified schools with the goal of developing an emergency operations plan for all schools in Pike County.

Network Partners

Organization	Location	Organization Type
BONCL School District	Louisiana, MO	School System
Bowling Green RI School District	Bowling Green, MO	School System
Clopton RIII School District	Clarksville, MO	School System
Louisiana RII School District	Louisiana, MO	School System
Pike County Memorial Hospital	Louisiana, MO	Hospital

Populations Served

- Children/Adolescents

Region Covered

- Pike County, MO

Rural Health Development

Eastern Montana Regional
Behavioral Health Network

P10RH49215

Primary focus area:
Mental/Behavioral Health

Other focus areas:
Substance Abuse Prevention and/or Treatment

Grantee Contact Information

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Program Description

Grant funds will be used to achieve efficiencies for delivering behavioral health services by developing a regional behavioral health vision and strategic plan to streamline identification of and referral for regional behavioral health services. The primary goal will be to standardize the identification and referral process in partnership with the Integrated behavioral health grant, which is designed to lessen the frequency of "crisis" scenarios, which were identified as a major concern by health care, mental health and substance use organizations, and law enforcement during a strategic planning conference in 2017. The network will begin planning activities by reviewing the 2017 strategic plan and its progress. In collaboration with regional stakeholders, the strategic plan will be updated with new information and recommendations. The network will also continue to advance activities to integrate behavioral health with primary care.

Network Description

The Eastern Montana Regional Behavioral Health Network will work in conjunction with the Montana Health Network's current Montana Healthcare Foundation grant to streamline identification of and referral for behavioral health services and integrate behavioral health with primary care in Fallon, Sheridan, Custer, Dawson, and Richland counties. Due to the nature of the region, planning activities will most likely benefit all communities and patients in the region. Network members include Fallon Medical Complex, Sheridan Memorial Hospital, Holy Rosary Healthcare, Glendive Medical Center, and Sidney Health Center. These facilities

operate Critical Access Hospitals and rural health clinics in the region. Additionally, the network will engage with partners to include behavioral health and community-based organizations, local governments, and law enforcement.

Network Partners

Organization	Location	Organization Type
Fallon Medical Complex	Baker, MT	Critical Access Hospital
Glendive Medical Center	Glendive, MT	Critical Access Hospital
Holy Rosary Healthcare	Miles City, MT	Critical Access Hospital
Rural Health Development	Miles City, MT	Nonprofit
Sheridan Memorial Hospital Association	Plentywood, MT	Critical Access Hospital
Sidney Health Center	Sidney, MT	Critical Access Hospital

Populations Served

- American Indian
- Children/Adolescents
- Justice-involved
- Older adults

Region Covered

- Custer, MT
- Dawson, MT
- Fallon, MT
- Richland, MT
- Sheridan, MT

Share Health Southeast Georgia

Women's Wellness Network

P10RH49219

Primary focus area:
Chronic Disease Prevention/ Management

Other focus areas:
Cancer Care
Social Determinants of Health
Wellness

Grantee Contact Information

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Program Description

The programmatic focus of the Women's Wellness Network (WWN) includes prevention, wellness, and primary care services for women in Evans and Tattnall counties. Specifically, the network's focus areas are chronic disease prevention and management, cancer care, social determinants of health, and wellness. In addition to addressing the health care shortages and barriers that women face in accessing preventive, wellness, and primary care services, the network will examine the impact of social determinants of health (poverty, rurality, and race/ethnicity) on chronic health conditions. The network selected these program areas because women's wellness is a need that, prior to this grant, was not being met.

During the planning year, the network will accomplish the following activities: (1) participate in a data boot camp to better understand and interpret existing women's health data and the structural and systemic barriers to obtaining access to quality health care and supportive services that women in Evans and Tattnall counties face; (2) conduct four community-engagement activities, two in each county, to solicit community input into needs, barriers, and challenges related to accessing preventive and wellness services; (3) develop a strategic

plan to identify strategies and activities to build capacity to address gaps in health services, such as improved access to breast cancer screenings and access to basic healthy lifestyle needs such as nutritious food and convenient, safe, and affordable physical activity; (4) identify evidence-based and promising practices that may be replicated in the target area, and engage and build capacity of new community partners; and (5) develop a sustainability plan to assist partners in identifying potential sources of revenue, including cost-sharing, maximizing reimbursement, grants, and other funding sources moving forward.

Network Description

The purpose of the WWN is to improve health outcomes for underserved women in Evans and Tattnall counties in rural southeast Georgia by engaging community stakeholders to develop and implement strategies and activities that improve access to women's health and prevention resources and services. WWN has a primary focus on chronic disease prevention and management (e.g., breast and cervical cancer, diabetes, and hypertension). These conditions were the leading causes of morbidity and mortality in both counties from 2017 to 2021.

WWN blends the expertise of several community agencies and the general community to change the way care is delivered to women in Evans and Tattnall counties. Network partners have collaborated in various capacities throughout the years, both formally and informally. WWN is vital for enhancing the capacity of the partners to build a comprehensive approach to delivering preventive, wellness, and primary care services, as resources are extremely limited in these two rural counties.

These 10 network partners represent nonprofits, government agencies, public health, Federally Qualified Health Centers, hospitals, and collaboratives. Each organization brings its unique knowledge, familiarity with the target population, service to these communities, and individual practice to the network. Each network partner will become more efficient by having this formalized process of collaboration. Thus, the unmet needs of women in Evans and Tattnall counties will be addressed by bringing together community stakeholders and developing tailored solutions.

Network Partners

Organization	Location	Organization Type
Evans County Community Center	Claxton, GA	Nonprofit
Evans County Family Connection	Claxton, GA	Collaborative
Evans County Health Department	Claxton, GA	Public Health
East Georgia Healthcare Center	Swainsboro, GA	Federally Qualified Health Center
Evans Memorial Hospital	Claxton, GA	Hospital
Good Health Ministries	Claxton, GA	Nonprofit
Southeast Georgia Communities Project	Lyons, GA	Nonprofit
Tattnall County Health Department	Glennville and Reidsville, GA	Public Health
UGA Extension–Evans County	Claxton, GA	Government

Populations Served

- Hispanic/Latinx
- Women

Region Covered

- Evans County, GA
- Tattnall County, GA

South Dakota

South Dakota Healthcare Association Healthcare Research, Education and Trust

South Dakota Coalition for the Advancement of Serious Illness Care

P10RH50532

Primary focus area:
Palliative Care and Hospice

Other focus areas:
Care Coordination
Increase Health System Efficiencies
Network Organization/Infrastructure Development

Grantee Contact Information

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Program Description

The programmatic focus of the Network Planning Grant is to assess the feasibility of developing a statewide network for the coordination and advancement of palliative care and hospice services in South Dakota. South Dakota is one of the few states that does not have a hospice and palliative care network, leading to inefficiencies and duplication of services with multiple entities working on support and education with no coordination. A network of health care and non–health care entities can collaborate on a unified strategic approach to delivering palliative care and hospice to the residents of South Dakota, inform and influence policy needed to deliver care, and coordinate and conduct education to professionals providing this care.

The approach to implementing the program will be developed in collaboration with network members through a strategic planning meeting and ongoing work identified at the planning meeting. It is in this strategic planning work that the network will support the three legislative aims: improving efficiencies by forming a network that identifies the current and future activities for hospice and palliative care across the state; identifying areas in need of hospice and palliative care and prioritizing ways to help these areas gain access to this care; and solidifying cross-organizational collaboration and leadership commitment to this plan. This will also improve efficiency by eliminating duplication of activities and prioritizing focus areas. Health care professionals' time will be better managed because of this collaboration.

Network Description

The network is newly formed for the purpose of this grant. It is composed of eight members, which includes the lead applicant, South Dakota Association of Healthcare Organizations Healthcare, Research, Education and Trust. The network members include a Critical Access Hospital, a hospice agency, two higher education universities, a nursing home, the South Dakota Department of Health, and a large tertiary hospital. The network members were identified based on past working relationships and their passion and commitment to improving palliative and hospice care throughout South Dakota. Many of the network members have been a part of previous grant work, and most of them are members of LifeCircle, an interdisciplinary and interinstitutional representation of people, organizations, and institutions in South Dakota whose purpose is to improve care at the end of life.

Each of the network members brings a unique perspective of palliative care and hospice services in the state. By having a variety of health care and non–health care organizations involved in this work, shared challenges are identified, as are the unique circumstances specific to their communities. The area being served is the state of South Dakota, with a focus on rural, underserved areas.

Network Partners

Organization	Location	Organization Type
Medicine Wheel Village	Eagle Butte, SD	Skilled Nursing Facility
Mobridge Regional Health and Clinic	Mobridge, SD	Critical Access Hospital
Monument Plus Home Health & Hospice	Spearfish, SD	Hospice
Sanford Health	Sioux Falls, SD	Hospital
South Dakota Association of Healthcare OrganizationsHealthcare Research Education and Trust	Sioux Falls, SD	Nonprofit
South Dakota Department of Health-Cancer Coalition	Pierre, SD	Government
South Dakota State University College of Nursing	Brookings, SD	College/University
University of South Dakota School of Health Science	Vermillion, SD	College/University

Populations Served

- Seriously ill individuals

Region Covered

- 64 rural counties in South Dakota

St. Joseph Hospital

Surgical Telehealth Planning and Facilitation Network

P10RH49217

Primary focus area:
Telehealth

Other focus areas:
Increase Health System Efficiencies
Network Organization/Infrastructure Development

Grantee Contact Information

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Program Description

The goal of the program is to develop a facilitated telehealth hub-and-spoke model available and readily adoptable in rural health care settings. Over the one-year period, network steering committee members will convene at least quarterly and meet with the project director at least monthly to strategically plan and create a turn-key model for adoption and implementation. The network will develop a memorandum of agreement (the legal structure for future service and delivery of surgical telehealth) and create policies and procedures to address the internal processes at the hospital, a second set of policies and procedures for the originating rural health centers, and a plan for implementation, dissemination, and expansion of the hub-and-spoke model.

In this process, a training course for telehealth facilitators will be developed, certified, and offered for enrollment at the local community college. The idea is that the adoption of these telehealth visits will be increased if they have facilitators trained and certified at the originating rural sites. The grant will afford the network partners the time to meet in the environment of workforce shortages and focus on an unmet need of the communities the network serves — timely access to surgical services.

Network Description

The Surgical Telehealth Planning and Facilitation Network comprises St. Joseph Hospital and four Federally Qualified Health Centers (FQHCs) in four rural counties. Two of the four FQHCs are in Washington County, Maine, and one is in Somerset County. The proposed network will operate in Penobscot (hub), Washington, Somerset, and Knox counties (spokes) initially but may extend to other health centers in counties in Northern, Downeast, and Central Maine over time. The hospital and the four FQHCs are members of the Community Care Partnership of Maine (CCPM), an accountable care organization. They were selected based on their rural geography and participation in other endeavors with CCPM or St. Joseph Hospital. Eastern Maine Community College was selected as a network member for its role in the community as an affordable option to gain workforce-relevant education. The college plays a key role in the network's strategy to develop a process for training and credentialing originating rural site telehealth facilitators.

Network Partners

Organization	Location	Organization Type
Eastern Maine Community College	Bangor, ME	College/University
Harrington Family Health Center	Harrington, ME	Federally Qualified Health Center
Island Community Medical Services	Vinalhaven Island, ME	Federally Qualified Health Center
Jackman Community Health Center	Jackman, ME	Federally Qualified Health Center
St. Croix Regional Family Health Center	St. Croix, ME	Federally Qualified Health Center
St. Joseph Hospital	Bangor, ME	Hospital

Populations Served

- General population

Region Covered

- Knox County, ME
- Penobscot County, ME
- Somerset County, ME
- Washington County, ME

St. Louis County

Better Together Behavioral Health Network

P10RH49218

Primary focus area:
Network Organization/ Infrastructure Development

Other focus areas:
Mental/Behavioral Health Substance Abuse Prevention and/or Treatment

Grantee Contact Information

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Program Description

The network will focus on behavioral health, which is defined as the promotion of mental health, prevention of substance use, and provision of access to treatment and recovery resources to support individuals and their families affected by mental health or substance use and to increase resilience and well-being. Through this project, a formal network will be developed to increase collaboration in northern St. Louis County while creating a plan to address gaps in the behavioral health care continuum. The large geographic span of northern St. Louis County and its high levels of behavioral health needs are a significant influence in building a behavioral health network. The membership will work to reduce silos and improve wraparound care for county residents.

Strategies to accomplish the network's goals include rural community networks, the Collective Impact Model, integration of behavioral health and primary care, community-based participatory evaluation strategies, and the Centers for Disease Control and Prevention's CORE Health Equity Strategy

Network Description

The Better Together Behavioral Health Network is tasked with supporting the development of the Mesabi Behavioral Health Network, which was formed in 2020. The Mesabi Behavioral Health Network members have met collectively through other venues since 2010. Network members created the Mesabi Behavioral Health Network with the goal of building a more formalized and action-oriented network. Since the inception of the Mesabi Behavioral Health Network, bylaws, workgroups, a formal decision-making model, and a strategic plan have all been adopted by the network. The Better Together Behavioral Health Network is focused on promoting the health and well-being of northern St. Louis County through improving behavioral health services and support for individuals of all ages.

Members of the Better Together Behavioral Health Network provide services across northern St. Louis County, which has a span of approximately 5,000 square miles and a population of 69,556 people. The partners for the network represent the various aspects of behavioral health service delivery, including a nonprofit agency, government agency, community behavioral health center, federally qualified health center, and a health care facility. The network members serve all communities in northern St. Louis County with a focus on behavioral health.

Network Partners

Organization	Location	Organization Type
Essentia Institute of Rural Health	Duluth, MN	Other, Hospital System
Northeast Service Cooperative	Mountain Iron, MN	School System
Range Mental Health Center	Virginia, MN	Behavioral Health
Scenic Rivers Health Services	Cook, MN	Rural Health Center
St. Louis County	Virginia, MN	Government

Populations Served

- American Indian

Region Covered

- North St. Louis County, MN

Tennessee Tech University

PRIDE project

P10RH49220

Primary focus area:
Health Equity

Other focus areas:
Network Organization/ Infrastructure Development
Social Determinants of Health

Grantee Contact Information

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Program Description

The focus of the PRIDE project network planning committee is to expand access to, coordinate, and improve the quality of rural sexual and mental health care services and associated health outcomes for people who are disadvantaged due to socioeconomic factors, minority status, or their LGBTQIA+ identification. The priority of the collaboration is to create a sustainable network of health care providers and staff to meet the needs of the community in a team-based delivery model. The Rural Health Equity Toolkit from the Rural Health Information Hub will provide best practice guidelines for the establishment and expansion of the PRIDE project network. The Health Equity Promotion Model through the lens of LGBTQIA+ health disparities will also guide the collaborative efforts.

The main goals of the planning network are to:

- Expand capacity of the local health care system
- Collaborate on health care access to achieve efficiencies
- Create a sustainable framework
- Conduct cultural competency education within the community
- Complete a needs assessment from the target population

Network Description

The network for the PRIDE project has come together to collaborate to improve health care outcomes for the rural community within Central Appalachia in Tennessee. The network intends to serve a population that is disadvantaged due to socioeconomic determinants, ethnicity, religious affiliation, or sexual orientation. Specifically, the network noted a lack of access to health care, including sexual and mental health services, for members of the LGBTQIA+ community within the Tennessee Tech University Campus and 14 surrounding counties. There is also no data collection on sexual orientation and gender identity at the university that would support efforts to decenter cisgender normativity.

The network is composed of four distinct partners, and each brings a different perspective and resources to the collaboration. J.J. Oakley Campus Health Services at Tennessee Tech University provides primary and acute health care to university faculty, staff, and students. The Whitson-Hester School of Nursing within Tennessee Tech University has two nursing educators and two health care providers experienced in delivering care to underserved populations in the community. Hope Springs Clinic is an urgent care mental health nonprofit provider experienced with crisis management within the rural community. Nashville Launchpad is a nonprofit experienced with providing services and safe spaces to the young homeless LGBTQIA+ community while providing invaluable lived experience.

Network Partners

Organization	Location	Organization Type
Hope Springs Clinic	Cookeville, TN	Behavioral Health
J.J. Oakley Campus Health Services	Cookeville, TN	Rural Health Center
Nashville Launchpad	Nashville, TN	Nonprofit
Whitson-Hester School of Nursing	Cookeville, TN	College/University

Populations Served

- LGBTQIA+
- People of color

Region Covered

- Cannon County, TN
- Clay County, TN
- Cumberland County, TN
- DeKalb County, TN
- Fentress County, TN
- Jackson County, TN
- Macon County, TN
- Overton County, TN
- Pickett County, TN
- Putnam County, TN
- Smith County, TN
- Van Buren County, TN
- Warren County, TN
- White County, TN

Third Street Family Health Services

Crawford County Rural Health Network

P10RH50533

Primary focus area:
Network Organization/
Infrastructure Development

Other focus areas:
Care Coordination

Grantee Contact Information

Grantee Contact: Peggy Anderson
Contact Title: President and CEO
Organization: Third Street Community Clinic (Third Street Family Health Services)
Organization Type: Federally Qualified Health Center
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Website: www.Thirdstreetfamily.org

Program Description

The Crawford County Rural Health Network's focus area is network organization and infrastructure development. The network is in the very early stages of development and needs a network director who can guide the process and build the capacity of network partners for the next steps of the project — creating and assisting partners in implementing the plan of action for the coming year. Once the network's infrastructure is developed, the goal is to address care coordination between all partners. The partners are committed to working together to build a high-quality, locally owned health care system that is accessible, affordable, and effective for its rural residents.

Network Description

The Crawford County Rural Health Network is in the infancy phase of its development with discussions that started a year ago. Although the partners have worked together on many projects over the years, they began conversations to formalize a network with the planning grant opportunity. The network comprises Third Street Family Health Services (Federally Qualified Health Center), Avita Health System (hospital), Community Counseling & Wellness Centers (behavioral health), Crawford County Public Health (public health), and Crawford-Marion Alcohol, Drug Addiction, and Mental Health Board (behavioral health). The network's purpose is to address gaps in care in the county, concentrate on current needs assessment activities, and combine efforts for care coordination and collaboration. The primary accomplishment to date is the convening

of the partners that are excited to be part of the planning activities to build the network.

The network is administratively led by Third Street Family Health Services. Network partners were selected because they serve patients across the health care continuum and collectively bring the expertise needed to address community health care needs. Strong prevention and public health work strengthens the foundation for any community, and as behavioral health needs continue to grow, Community Counseling & Wellness Centers and Crawford-Marion Alcohol, Drug Addiction, and Mental Health Board are crucial to the success of the network. Additionally, Third Street Family Health Services and Avita Health System cover the range of services from primary care to inpatient, specialty, and emergency care. The range of services and reach of the partner organizations collectively covers the highest-need areas in the community.

Network Partners

Organization	Location	Organization Type
Avita Health System	Ontario, OH	Hospital
Community Counseling & Wellness Centers (now formally merged with Third Street Family Health Services)	Bucyrus, OH	Behavioral Health
Crawford County Public Health	Bucyrus, OH	Public Health
Crawford-Marion Alcohol, Drug Addiction, and Mental Health Board	Bucyrus, OH	Behavioral Health
Third Street Family Health Services	Mansfield, OH	Federally Qualified Health Center

Region Covered

- Crawford, Ohio

Tillamook County Community Health Centers

Tillamook County Healthcare Network

P10RH49206

Primary focus area:
Network Organization/
Infrastructure Development

Other focus areas:
Chronic Disease Prevention/Management
Health Equity
Social Determinants of Health

Grantee Contact Information

Grantee Contact: Shelby Porter
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Organization: Tillamook County Community Health Center
Organization Type: Public health department
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Website: www.tillamookchc.org

Program Description

The Tillamook County Healthcare Network has identified a collective impact model as best practice for leveraging resources to create change. In addition, program elements include utilizing a closed-loop referral system and the integration of community health workers to increase health care delivery. These program elements will provide a structure and needed tools to meet program and network priorities.

The programmatic focus of the Rural Health Network Development Planning Program grant activities include:

- Creating a shared action plan and agreements (e.g., business associate agreements, data sharing).
- Conducting three community action sessions to identify needs and priorities.
- Creating a shared data-tracking and monitoring system to increase understanding of population health inequities and poor health outcomes.
- Developing a community health worker framework (training, workforce development, workflow, policy and procedure, supervision, etc.).
- Implementing a shared system of closed-loop referral (UniteUs or Connect Oregon Network) to address social determinants of health.

Network Description

Health care partners in Tillamook County, Ore., have had similar goals to improve health access and remove barriers to care for multiple years. Limited resources and capacity, and siloed processes, have prevented health care partners from collaborating in a unified network until now. The Tillamook County Healthcare Network, a new collaborative, will leverage resources to engage and convene health care partners, key stakeholders, and the target population to identify and address barriers to accessing care to reduce health disparities and improve health outcomes. This project will identify training, outreach, health promotion, data collection, logistical challenges, and resources to implement project priorities.

Network partners comprise of all major health care organizations in Tillamook County, Ore., such as Adventist Health Tillamook, Tillamook County Community Health Centers, Nehalem Bay Health Center, and Tillamook Family Counseling Center. Additionally, the network includes agencies that have a key role in health systems and efficiency, such as Columbia Pacific Coordinated Care Organization and Oregon Health & Science University.

Network Partners

Organization	Location	Organization Type
Oregon Health & Science University	Portland, OR	College/University
Adventist Health Tillamook	Tillamook, OR	Critical Access Hospital
Tillamook Family Counseling Center	Tillamook, OR	Behavioral Health
Nehalem Bay Health Center	Wheeler, OR	Federally Qualified Health Center
Columbia Pacific Coordinated Care Organization	Portland, OR	Medicaid Managed Care Organization
Tillamook County Community Health Centers	Portland, OR	Federally Qualified Health Center

Populations Served

- Children/Adolescents
- Hispanic/Latinx
- Individuals experiencing housing insecurity
- LGBTQIA+
- Older adults

Region Covered

- Tillamook, OR

Tri-Area Community Health

Carroll County/Grayson County/Galax City Health Network

P10RH50534

Primary focus area:
Network Organization/ Infrastructure Development

Other focus areas:
Care Coordination
Health Equity
Social Determinants of Health

Grantee Contact Information

Grantee Contact: Howard Chapman Jr.
Contact Title: Project Director
Organization: Tri-Area Community Health
Organization Type: Federally Qualified Health Center
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Program Description

The programmatic focus of the Network Planning Grant activities is on coordination of care and referral management. The community partners are working at capacity with their limited resources to meet the needs of the people they serve. The staff funded through the HRSA Network Planning Grant will help develop systems of care among the network providers that focus on helping people find a medical home and tracking the person and their progress toward getting the care and services they need. Collaborating and coordinating care will save resources and minimize duplication of efforts, thereby increasing efficiency and effectiveness of all the partners.

The network's efforts will be implemented through utilizing needs assessment data, focusing on accessibility and affordability of broadband, and data sharing among partners. Other organizations and individuals in the service area will be approached to join the network and serve as advisory board members.

Network Description

The network was formed in January 2023 in anticipation of applying for the HRSA Rural Health Network Development Planning Grant. The community partners have a history of collaborating on the referral and treatment of low-income patients and wanted to move to a more formal arrangement in the coordination

of care. They also wanted to seek a more permanent solution to address the barriers to care in the rural, mountainous area of Southwest Virginia.

The network consists of four community partners: Tri-Area Community Health (community health center), Mount Rogers Health District (regional office of the Virginia Department of Health), Mount Rogers Community Services (state-based behavioral health service organization), and Ohlen R. Wilson Health Center (formerly the Free Clinic of Twin Counties). The network will collaborate in the coordination of care to maximize opportunities for access, especially for those in need of affordable care. There is a shortage of primary care, behavioral health, and dental care providers in Carroll County, Grayson County, and the city of Galax. Collaborating to coordinate care and help people find a "health home" will allow the network members to help improve the health outcomes and quality of life for the people served. The network will attempt to secure permanent and sustainable funding to support these efforts as they work to build an improved system of care through this HRSA Network Planning Grant. The project director will work to strengthen the network and expand to other community partners and programs that serve low-income individuals and families, and uninsured and underinsured individuals and families.

Network Partners

Organization	Location	Organization Type
Tri-Area Community Health	Laurel Fork, VA	Federally Qualified Health Center
Mount Rogers Health Department	Marion, VA	Public Health
Mount Rogers Community Services	Wytheville, VA	Behavioral Health
Ohlen R. Wilson Health Center (formerly Free Clinic of the Twin Counties)	Galax, VA	Other/Free Clinic

Populations Served

- Children/Adolescents
- Hispanic/Latinx
- Individuals experiencing housing insecurity
- Older adults

Region Covered

- Carroll County, VA
- City of Galax, VA
- Grayson County, VA

Trivium Life Services

Southwestern Iowa Mental and Behavioral Health Network

P10RH50535

Primary focus area:
Mental/Behavioral Health

Other focus areas:
Care Coordination
Social Determinants of Health

Grantee Contact Information

Grantee Contact: Drew Holliday
Contact Title: Grants Manager/Project Director
Organization: Trivium Life Services
Organization Type: Behavioral Health Provider — Nonprofit Organization
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Website: www.triviumlifeservices.org

Program Description

As a newly established network, the Southwestern Iowa Mental and Behavioral Health Network will develop its programmatic focus by examining existing service gaps for mental and behavioral health care in Page and Montgomery counties through the development of community needs assessments and environmental scans. These tools, coupled with the creation of a public forum for community member feedback, will guide the network in identifying at minimum two areas of action regarding programmatic implementation in subsequent years. The network will work to identify and utilize best practices throughout the development of programmatic focus and approach to implementation to achieve the desired outcome of increased mental and behavioral health supports within the target areas.

Network Description

The Southwestern Iowa Mental and Behavioral Health Network is a newly developed network established in 2023. The network's primary focus is to establish a behavioral health network aimed at collaborating on, identifying, and streamlining essential behavioral health services in the rural areas of the Southwest Iowa region, particularly focused on public schools (K–12) and the children and families they serve. Page and Montgomery counties were selected as the primary focus based on the needs assessment. Additionally, the region's Green Hills Area Education Agency (AEA) cited both counties as the most in need of increased comprehensive mental and behavioral health care access, especially for children in grades K–12. This focus laid

the foundation for establishing the network's seven partners, including two public health agencies, two school systems, the region's AEA, and a Critical Access Hospital. The inclusion of these partners within the network is key, as each organization holds a unique perspective and expertise regarding the mental and behavioral health needs of the target communities and ways in which access and integrated health services may be improved.

Network Partners

Organization	Location	Organization Type
Clarinda Community School District	Clarinda, IA	School System
Clarinda Regional Medical Center	Clarinda, IA	Critical Access Hospital
Green Hills Area Education Agency	Creston, IA	School System
Montgomery County Public Health	Red Oak, IA	Public Health
Page County Public Health	Clarinda, IA	Public Health
Red Oak Community Schools	Red Oak, IA	School System

Populations Served

- Children/Adolescents
- Persons adversely affected by persistent poverty

Region Covered

- Montgomery County, IA
- Page County, IA

Upper Peninsula Health Care Solutions

Upper Peninusula Behavioral Health Network

P10RH50536

Primary focus area:
Network Organization/ Infrastructure Development

Other focus areas:
Health Equity
Integrated Health Services
Mental/Behavioral Health

Grantee Contact Information

Grantee Contact: Katrina Keough, MPA
Contact Title: Project Director
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Organization Type: Nonprofit Organization
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Website: www.uphcs.org

Program Description

Upper Peninsula Health Care Solutions (UPHCS) engaged stakeholders to form the Upper Peninsula Behavioral Health Network (UP-BHN) because the shortage of behavioral health providers in the region is linked to suboptimal health outcomes for residents of the Upper Peninsula. Members understand the impact of these shortages and efforts by individual organizations to address shortages have had insufficient impact, largely due to the rural nature of the communities in the Upper Peninsula. The UP-BHN offers an opportunity for members to contribute to a wider regional response designed to benefit all members and the communities that they serve. UP-BHN increases behavioral health service capacity and improves access to behavioral health services through the development of referral systems that ease transitions between members and strengthens the reach and response to the demand for behavioral health services, leveraging a contracted facilitator with experience as a behavioral health service provider in the region and as a leader of a provider organization.

During the planning year, UPHCS will formalize the UP-BHN with a memorandum of understanding that details the roles and responsibilities of members, develop a website for the UP-BHN, establish workgroups, facilitate regular meetings, and develop a regional response plan document for dissemination. In addition, UPHCS will convene an in-person summit of all UP-BHN members and other regional stakeholders, conduct an Upper Peninsula community behavioral health capacity assessment, and conduct surveys to assess the impact of the UP-BHN and garner feedback from members and providers in the region.

Network Description

In April 2022, the first ever Upper Peninsula Behavioral Health Care Summit took place with representatives from stakeholder organizations from across the 15 UP counties of Michigan. Participants discussed the impacts of and potential solutions to the shortage of behavioral health care services in the region. UPHCS established a Behavioral Health Committee to continue addressing gaps in access to behavioral health care and resources following the summit. The UP-BHN represents an effort to formalize the UPHCS Behavioral Health Committee into a provider network and is established under a collective memorandum of understanding, to which members are signatories, and which defines the purpose, goals, objectives, member roles, expectations, resources, meeting schedule, and governance structure. The UP-BHN comprises 21 member organizations serving the Upper Peninsula, including health systems and Critical Access Hospitals, a Medicaid managed care organization, tribal health systems, a Federally Qualified Health Center with 11 service delivery locations, universities (including a rural psychiatry residency program), social service agencies, and a regional nonprofit substance abuse treatment provider.

The UP-BHN works to address behavioral health care gaps for residents of the Upper Peninsula by assembling and codifying the relationships between member organizations. The purpose of the UP-BHN is to develop a feasible, actionable, regionwide plan to improve behavioral health care access in the region. Organizations were approached for membership based on their involvement in the UPHCS Behavioral Health Committee; their demonstrated willingness to participate in, collaborate on, and contribute to UP-BHN initiatives; the impact that the shortage of behavioral health care providers has on their consumers; their capacity to have an impact on behavioral health provider shortages; and their role in the communities they serve.

Network Partners

Organization	Location	Organization Type
Aspirus Hospital Ironwood	Ironwood, MI	Hospital
Aspirus Hospital Keweenaw	Calumet, MI	Hospital
Aspirus Hospital Ontonagon	Ontonagon, MI	Hospital
Great Lakes Recovery Center	Ishpeming, MI	Nonprofit
Helen Newberry Joy Hospital	Newberry, MI	Hospital
Keweenaw Bay Indian Community	Baraga, MI	Tribal Health Clinic
Mackinac Straits Health System	St. Ignace, MI	Hospital
Michigan Opioid Collaborative	Ann Arbor, MI	College University
MSU Psychiatry Residency	Marquette, MI	College/University
MSU UP Education Corp.	Marquette, MI	Other
MyMichigan Medical Center Sault	Sault Ste. Marie, MI	Hospital
NorthCare Network	Marquette, MI	Social Services Agency
Sault Tribe of Chippewa Indians	Sault Ste. Marie, MI	Tribal Health Clinic
Schoolcraft Memorial Hospital	Manistique, MI	Hospital
UP Health System–Bell	Ishpeming, MI	Hospital
UP Health System–Marquette	Marquette, MI	Hospital
UP Health System–Portage	Hancock, MI	Hospital
Upper Peninsula Health Plan	Marquette, MI	Medicaid Managed Care Organization

Organization	Location	Organization Type
Upper Great Lakes Family Health Center	Calumet, MI	Federally Qualified Health Center
Upper Peninsula Health Care Solutions	Marquette, MI	Nonprofit

Region Covered

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

Van Buren County Hospital

Southeast Iowa Complex
Care Network

P10RH49221

Primary focus area:
Network Organization/
Infrastructure Development

Other focus areas:
Care Coordination
Integrated Health Services
Older Adult Care

Grantee Contact Information

Grantee Contact: Garen Carpenter
Contact Title: CEO
Organization: Van Buren County Hospital
Organization Type: Hospital
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Program Description

The Southeast Iowa Complex Care Network seeks to develop an innovative system of collaboration and managed care that will guide elderly patients with complex care issues to all available resources, simplifying access to services and delivering improved health outcomes. These patients regularly face barriers to care due to a lack of infrastructure within the two counties to facilitate access to specialty care and needed social services.

Network partners will work collaboratively to identify gaps in health care and social services and develop ideas for closing those service gaps. This will create opportunities for services to be available locally and for patients to have access to these services as needed. The expected outcome is that patients with complex care issues will experience improvements in their health care experiences and overall health.

Network Description

The Southeast Iowa Complex Care Network includes seven organizations that provide services in either or both Van Buren County and Davis County in Southeast Iowa. They are Van Buren County Hospital and Clinics, Davis County Hospital and Clinics, Van Buren Public Health, Lee County Public Health, Wells Pharmacies in Bloomfield and Keosauqua, and Senior Life Solutions. The rationale for including these partners in the network is that they

are the current primary care providers in Van Buren and Lee counties that deliver health care, mental health, and pharmacy services.

These members have worked together informally for several years, with each of the members providing services to the target population of individuals 65 years old and older with complex care needs. More formal agreements will be developed over the next year in which memoranda of understanding will be signed with specific expectations for each organization being identified. The network anticipates adding additional members as gaps are identified during the strategic-planning process.

Network Partners

Organization	Location	Organization Type
Davis County Hospital and Clinics	Bloomfield, IA	Hospital
Lee County Public Health	Keosauqua, IA	Public Health
Senior Life Solutions	Keosauqua, IA	Behavioral Health
Van Buren County Hospital and Clinics	Keosauqua, IA	Hospital
Van Buren County Public Health	Keosauqua, IA	Public Health
Wells Pharmacy	Bloomfield, IA	Other
Wells Pharmacy	Keosauqua, IA	Other

Populations Served

- Older adults

Region Covered

- Davis County, IA
- Van Buren County, IA

Wabanaki Public Health and Wellness

Primary focus area:
Mental/Behavioral Health

Wabanaki Public Health and Wellness

Other focus areas:
Increase Health System Efficiencies
Integrated Health Services
Substance Abuse Prevention and/or Treatment

P10RH50537

Grantee Contact Information

Grantee Contact: Sue Duffy
Contact Title: Director of Clinical Support and Innovation
Organization: Wabanaki Public Health and Wellness
Organization Type: Nonprofit
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Website: www.Wabnakiphw.org

Program Description

The Wabanaki Youth Healing & Recovery Network has two primary overarching goals: to improve the mental health of tribal youth and to decrease substance use by tribal youth. The network will carry out these goals through several objectives and activities. The first is the formation and convening of the Wabanaki Youth Healing & Recovery Network, which pulls together strong and capable member entities with experience in health care and workforce development in Washington County and with the tribal communities of Maine. The network will meet at least once each quarter of the grant year to provide planning input and ensure cultural integrity. The objective of these meetings is to develop a mental health training plan for Wabanaki communities to be piloted in the Indian Township community, and eventually, after the grant, to all the tribal communities in Maine.

With the assistance of network member Bradley Reach, the network will provide Youth Mental Health First Aid training for Tribal Communities and Indigenous Peoples. This training will be provided to network team members and then will be offered within the township community to include community members, educators, youth workers, health care providers, and others. Concurrently, the network will convene to develop a Wabanaki Youth Mental Health strategic plan designed to address the community need for a Wabanaki Youth Healing and Recovery Center that incorporates Wabanaki culture, clinical best practice, and community involvement. The strategic plan will also outline strategies aimed at building community capacity to provide wraparound youth services, providing wellness for generations to come. Underlying all this work is the desire

to have tribal traditions and customs incorporated into the plans developed while using evidence-based models to drive the programming design. Consulting with elders, youth, and community members will be essential in this process to ensure that programs are culturally relevant and responsive to the community.

Network Description

The Wabanaki Youth Healing & Recovery Network was formed through Wabanaki Public Health and Wellness's (WPHW's) programs within the community, relationships through other grant opportunities, and already existing relationships. The network has previously worked together to plan and develop a healing lodge and recovery network for indigenous adults. The proposed Wabanaki Youth Healing & Recovery Network planning project was designed by WPHW staff to improve the mental health of Wabanaki tribal youth and decrease substance use among Wabanaki youth by leveraging its members' diverse strengths and expertise. The planned Wabanaki Youth Healing & Recovery Network comprises three health care providers serving the Passamaquoddy Tribe at Indian Township, Wabanaki Public Health and Wellness, the Indian Township Health Center, and Bradley Hospital's REACH program. Additionally, Eastern Maine Community College's Katahdin Higher Education Center was identified for their expertise and experience working within the region providing rural workforce development and health career pathway expertise.

For this proposed planning project, WPHW will work with the Passamaquoddy Tribe at Indian Township — the largest tribe in Maine. For nearly a century, Bradley REACH Hospital has been providing leading-edge care for people experiencing mental health challenges. It is a national center of excellence for training the behavioral health workforce and for research in psychiatry and psychology. As part of the proposed network, Bradley REACH will participate in strategic planning and training activities targeted at the development of healing and recovery services for indigenous youth and in providing high-quality, age-appropriate clinical expertise for youth healing and recovery.

Network Partners

Organization	Location	Organization Type
Bradly REACH Hospital	Providence, RI	Hospital
Katahdin Higher Education Center	Millinocket, ME	College/University
Passamaquoddy at Indian Township	Princeton, ME	Tribal Nation

Populations Served

- American Indian

Region Covered

- Aroostook County, ME
- Penobscot County, ME
- Washington County, ME

West River Area Health Education Center

Western South Dakota Maternal Health Network

P10RH49222

Primary focus area:
Health Equity

Other focus areas:
Network Organization/Infrastructure Development
Pregnancy Continuum of Care

Grantee Contact Information

Grantee Contact: Stephanie Mayfield
Contact Title: Executive Director
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Organization Type: Nonprofit
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Program Description

The Western South Dakota Indigenous Maternal Health Network has identified the need to improve health outcomes, particularly among high-risk, indigenous birthing people from the Pine Ridge Reservation. Additionally, untreated sexually transmitted infections, substance use disorders, and alcohol use disorders have contributed to poor health outcomes in infants. The lack of continuity of care and barriers to adequate health care services that largely contribute to these poor health outcomes in both the birthing person and child will be the network's primary focus.

The network plans to hold two half-day, in-person sessions to work on the issues identified. The first session will consist of value stream mapping exercises to identify the current state of health for birthing people living on Pine Ridge. This will include an assessment of the current state for low-risk and high-risk pregnant people through delivery. After the mapping event, the network will identify gaps and barriers in care. The second session will be to prioritize the gaps and barriers in care identified and create a plan and timeline for implementation to address them. Utilizing subject matter experts during these work sessions, the network hopes to identify best practices to implement in Pine Ridge to ensure better outcomes for pregnant people living there. The network has hypothesized that providing community health representatives (living in Pine Ridge) with doula training may assist in improving continuity of care and reduce current barriers. The work sessions will ensure the network develops and implements a framework for successful programs that are culturally appropriate and evidence-based.

Network Description

The Western South Dakota Indigenous Maternal Health Network was formed through multiple discussions with agencies that saw a need to address the health of birthing people, particularly among pregnant people living in the Pine Ridge Reservation. The issue was initially raised to the West River Area Health Education Center (West River AHEC) by the Great Plains Tribal Leaders Health Board regarding increasingly poor outcomes of birthing people and infants on the Pine Ridge Reservation. Additionally, Monument Health shared that there is an increase in birthing people from Pine Ridge delivering babies without prenatal care. Many are born with congenital syphilis, fetal alcohol syndrome, and addicted to drugs due to the lack of prenatal screening and monitoring for these conditions. In turn, the West River AHEC met with the Avera Research Institute to discuss the current landscape of indigenous birthing people and children, as they have a specialized research focus on the indigenous population and their health outcomes. The network was officially established in December 2022, with West River AHEC, the Great Plains Tribal Health Leaders Board, Monument Health, and the Avera Research Institute being founding members.

Since its inception, the network has expanded partnership to additional agencies that have a vested interest in improving health outcomes for birthing people and children from the Pine Ridge Reservation. Monument Health in Rapid City delivers a large portion of babies from Pine Ridge. The Avera Research Institute is conducting research on indigenous birthing people and children in Rapid City and on Pine Ridge Reservation. The Great Plains Tribal Leaders Health Board works to ensure people living in tribal nations are provided quality care and work to improve outcomes as well. The South Dakota School of Mines and Technology has an agreement for data sharing with Monument Health that will provide real-time data of indigenous people and their babies. This information will be key to identifying the elements of prenatal health care that are lacking to ensure the network creates a comprehensive plan to improve outcomes. Additionally, the South Dakota School of Mines and Technology has premed students who are interested in supporting this data mining and analysis for the network through research internships.

Fall River Health Systems is a Critical Access Hospital in the county adjacent to Oglala Lakota County, which is home to the Pine Ridge Reservation. Horizon Healthcare has a community health center in Bennett County, another county bordering Pine Ridge. Additionally, Horizon Health is also working to improve birthing people and infant outcomes on South Dakota reservations through a new grant in which West River AHEC will be a partner. Finally, the Indian Health Service hospital in Pine Ridge sees the majority of indigenous people in Pine Ridge to conduct the initial exams for pregnancy. Together, the Western South Dakota Indigenous Maternal Health Network will review current state data and identify gaps in care and create a plan to improve health outcomes in Pine Ridge, S.D. The subsequent goal is to use that pilot program to share with other partners within the Rosebud and Cheyenne River reservations.

Network Partners

Organization	Location	Organization Type
Appletree Midwifery	Rapid City, SD	Physician's Clinic
Avera Research Institute	Rapid City, SD	Other
Center for Rural Health Improvement at USD	Sioux Falls, SD	College/University
Fall River Health Services	Hot Springs, SD	Critical Access Hospital
Great Plains Tribal Leaders Health Board	Rapid City, SD	Tribal Nation

Organization	Location	Organization Type
Horizon Healthcare	Howard, SD	Federally Qualified Health Center
IHS Pine Ridge Hospital	Pine Ridge, SD	Hospital
Monument Health	Rapid City, SD	Hospital
Oyate Health Center	Rapid City, SD	Tribal Health Clinic
South Dakota School of Mines and Technology	Rapid City, SD	College/University

Populations Served

- American Indian
- Pregnant people

Region Covered

- Bennett, SD
- Oglala Lakota, SD

Westchester County Health Care Corp.

Rural New York Nursing Workforce Development Network

P10RH50538

Primary focus area:
Mental/Behavioral Health

Other focus areas:
Workforce Development

Grantee Contact Information

Grantee Contact: Cynthia Ronconi-Raplee
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Program Description

This project will facilitate the expansion of network workforce development efforts to support patients in the rural Mid-Hudson and Catskills regions, with a targeted focus on Delaware County and HRSA-rural designated areas of Orange and Ulster counties. The network will develop a strategic, comprehensive plan for an expansion of its Rising Senior Program focused on addressing nursing workforce shortages in rural upstate New York. The strategic plan will specifically address how to expand the Rising Senior Program into Delaware and Ulster counties with Margaretville Hospital, a Critical Access Hospital, as a participating site and how to develop a behavioral health "track" for students interested in specialization. The strategic plan will be based on a workforce needs assessment that analyzes the rural area's shortage of nurses and primary care providers and the known social determinants of health that contribute to mental and behavioral health.

The Rising Senior Program is an eight-week paid mentorship offering nursing students an opportunity to expand clinical knowledge by providing direct patient care, reinforcing nursing skills, and increasing clinical competency in practice. The nursing student is paired with a registered nurse and works as part of a highly skilled and experienced team to deliver excellent care. Additional observational experiences in areas of interest and with community members are available, and the nursing student is encouraged to participate in educational offerings and in-services throughout the summer.

Network Description

The Rural New York Nursing Workforce Development Network partners include Bon Secours Community Hospital (BSCH, nonprofit acute care hospital), Margaretville Memorial Hospital (Critical Access Hospital), and the State University of New York (SUNY) Delhi. The first two partners listed are already part of Westchester Medical Center Health (WMCHealth) Network, which is a health system with nine hospitals and two medical practices. As members of the larger WMCHealth Network, the Rural New York Nursing Workforce Development Network partners have worked together on numerous public and community health initiatives over the years and have a long history of collaborating in a variety of coalitions and networks.

A number of partners were selected to participate in a network initiative to expand the Rising Senior Program. The selection of network members was determined based on rural location and participation with already established behavioral health programs. BSCH in Port Jervis, N.Y., has two departments in their acute care facility that work specifically with mental health and addiction. Margaretville Memorial Hospital in Delaware County, N.Y., will also be a network partner for the expansion of the Rising Senior Program. The expansion of the Rising Senior Program to include Margaretville will ultimately enhance access to both primary and behavioral health care much closer to home.

WMCHealth plans to formalize the partnership with institutions of higher education, expand its collaboration with Margaretville Hospital, and explore opportunities for collaboration with other educational and workforce partners in Delaware and Ulster counties, including SUNY Dutchess and SUNY Orange and the local Catskill Hudson Area Health Education Center (CHAHEC).

The establishment of the proposed network will increase primary care access in the region by providing critical resources to area providers, and ultimately local institutions of educations, to address barriers to recruitment and retention of a diverse nursing workforce competent in mental and behavioral health care. Network partners plan to officially and formally collaborate on a regional approach to address the nursing workforce shortage and the issues around recruiting and retaining culturally competent nurses in a rural area.

Network Partners

Organization	Location	Organization Type
Bon Secours Community Hospital	Port Jervis, NY	Hospital
Margaretville Memorial Hospital	Margaretville, NY	Hospital
SUNY Delhi	Delhi, NY	College/University

Region Covered

- Delaware County, NY
- Orange County, NY
- Ulster County, NY

Western Lane Fire and EMS Authority

Mental Health Crisis Response Network

P10RH49223

Primary focus area:
Care Coordination

Other focus areas:
Mental/Behavioral Health
Reimbursement for Health Services
Social Determinants of Health

Grantee Contact Information

Grantee Contact: Camille J. Reyes Griswold/Kathy Smith
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Program Description

The Western Lane Crisis Response Network is an informal multisector collaboration that includes an emergency response authority, law enforcement, a medical clinic, and a Critical Access Hospital that have a shared interest in reducing the human and system impacts of mental health crises in its service area of rural communities and unincorporated areas in remote Western Lane County, Ore.

Some members of the network first convened in 2019 and, with Lane County funding, conceived and piloted the first rural mobile crisis response program in Lane County. Now, Western Lane Crisis Response (WLCR) is a program of applicant agency Western Lane Fire and EMS Authority. Buoyed by excellent relationships with local law enforcement agencies, WLCR offers crisis de-escalation and stabilization for people experiencing crises in rural Western Lane County 24 hours a day, seven days a week, 365 days a year. Despite this progress, challenges remain and provide the programmatic focus for the network planning activities.

Network Description

The programmatic focus of the network's planning activities is threefold: First, the network will focus on improving community-based care coordination of mental health and social issues "upstream" to reduce the strain on the overtaxed and constrained mental health system. Second, the network will work to develop joint

protocols for more rapid, consistent access to intensive mental health assessment and psychiatric care when needed. And, third, the network will develop a plan for program sustainability.

The network approach for implementing the identified programs will build on the success of the mobile crisis response pilot, which was based on the CAHOOTS (Crisis Assistance Helping Out On The Streets) model, originated in Eugene, Ore., but will adapt it for the unique challenges of a rural and remote service area and population. The network will draw on, integrate with, and influence a broad, active, countywide planning effort to expand crisis response to all corners of the county.

Network Partners

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Organization	Location	Organization Type
Florence Police Department	Florence, OR	Law Enforcement
Oregon Integrated Health Clinic	Florence, OR	Physicians' Clinic
PeaceHealth Peace Harbor Medical Center	Florence, OR	Critical Access Hospital
Western Lane Fire and EMS Authority, Mobile Crisis Response Program	Florence, OR	Emergency Medical Services

Populations Served

- Children/Adolescents
- Veterans

Region Covered

- Western Lane County, OR

Windom Area Health (WAH)

WAH Walk-In Mental Health Clinic Network

P1ORH49224

Primary focus area:
Mental/Behavioral Health

Other focus areas:
Care Coordination
Network Organization/Infrastructure Development
Social Determinants of Health

Grantee Contact Information

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Program Description

Access to mental health care is a major area of need in Cottonwood, Jackson, and Nobles counties. The closest location to obtain walk-in mental health services for the target population is Sioux Falls, S.D., which is approximately 90 miles away. Additionally, in 2021, one of the larger mental health provider agencies for the geographic service area closed offices in Windom (Cottonwood County), Jackson (Jackson County), and Pipestone (Pipestone County). While they still operate offices in Luverne (Rock County, adjacent to Nobles County) and Worthington (Nobles County), the recent loss of the three facilities has put a significant strain on the remaining resources in southwest Minnesota. To best serve the target population, Windom Area Health opened a new local option for walk-in crisis management and outpatient therapy coupled with an on-site telehealth connection to a nurse practitioner for medication management, which eliminates the need for at-home internet access to receive care and increases options for attending appointments locally. The project will strengthen connections between the organizations that currently provide mental health or wraparound services for the three-county service area.

The network will identify and consistently communicate gaps or limits in services as well as coordinate resources to make up for the mental health professional shortages that are elevated in the target area. Educating community members about mental health and the resources available is crucial to both mental health outcomes for the region and readiness for the launch of the clinic. The network will work together

to build referral pathways that best leverage resources and disseminate information to other community stakeholders about the referral pathways. Community input will be a critical part of the ongoing decision-making process for the network as it looks to expand services. The network will meet quarterly with a full community team that includes stakeholders such as school counselors, alternative school social workers, public health, representatives from the other major local health care providers (Avera), and law enforcement.

Network Description

In May 2023, Windom Area Health opened the first ever program of its kind in the three-county region — a walk-in mental health clinic that serves adults 18 and older. The origin of the walk-in clinic is a recent yet long-standing community awareness that the region severely lacks adequate mental health resources. In 2019, Windom Area Health was one of six Critical Access Hospitals in Minnesota chosen for the Minnesota Path to Value Project. The initial project focused on providing Hispanic households with diabetes education, and later evolved to providing mental health support to Hispanic households. The focus then shifted to providing support to any person presenting to the emergency department with mental health or substance use issues who could benefit from an in-the-moment, walk-in approach. In addition to the Path to Value Project, Windom Area Health's regular attendance at the local Mental Health Taskforce meetings birthed the idea of a mental health walk-in clinic.

The task force comprises local organizations and businesses committed to addressing mental health concerns in Cottonwood, Jackson, and Noble counties. This includes Des Moines Valley Health and Human Services (local public health), law enforcement, schools, therapists, clinics, and other health providers. All entities in the task force have been involved in the creation of the clinic and the continued support of it. Additionally, regional entities are referral partners and advocates of the program. Through task force meetings, Windom Area Health identified Des Moines Valley Health and Human Services and Midwest Wellness as agencies that could further establish a vision and network. Des Moines Valley Health and Human Services is the main mental health hub in the community. Midwest Wellness will provide a nurse practitioner for medication management for clients. With network partners, Windom Area Health hopes to continue to implement crisis mental health services, gain valuable feedback regarding gaps in services, implement a simple referral process, and provide continued education to expand knowledge regarding available services and resources.

Network Partners

Organization	Location	Organization Type
Des Moines Valley Health and Human Services	Windom, MN	Public Health
Midwest Wellness	Sioux Falls, SD	Behavioral Health

Populations Served

- General population

Region Covered

- Cottonwood County, MN
- Jackson County, MN
- Nobles County, MN

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