Rural Health Network Development Planning Program Sourcebook

October 2023

U.S. Department of Health & Human Services
HRSA
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Introduction

Background

Rural communities have a higher burden of preventable conditions such as obesity and diabetes[1] and higher rates of the leading causes of death (heart disease, cancer, unintentional injuries, chronic lower respiratory disease, and stroke)[2] than their urban counterparts. Poverty, geographic isolation, travel burdens, and scant resources contribute to poorer health outcomes experienced by rural Americans when compared to urban counterparts. Inadequate access to health care services, hospital closures, workforce shortages and broadband challenges further exacerbate the issue.

The Federal Office of Rural Health Policy (FORHP) of the Health Resources and Services Administration invests in rurally generated solutions that provide needed capacity to meet the health care needs of their communities in ways that are efficient, effective, and accessible. Under Section 330A 254(c) of the Public Health Services Act, Congress enacted legislation to provide funding that addresses rural health needs through a focus on expanded delivery of health care services, development of integrated health networks, and enhancement of initiatives to improve provider quality.

FORHP's Rural Health Network Development Planning Program (also known as the Network Planning Grant Program) supports rural communities to respond to the changing rural health care landscape and the persistent health and health care challenges they face. A rural health network is defined as "a formal organizational arrangement among rural health care providers (and possibly insurers and social service providers) that uses the resources of more than one existing organization and specifies the objectives and methods by which various collaborative functions are achieved."[3] Health care networks can be an effective strategy to help smaller rural health care providers and 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. The purpose of the Network Planning Grant Program is to assist in the planning and development of an integrated health care network to:

- achieve efficiencies;
- expand access to, coordinate, and improve the quality of essential health care services; and
- strengthen the rural health care system.

The Network Planning Grant 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 supports one year of planning, with the primary goals of helping networks create a foundation for their infrastructure and focus member efforts to address important regional or local community health needs.

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[1] Richman L, Pearson J, Beasley C, Stanifer J. (2019). Addressing health inequalities in diverse, rural communities: An unmet need. *SSM Popul Health*. 7:100398. doi: 10.1016/j.ssmph.2019.100398.

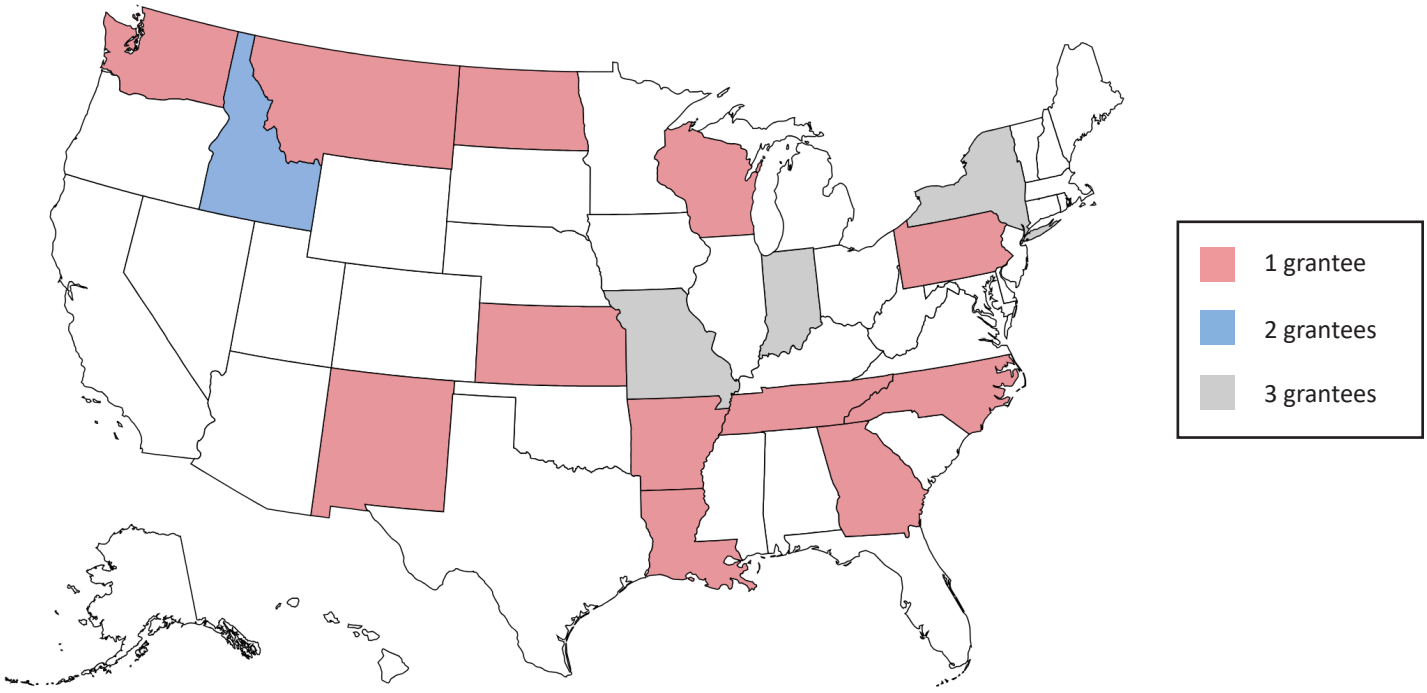
[2] Centers for Disease Control and Prevention. (2023). *Rural Health*. Centers for Disease Control and Prevention. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2751063/pdf/milq_069.pdf#page=2

[3] Muscovice, Wellever, Christianson, et al., (1997). Understanding integrated rural health networks. *Millbank Quarterly.* 75, (4). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2751063/pdf/milq_069.pdf#page=2

Cohort Snapshot

Twenty-three grantees located in 16 states were funded during the fiscal year 2022 grant period. Grantees were awarded up to $100,000 for the 12-month grant period.

Grantee Location Map



The Rural Health Network Development Planning Grant supported grantees in:

- Transitioning from a collaborative partnership to a more formal rural health network in which grantees focused on developing by-laws that detail network structure, staffing and purpose, and executing memoranda of understanding that outlined the commitments of network partners
- A planning process to structure the vision and mission of the group and motivate individuals and organizations to support the program vision through goal setting and collaboration
- Conducting community needs assessments
- Strategic planning efforts to lay out collaborative approaches for improving access to care, building local health system capacity, and improving health outcomes in rural communities

The 23 grantees focused on a range of populations within their rural communities (e.g., migrant, BIPOC, LGBTQIA+, justice-involved, the elderly, etc.) and explored ways to expand access to services in areas including chronic disease prevention and management, behavioral health, mental health, substance abuse prevention and treatment and maternal child health. Some grantees focused on addressing social determinants of health, including addressing transportation and housing barriers.

During the planning year, grantees developed strategic plans for building care coordination initiatives, developed policies and workflows to support new telehealth programs, and explored joint quality improvement initiatives. Multiple grantees focused their planning efforts around strengthening their network organization by formalizing their collaboration through defining their leadership and decision-making structures and establishing policies and workflow for future joint programming.

Grantee Primary Focus Area

Grantee Organization	Cancer Care	Care Coordination	Chronic Disease Prevention/Management	Health Equity	Health Information Technology	Housing	Increase Health System Efficiencies	Integrated Health Services	Mental/Behavioral Health	Network Organization/ Infrastructure Development	Telehealth	Transportation
Arkansas Behavioral Health Integration Network									•			
Bingham Healthcare			•									
Citizens Memorial Hospital								•				
Cornerstone Whole Healthcare Organization				•								
COVE Jamies Place							•					
Foundation for Health Leadership & Innovation										•		
Garnet Health Medical Center - Catskills												•
Good Samaritan Hospital		•										
HOPE for a Drug Free Stephens		•										
Indiana Rural Health Association										•		
Louisiana Rural Health Association		•										
Missouri Alliance of YMCAs										•		
North Country Healthy Heart Network										•		
Rio Arriba County						•						
Rural Health Association of Tennessee										•		
HSHS St. Clare Memorial Hospital											•	
Sullivan County Memorial Hospital										•		
Thrive Allen County									•			
Union Hospital	•											
University of Montana										•		
University of North Dakota										•		
UPMC Kane			•									
Westchester Ellenville Hospital											•	

Impacts

The investment in the developing rural health networks is designed to support rural health organizations in developing new ways of working together and building the infrastructure to support and sustain collaborative efforts over the long term. Grantees reported the following accomplishments/impacts resulting from the planning grant:

Strengthened & Expanded Partnerships

- Nearly all grantees reported that the Network Planning Grant allowed them the opportunity to build trust and meaningful relationships with network partners. Through regular meetings to assess community needs and assets, partners worked together to develop shared mission statements and detail the roles of all partners involved.
- Grantees reported that as a result of the grant, they were able to expand their networks' membership, which strengthened their networks and their capacities. One grantee shared the following: "We started with a group of 11 network members. The group kicked off the work with an in-person network meeting to get to know each other and added 15 additional members. This resulted in more collaboration, but also required the creation of a steering committee to maintain effectiveness and focus on work outcomes."
- Each grantee completed a network organizational assessment in which they assessed the strengths and weaknesses of their networks and confirmed the determined rationale behind forming a rural health network. Many grantees shared that this activity led to shared understanding and goals related to network sustainability.

Strategic Program Planning

- The Network Planning Grant is dual-focused, meaning grantees are focused on infrastructure development (i.e., network structure, vision, mission) and program planning (i.e., needs assessment, gap analysis, best practice models). As a result, grantees were able to begin building out their programs. Grantees reported the creation of social determinant of health databases, resource guides, and new referral pathways and workflows for improved care coordination. Forming networks created templates, protocols, service implementation plans, and jointly sought additional funding to support future programming and service delivery.
- Grantees also used the planning year to determine and develop their network structures. Many grantees established dedicated committees and work teams to address the specific network and programmatic objectives.

Community Assessment to Inform Programming

- Grantees focused on gathering data from various stakeholders. Among others, these stakeholders included patients and service users, health care managers operating critical access hospitals, federally qualified health centers, and rural health clinics serving rural communities. Many grantees used the planning year to identify and better understand the needs of their populations using various methods including disseminating surveys and conducting key informant interviews, site visits, and focus groups. This information was used in network and programmatic planning efforts to ensure networks were responsive to community needs.

Increased Capacity

- The Network Planning Grant supported hiring staff to lead planning activities. As a result, many grantees were able to hire network directors, data analysts, evaluators, and consultants. One grantee hired a tribal liaison to ensure that perspectives of the tribal community were represented in community needs data and to ensure the network worked with tribal partners in a culturally responsive way.
- Grantees provided workshops and education opportunities to network members to strengthen knowledge and skills and to support programmatic goals.

This sourcebook provides a summary of 23 network planning grant projects that were funded during the 2022-2023 grant period. The awardee entries include the network statement developed and approved by network partners, a summary of the activities implemented over the planning year, network focus, organizational and programmatic development, and plans for long-term sustainability.

Arkansas Behavioral Health Integration Network

Arkansas Lives Network of Care

P10RH45760

Project focus area:
Mental Illness/
Mental Health Services

Other focus areas:
Behavioral Health
Increase Health System Efficiencies
Integrated Health Services

Network Statement

Every 10 minutes, someone dies by suicide in the U.S., and with an alarming 41% increase of suicides over the last two decades, Arkansas is no exception. Those numbers continue to rise, especially in rural areas where the available resources are minimal at best. That's why Arkansas Lives Network of Care (ALiNC) was formed. Together, partners understand that it takes a whole-community approach to combat suicide in rural north Arkansas, including Baxter, Stone, and Cleburne counties. It's estimated that around 115 people are exposed to each suicide with one in five individuals reporting the experience having a devastating and traumatic impact. Survivors of suicide loss have an increased risk of suicide themselves and typically need supportive services to help reduce the stigma, manage the trauma, and heal from the grief of their experience. Those survivors who receive support at the scene will, on average, seek help within three months, compared to four years for those who don't receive support at the scene. How quickly someone receives help can quite literally be a matter of life and death.

ALiNC is composed of strong cross-sector partners who are dedicated to supporting loss survivors and ensuring they have quick access to available suicide postvention resources, such as mental health services, basic comfort needs, and peer support services, among others. The network is creating a suicide postvention network that represents key stakeholders from every sector and working collaboratively to develop a rapid community response to suicide. Efforts are focused on reducing the stigma related to suicide, educating communities and policymakers, and improving access to resources in the immediate aftermath of a tragedy, which will ultimately reduce survivors' isolation, generate collaborative solutions, and stimulate a healing community involvement.

Network Development

ALiNC was awarded a Rural Health Network Development Planning Grant in July 2022. Since that time, the network has made significant progress in formalizing the network. Although one of the original network partner organizations withdrew participation due to staffing issues, the network was able to expand to include two additional health systems in the region including Boston Mountain Rural Health Center and White River Medical Center. ALiNC is also working to include additional multi-sector partners in the three counties, including law enforcement, coroners, emergency medical services, faith leaders, schools, and community-based organizations that address social determinants of health. The network conducted an environmental

scan that included interviews and surveys with community leaders, which allowed the network planning group to identify the partners necessary to combat suicide in the region. The network planning group was also able to develop a resource list through this process, which will be published and maintained during program implementation. Partners have been engaged throughout the process. Because partners are located across a large geographic area, monthly meetings were held via Zoom. While there were some initial challenges in partner engagement due to limited staff availability, ALiNC addressed those challenges by identifying and working with different staff members from the partner organizations that had time to devote to the project. Innovative methods that can be used for engaging partners can be as simple as emailing periodic surveys or developing an email listserv for group news and updates. The ALiNC Network has been able to adapt quickly to the changing landscape and community needs, which has been critical to network development.

Programmatic Development

While the original focus of the ALiNC Network was broad access to mental health services through a referral and consultation network, several back-to-back suicides occurred in the region shortly after award notification. Community members reported a pressing need for coordinated, community-based response to help survivors and first responders. Suicide postvention is an organized response in the aftermath of suicide designed to promote healing and ease the negative effects of exposure to suicide. Postvention is a critical aspect of suicide prevention, but it is more often than not neglected. Suicide loss survivors are not provided with resources or support they need after such trauma, and this can increase the risk for additional suicides. Recognizing this gap in support, the network shifted to narrow in on this new focus – suicide postvention services. Partners began looking at existing models of suicide postvention. Of particular note, the team found a suicide postvention toolkit specifically for rural communities developed by the California Mental Health Service Authority ("After Rural Suicide: A Guide for Coordinated Community Postvention Response"). This guide was very helpful as partners began developing ideas for the program.

Partners conducted an environmental scan which helped identify and prioritize three initial opportunities: peer support, telehealth, and training. The development of a peer support program will provide knowledge, experience, emotional support, and practical help to survivors after a loved one has died by suicide. The use of telehealth technology has potential to eliminate delays when a mental health crisis occurs. When a suicide occurs, it can take days to recruit mental health professionals and get them onsite to support survivors. When used in a way that connects loss survivors and first responders to needed mental health resources quickly, telehealth can reduce the risk of contagion after a suicide as well as prevent suicide. Training is also a foundational opportunity. Educating ALiNC partners and stakeholders as well as community leaders and policy makers will ensure a solid foundation for ALiNC activities and further the purpose of postvention programming.

Identifying key challenges also helped partners develop ideas for a program. Potential challenges included limited funding sources and stigma. Innovative ways to overcome these potential challenges were identified through a formalized "sense-making" process and will become part of the strategic plan. Being adaptable and open to changes in direction has allowed space for innovation in this planning process.

Sustainability

The ALiNC Network will continue expanding to include community stakeholders in each of the target counties to begin implementing coordinated postvention response activities when deaths by suicide occur. To ensure sustainability, additional stakeholders across city and county governments (including first responders and policy leaders) will be asked to participate in network activities. A formal memorandum of understanding will be developed during the remaining planning grant period, as well as plans for staff and funding. A network director job description will be developed, and potential candidates will be identified by network partners.

The postvention programming that partners identify in the strategic plan will be sustained by a combination of potential funding from city, county, state, and federal sources. Network partners will also work with state advocacy groups, such as the Arkansas Foundation for Suicide Prevention, to identify other potential funding sources (such as private foundations) and opportunities for expansion. Partners will continue to work with regional suicide prevention providers and legislative workgroups to help ensure state support for postvention programming (as part of prevention programming) in these rural counties. Finally, program evaluation will capture information that can help other rural counties implement coordinated suicide postvention response using a rural health network model. Overall, a statewide postvention network could maximize scarce resources such as peer support for survivors and could help support sustainability.

Region Covered

- Baxter County, AR
- Cleburne County, AR
- Stone County, AR

Network Partners

Member Organization	Location	Organizational Type
Arkansas Behavioral Health Integration Network	Greers Ferry, AR	Nonprofit
Baxter Regional Medical Center	Mountain Home, AR	Hospital
Boston Mountain Rural Health Center	Marshall, AR	Federally Qualified Health Center
Dr. Andy's Family Practice Clinic	Mountain View, AR	Physicians' Clinic
White River Health	Batesville, AR	Hospital

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Bingham Healthcare Pharmacy Population Health

Integrated Rural Enhancement

PH10RH45761

Project focus area:
Chronic Disease Prevention/ Management

Other focus areas:
Care Coordination
Integrated Health Services
Population Health/Social Determinants of Health

Network Statement

"There is no power for change greater than a community discovering what it cares about."
–Margaret J. Wheatley

Here in southeast Idaho, health care providers and community agencies have joined efforts to focus on residents in this rural area who who are disproportionately affected by diabetes and the resulting challenges that plague them. Diabetes is a chronic disease that requires long-term management and care. In rural areas, access to health care facilities that provide diabetes education, diagnostic services, and treatment services can be limited. This unfortunately results in difficulties in early detection and management of diabetes, in turn leading to higher rates of complications and mortality. Poor living conditions, transportation constraints, limited physical activity, affordability of fresh and healthy food options, and lack of awareness about diabetes also contribute to the problem.

The Pharmacy Population Health Integrated Rural Enhancement (PPHIRE) Network is working to improve the management of diabetes in this rural area by increasing access to health care services and resources, improving patient education and self-management, and collaborating with health care providers and agencies to ensure patients receive the necessary screening, treatment, education, and monitoring. Pharmacists are also working to collaborate with health care providers to ensure medication adherence issues are identified and addressed and provide medication management and optimization. The PPHIRE Network is dedicated to improving the health care journey for patients with diabetes as it explores opportunities and expand on programs that will better address social determinants of health (SDOH) and the significant impact they have on diabetes treatment and management.

Network Development

The PPHIRE was led by two project directors who convened the network members monthly to establish the PPHIRE network's mission, vision, and values and develop the network statement. Network members worked collaboratively on an external environmental scan to help identify opportunities and threats that could impact program activities. Additionally, network members completed a network organizational assessment to help

identify strengths and weaknesses as the network transitioned from a collaborative partnership to a more formal rural health network.

As an emerging network, initial challenges included getting to know network members and gaining their trust. These challenges also sometimes impacted receiving buy-in and input from members. It took time to truly build relationships with members who, for the most part, had never collaborated in a direct capacity. Compounding the challenge around engagement with network members were changes in members who represented partner organizations. To foster new relationships and address barriers around engagement and decision-making, time was spent learning about members' backgrounds, practice locations, challenges, achievements, and opportunities. For example, project directors traveled to Lost Rivers Medical Center to meet with their CEO, diabetes educator, and clinic manager, and tour the hospital. Over time, network members were able to better address challenges shared by multiple members, including identifying resources to address social determinants of health needs in the service area(s). As project directors were new to leading a network, an additional challenge was understanding how rural health networks operate. It took time to learn network-building strategies and key steps to bringing a group together with the goal of working together beyond the grant project funding. One of the biggest successes for the network was the increase in partner engagement. Partners meetings were an opportunity for members to discuss their current activities and future projects. Having a slide deck at each meeting helped guide discussion and keep agenda items in focus. Using open-ended questions to facilitate conversation was also very beneficial. Bringing resources to the group to review (e.g. a social determinants of health tool and the Idaho Primary Care Needs Assessment from the state Department of Health and Welfare) sparked meaningful dialogue among network members. These strategies helped set the tone for meetings and resulted in more effective and productive discussions.

Programmatic Development

Program development included developing workflows, templates, and protocols to expand the role of the pharmacist working in primary care by providing direct patient care to diabetics and patients at risk for developing diabetes. This provided the opportunity to redesign a myriad of services ranging from medication therapy management, screening, and testing to designing academic detailing (unbiased, non-commercial, evidence-based educational material) with the patient in mind. Materials created included a brochure that identified clinical pharmacists and the program description, a resource tool to address SDOH, clinical decision tools based on guidelines and protocols, and patient education materials. The development of these resources took time and required the support of others across various departments. Ultimately, the various resources mentioned above were bundled into a toolkit for integrating pharmacists into care teams. As a result of network efforts, pharmacist clinic involvement increased from three providers to 11 in six months' time. Additionally, Project Directors helped launch the Advanced Services Pharmacy Network, a group of pharmacists throughout the state of Idaho working on various topics involving pharmacist credentialing, clinical platforms and protocols, academic detailing, and data analytics.

The hospital IT department developed a diabetic registry as well as a pharmacist and dietitian referral system. They developed templates to include necessary measures such as A1C, foot exams, eye exams, etc. A pharmacist from Bingham Healthcare also received a community health worker certification which will help expand the role of coordinated care in the clinic setting as well as provide support and guidance to the outpatient pharmacy. The network is exploring ways to incorporate telehealth services to increase access for patients with limited transportation. During the duration of the planning grant, network members provided advice and expertise ranging from funding opportunities and community support resources to best practices that have supported transforming clinics, including providing traditional fee-for-service and operating in conjunction with value-based care models.

Success in program development came with challenges. In the clinic, skepticism from providers combined with a lack of developed protocols for integrating a pharmacist into a clinic made some providers hesitant to participate. Another large hurdle was the electronic health record, which required templates, registries, referrals, scheduling, and billing to be built by IT personnel for pharmacist integration to occur. This took time away from being able to integrate a pharmacist into a clinic. Educating providers and clinic managers, which is required for a successful roll-out, was somewhat challenging as it was often difficult to get all the necessary stakeholders together for a meeting. A lack of framework on multiple fronts, including education materials, provider trust, office staff training, templates, and standardized billing codes all created barriers to getting the program to its current functionality.

Sustainability

Network pharmacists have identified ways to help clinics offset the financial burden of having a pharmacist work within the clinic setting. This includes scheduling combined visits that allow the pharmacist to work with a patient while the provider sees additional patients. Pharmacists are also scheduled for 60-minute visits, which allows the clinic to bill for the extra time. Network members also discovered billing codes for continuous glucose monitors (CGM) which were not previously utilized. Since the program's inception, numerous patients have been added to the CGM clinic program. Other indirect pharmacist billing modalities include performing medication reconciliation for transitions-of-care patients, medication adherence screening to address non-compliance, assisting with chronic care management, and other requests, such as de-escalation to reduce the use of benzodiazepines and sedative hypnotics. Pharmacists will also educate providers on diabetes and make treatment recommendations and insulin adjustments while also working closely with the front office staff to train them on how to schedule and help navigate diabetic patients needing services.

Further, in Idaho, pharmacists are recognized by Medicaid as mid-level practitioners despite billing capabilities that are still in the development phase. Surrounding states also recognize pharmacists as providers, and they are further credentialed with other third-party payors. Over time, pharmacist credentialing will be within reach and will provide the necessary funding to facilitate pharmacists' involvement in the care team working in direct patient care settings. In the meantime, pharmacists will expand ways to generate revenue by working under a collaborative practice agreement and tailoring chart notes to capture time and expertise. Bingham Healthcare's administrative team is also supportive of a robust and integrated diabetes program throughout the organization. Lastly, network members will also continue to utilize grants and other funding opportunities to help sustain the program until it is fully autonomous.

Region Covered

- Bannock, ID
- Bingham, ID
- Butte, ID
- Lemhi, ID
- Payette, ID

Network Partners

Member Organization	Location	Organizational Type
Bingham Healthcare	Blackfoot, ID	Critical Access Hospital
Cornerstone Whole Healthcare Organization	Payette, ID	Nonprofit
Idaho Division of Public Health	Pocatello, ID	Government
Idaho Public Health District 6	Pocatello, ID	Government
Lost Rivers Medical Center	Arco, ID	Critical Access Hospital
Steele Memorial Medical Center	Salmon, ID	Critical Access Hospital

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Citizens Memorial Hospital

Southwest Missouri Rural Health Network

TR1RH45763

Project focus area:
Community Paramedicine

Other focus areas:
Integrated Health Services
Quality Improvement

Network Statement

The agricultural, rural region of southwest Missouri is often recognized by rolling hill farms spotted with small towns often connected by two-lane roads. Those who call this region home do so with great pride, and it is an expectation to "look out for your neighbor." However, within this region, many with debilitating physical or mental health conditions cannot access or utilize typical health care systems. The Southwest Missouri (SWMO) Rural Health Network is composed of local organizations that hold to this same principle and have come together to take care of the local community by bridging the gaps for the most vulnerable neighbors and helping them access care.

Poverty, geospatial limitations, health inequity, and lack of transportation are the most common barriers to high-risk individuals who lack access to health care and ancillary services across their lifespans. To meet these needs, the SWMO Rural Health Network has developed an innovative and coordinated service delivery program to provide care to underserved individuals in their homes through a mobile collaborative team coordinated through community paramedics. By offering care within someone's home, community paramedics can treat individuals and coordinate services through integrated, comprehensive resources found within the SWMO Rural Health Network and regional partners. By integrating a coordinated care approach that does not rely on individuals walking through the door of a clinic, vulnerable community members can access a network of services from their homes. This provides a safety net for those in this community who cannot access care through local coordinated support structures, which will improve their health and welfare.

The SWMO Rural Health Network has gained momentum to offer expanded health care and social supports and meet individual needs through coordinated services. This transformative strategy will effectively link patient care needs to solutions in real time, which is unprecedented in this rural region. The network is expanding partnerships that create patient-centered solutions for overcoming barriers through caring referrals, coordinated care, empathetic education, and compassionate treatment.

Network Development

The SWMO Rural Health Network has consistently met at in-person monthly meetings with virtual options for members who are unable to attend in person. Each meeting consisted of strategic conversations focused

on building partnerships and developing a plan to enhance in-home services through a robust community paramedicine program. This planning process included work to structure the vision and mission of the group and motivate individuals and organizations to support the program vision through goal setting and collaboration. Once gaps in care were identified that might be bridged through the community paramedicine program, consortium partners felt engaged to develop and support the program planning process.

Because the consortium consisted of both clinical and non-clinical partners, it was sometimes difficult to pivot between the different perspectives and evaluate how the proposed community paramedicine project could fit needs perceived by each group. For example, when a health care worker discussed entering a patient's home to provide treatment, a law enforcement agency would see that as an opportunity to assess for domestic abuse. Keeping an open mind and discussing why each organization identified a need was important to making progress. This specific example led to a conversation about an increase in domestic violence since the start of the pandemic, and the value the law enforcement agency saw in supporting victims who may not otherwise have a point of access to care. The success of consortium meetings was due to engagement and consistency. The project director ensured each meeting was preceded by a reminder email and followed with a thank-you email that included the meeting's notes. These small reminders kept the consortium at the forefront of partners' minds and enhanced engagement.

Programmatic Development

The purpose of grant funding was to strengthen community partnerships that would impact the success of a mobile integrated health program through community paramedics. Participating community organizations would offer supportive services that impact social determinants of health. Community paramedics would be able to link patients to services with these agencies and help bridge identified gaps in care and care coordination. This includes bi-directional support as community agencies are able to refer to the community paramedic program for high-risk patients and community paramedics are able to engage with local organizations to provide services and support. This also includes linking patients to a nearby medical home through transportation assistance and through telehealth services. Each community paramedic will have capable devices and equipment to link patients to providers in real-time and conduct in-home assessments and screening that can be immediately discussed with the provider.

One barrier in this collaborative plan is that different agencies use different electronic medical record (EMR) platforms. For example, if the health department wanted to refer a patient, the community paramedic would have difficulty relaying medical information to the EMR used by the public health department which is different from the system used by Citizens Memorial Hospital (CMH). This challenge was theoretically resolved (not yet operationally resolved) by first seeing patients in an "assessment" capacity that could be entered through an EMR platform specific to EMS departments that can be sent to both CMH and the local health department.
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Sustainability

The consortium plans to formalize as a state-recognized coalition focused on rural health and wellness. This formalized process must be supervised by a state fiscal agent that will support the application and start-up process. The consortium has agreed to move forward with this arrangement and will work with the state agency this summer. State-recognized coalition status will enable the SWMO to apply for state-level grant funds and continue to come together to discuss rural health-care gaps and strategies to expand access to services. It is expected that the Community Paramedicine program will be sustainable for an additional two years through grant funding. However, instead of only discussing the community paramedicine program that is led by CMH, a formal coalition will introduce additional programs and activities that are led by other

community organizations and further the reach of participants and the coalition's impact in the community.

Region Covered

- Dade County, MO
- Dallas County, MO
- Cedar County, MO
- Hickory County, MO
- Polk County, MO

Network Partners

Member Organization	Location	Organizational Type
30th Children's Circuit	Bolivar, MO	Social Services Agency
Bolivar Police Department	Bolivar, MO	Law Enforcement
Citizens Memorial Hospital	Bolivar, MO	Hospital
Citizens Memorial Hospital EMS Department	Bolivar, MO	Emergency Medical Services
Dallas County Health Department	Buffalo, MO	Public Health
Ellet Memorial Hospital	Appleton City, MO	Hospital
Hickory County Health Department	Hermitage, MO	Public Health
Ozarks Community Health Center	Hermitage, MO	Federally Qualified Health Center
Polk County Health Department	Bolivar, MO	Public Health

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Cornerstone Whole Healthcare Organization, Inc.

Pride in Idaho Care Neighborhood

6P10RH47310-01

Project focus area:
Health Equity

Other focus areas:
Network Organization/
Infrastructure Development

Network Statement

People who identify as LGBTQ+ face significant health disparities including poorer chronic health outcomes, twice the rate of uninsurance, and nearly five times the rate of suicidal ideation as non-LGBTQ+ peers. Those living in rural areas face additional barriers to health such as poor access to care and less community support for LGBTQ+ protections. Health-care organizations have the opportunity to champion the needs of this community by providing affirming and appropriate care. However, many fall short in truly supporting the needs of LGBTQ+ patients, resulting in health disparities and broader community rejection or refusal to acknowledge the needs of LGBTQ+ neighbors.

The Pride in Idaho Care Neighborhoods (PiICN) Project was formed to develop a statewide network of rural primary care providers dedicated to developing the capacity for excellent LGBTQ+ care practices among peer health care organizations. The network has developed tailored curriculum and outreach to address issues ranging from access to hormone replace therapy in rural primary care to utilization of Ryan White funding in non-population centers. Key partners include state academic training institutions for care providers, residency sites, and providers in practice. Together with these partners, PiICN aims to expand reach into more health care organizations, provide individualized consultation to rural health sites, develop novel training material, and engage more state and regional resources to better equip rural communities to address the health needs of LGBTQ+ residents.

Network Development

The PiICN Project has developed a statewide network to support appropriate and affirming care for LGBTQ+ individuals living in rural areas of Idaho. Through the period of performance, the network has expanded to include additional partners such as Project ECHO, the Idaho Area Health Education Centers, legal consultation, and the National Rural Health Association (NRHA). e small reminders kept the consortium at the forefront of partners' minds and enhanced engagement.

Programmatic Development

The PiICN Network has successfully developed a cadre of training and engagement tools. These range from the PiICN Roadmap, to a variety of trainings, to press releases and best practices. The PiICN resources have been particularly critical in the midst of increasingly hostile state legislation. The network has focused extensive effort on responses to HB71 from the 2023 Idaho Legislative session, which makes it illegal for providers to provide gender-affirming care. Efforts included hosting legal Q&As and producing and disseminating the only medical guidance webinar in the state. The program has also developed a consultation model to facilitate enhanced supports for LGBTQ+ patients within their local communities of care.

Sustainability

The consortium plans to formalize as a state-recognized coalition focused on rural health and wellness. This The PiICN Network has expanded significantly through the period of performance. Moving forward, the network will continue to meet and respond to changes in the health care, legislative, and community context. Specifically, PiICN has engaged national leadership (PACT, NRHA, New Ways) and national foundations to continue developing resources for the state and beyond. Trainings, guidance, and documents have all been posted to the PiICN page.

Region Covered

- Clearwater County, ID
- Gem County, ID
- Payette County, ID
- Power County, ID

Network Partners

Member Organization	Location	Organizational Type
Cornerstone Whole Healthcare Organization, INC	Payette, ID	Nonprofit
Full Circle Health	Nampa, ID	Federally Qualified Health Center
HealthWest	American Falls, ID	Federally Qualified Health Center
Valor Health	Emmett, ID	Critical Access Hospital

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COVE Jamie's Place

Methow Valley Community-Based Long -Term Care Network

P10RH45765

Project focus area:
Care Coordination

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

Network Statement

The Methow Valley lacks the critical support for seniors to remain safely at home as they age. The network believes all members, especially the most vulnerable of the community, deserve access to quality care to support their wish to age in place. These vital needs include transportation, housing, food, and caregiving. Agencies across Okaanogan County are creating a sustainable network that will provide access to essential resources that support a high quality of life.

The Winthrop ZIP code is the "second oldest" in Washington. The aging population and the rapidly growing population strain the limited resources. Network partners are building a caregiver workforce, providing community-based support to aging in place, and increasing access to long-term care options to meet the growing need. The intent is to create a sustainable community-based network that can think outside the box to find solutions to inefficiencies and barriers to care so that the seniors in this community can live out their lives in the valley they love.

Network Development

Network members are acutely aware of the impacts on the quality of life associated with a lack of long-term care, including caregiving staff, services, support, and facilities in the Methow Valley community. On the heels of the comprehensive Senior Assessment Support for Housing Assessment, the awarding of the Health Resources and Services Administration (HRSA) Network Development Planning Grant in early 2022 allowed for formalization of the network and has guided the prioritization of objectives and programs that will support implementation of a sustainable infrastructure, services and support for the Methow Valley community.

The network established through the planning grant includes three members: Jamie's Place Adult Family Home, Family Health Centers, and Methow at Home. It also includes a number of collaborating organizations that support the work of the network. Through planning efforts, the network has determined the need to expand its official membership to include the Methow Valley School District, Liberty Bell High School, and other collaborative organizations. These organizations have committed to being at the table with the network

and to work side-by-side to implement the goals and objectives outlined in the strategic plan. Next steps include establishing a system of governance with policies and procedures as well as recruiting additional partners.

Programmatic Development

Programming has developed through the efforts of dedicated work teams, each addressing the specific objectives of the network.

1. The workforce development team has initiated a program with Liberty High School to certify high school seniors as health care aides so they can move directly into jobs at Jamie's Place or elsewhere in the community when they graduate. Training has begun, and the first group graduated in May 2022.
2. The network collaborated with Wenatchee Valley College to develop a certified nursing assistant bridge program for current home care aides to provide professional development career advancement opportunities.
3. Methow at Home has been working on many of the Aging in Place team initiatives.
    - Stay Active and Independent for Life
    - Community-wide fall prevention program in collaboration with local clinics and agencies
    - Stress reduction and resiliency community programs
    - Creative Expressions with Dementia art program
    - SilverNest home sharing program
4. The facilities team has been working with Jamie's Place board of directors to continue feasibility research on the expansion of Jamie's Place capacity.
    - Two tiny homes were purchased to provide short-term housing solutions for Jamie's Place caregivers.
    - Workforce Housing, collaborating with the Housing Solutions Network and Methow Housing Trust, continues to push for affordable workforce housing.
5. The Grant Readiness team has been working to identify large grants that could support the network's work. Grants received from the Methow Valley Fund of the Community Foundation of North Central Washington enabled the network to hire a grant-writing service to help prepare proposals for the HRSA Rural Health Network Development Planning Grant and the 2023 Network Development Grant.
    - Washington State Department of Rural Health provided a grant for caregiver training.
    - Community Foundation of North Central Washington provided a grant for the purchase of two tiny homes for caregiver crisis workforce housing.
    - WorkSource Washington provided funding for the CNA Bridge program.
6. The Care Management/Coordination team is the linchpin to this grant. Through their activities, the network will enhance coordination of services within the existing health, social, and long-term care service capacity and will also develop the ability to ensure new services and programs developed are integrated throughout the system. Activities include:
    - Continue to inventory network members and collaborators to identify existing capacity and current available resources.
    - Collaborate and share inventory data with network members
    - Identify potential other community resources and providers that need to be integrated into the work of the network based on identified gaps.

- Identify innovative mechanisms for cross-training; sharing resources; new revenues for integrating care, services and supports; and coordinating across primary care, specialty care, long-term care/ social services.
- Determine location, governance, funding, and revenue streams for implementation for each objective (tied to strategic/business planning).
- Confirm resources/services not available locally and explore options for addressing those gaps.

The work of these teams will continue to break down silos in order to link health care and social services to promote patient safety, quality of care, and cost-effective outcomes.

Sustainability

The network understands the key to sustainability is adequate reimbursement for services provided. To achieve sustainability, the network plans to focus simultaneously on efforts in several areas including: 1) braiding existing reimbursement streams, 2) collecting/analyzing and reporting the data that demonstrate the efficacy of these efforts, thereby helping to secure dedicated reimbursement due to the positive impact on total costs of care and advancement of value-based care; and 3) securing commitments from Valley organizations and residents for ongoing support.

The network has recently been notified that it has been awarded the 2023 HRSA Network Development Grant to further the development of the programs that have already been established and to continue expansion and formalization of the network. The network's first order of business is to establish a system of governance and draft formal policies and procedures to guide the network. Recruitment of additional partners from Okanogan County will broaden the network's programs throughout the community as well as further streamline services through collaboration and care management. The network development grant will also provide paid positions for programs currently being run with volunteer committees.

Network partners have committed to work together to improve equitable systems, workflows, and strategies, and have made commitments to provide resources, improve systems, enhance communication and collaboration, and implement innovative and evidence-based practices. By establishing a comprehensive system of community-based care coordination for at-risk seniors in the Valley, the network will promote patient safety, quality of care, and cost-effective outcomes across all providers, agencies, and resources. This objective is the true linchpin for the work of the network and ties together the other network objectives and strategies. The network will work to further break down the silos between systems and programs, strengthening community collaboration and coordination between clinical providers and community-based organizations as well as linking health care and social supports together.

Importantly, this work will evaluate, combine, and modify, where necessary, several evidence-based models of care coordination. The result will be a system that is tailored to the unique experience of the Valley, using the strengths of the network members and collaborating organizations and recognizing the enhanced "touch points" in the community available to support and expand services for the benefit of seniors and the entire community.

Region Covered

- Okanogan County, WA

Network Partners

Member Organization	Location	Organizational Type
Family Health Centers	Twisp, WA	Physicians' Clinic
Jamie's Place	Winthrop, WA	Skilled Nursing Facility
Methow At Home	Twisp, WA	Area Agency on Aging

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Foundation for Health Leadership & Innovation

Bertie County Integrated Behavioral Health Network

P10RH45766

Project focus area:
Behavioral Health

Other focus areas:
Integrated Health Services
Mental Illness/Mental Health Services
Network Organization/Infrastructure Development
Substance Abuse/Addiction

Network Statement

Bertie County, a rural county located in eastern North Control, has limited mental health and substance use resources and access to care. As a result of rurality, poverty, and lived experiences in an historically underserved area, Bertie County residents experience disproportionate behavioral health outcomes and disparities of care. While there have been longstanding access and health equity issues, there is a strong spirit of community in Bertie County.

Local organizations, providers, and residents recognize the need to address behavioral health in the county and came together in 2022 to establish the Bertie County Integrated Behavioral Health Network. The vision is that all people in Bertie County live in communities that foster and support positive behavioral health. The network identified community behavioral health concerns, including suicide and opioid overdose rates, and the needs of rural health providers to improve health in the community. The network hopes to increase community awareness of existing services and bring new behavioral health resources to the community. Partnerships with many organizations and individuals in Bertie County that will help improve the mental well-being of the community.

Network Development

The Foundation for Health Leadership and Innovation, Access East, Albemarle Regional Health Services, Greater Wynns Grove Baptist Church, and East Carolina University (ECU) established partnerships in early 2022 to develop the Bertie County Integrated Behavioral Health Network. The partnered organizations set out to elevate community voices in Bertie County to build a network to address unmet behavioral health needs of county residents. The initial network partners conducted outreach to providers and community-based organizations, local government, faith-based organizations, school systems, and others. The first network meeting had six attendees with five organizations represented. Today, the network has 60 people registered for network meetings representing 30 organizations. The network has been formalized through developing a shared vision and outlining an implementation plan with four focus areas for improving behavioral health care access in the community. The network has a standing monthly meeting that is open to all network organizations. These have been primarily hybrid meetings to be inclusive of regional and state partners, as well as partners who work on different sides of the geographically large county. The network developed an implementation plan early in the process to prepare a submission for an open grant cycle. Designing

the implementation before spending more time on network development was beneficial and challenging. The network was able to quickly identify focus areas and felt energized by the possibilities in the proposed implementation, but then the group had to backtrack to catch up on network development activities.

Programmatic Development

The Bertie County Integrated Behavioral Health Network is focused on improving access to behavioral health care, including mental health and substance use treatment. During the course of network planning activities and continually recruiting more community-based organizations in the network, network participants have been able to raise awareness about their own services available in the community and learned of others. The network witnessed organic referral processes during network meetings when partners shared what was available through their organizations. Network meetings were also an opportunity to provide education to the community about integrated behavioral health care, behavioral health stigma reduction, and connecting to social health resources.

Through program development, network partners identified several focus areas and goals. The network learned to be responsive to community needs and policy changes happening at both state and federal levels.

For example, during the network planning year, the state of North Carolina expanded Medicaid, which will impact the implementation goals of the network. It has been challenging to develop innovative solutions to behavioral health care access with a lack of transportation resources and broadband internet access in the county. However, the consistency of identifying those areas as a barrier has inspired the network to include more partners from those systems in the network. The network identified transportation infrastructure and behavioral health workforce development as focus areas based on the stories shared from community about experiences accessing care and trying to identify providers. There were also several advocates for children involved in the network who helped the network partners prioritize plans for school-based behavioral health services for children and families, as well as addressing behavioral health stigma in the community. Through network planning, several partnerships have evolved that will make these services a reality for the Bertie County community.

Sustainability

Network partners are committed to continue organic network development. The network partners have submitted an application for an implementation grant and will use the work on that grant application to continue to pursue funding for network implementation projects if it is not funded with the first application. The Georgia Health Policy Center's (GHPC) Sustainability Framework will guide the continuation of the Bertie County Integrated Behavioral Health Network. The Sustainability Framework has identified nine attributes that are common to sustained programs and organizations. These include: collaboration, leadership, communication, evaluation, return on investment, capacity, efficiency, effectiveness, relevance, practicality, and resource diversification. The network will stay mutually accountable through partnerships and communication, and will evaluate the network's vision and efforts against the GHPC Sustainability Framework's model. During planning, several innovative and sustainable practices have been established that have facilitated the move from emerging to mature network organization and action.

These include:

1. Supplementing the original needs assessment with ongoing surveillance and additional voices who provide first-hand experience and understanding of the needs and opportunities of the county
2. Establishing monthly network meetings, during which the broad base of partners and community

members discuss long- and short-term strategies, implications, and opportunities

3. Constantly scanning the people, resources, data, experience, and enthusiasm available to add value to implementation, influence public policy more broadly, and establish long-term change, and
4. Providing network workshops, education, or both as needed for integrated behavioral health, network planning, or other topics that will benefit members.

The network partners have collaborated over the past year to build new relationships in Bertie County to ensure broad participation and ownership of the network, assure that the network can adapt to circumstances as they evolve, and build a team best suited to implementing the actions most likely to add value going forward.

Region Covered

- Bertie County, NC

Network Partners

Member Organization	Location	Organizational Type
A Better Chance A Better Community	Enfield, NC	Nonprofit
Access East	Windsor, NC	Public Health
Albemarle Alliance for Children and Families	Elizabeth City, NC	Nonprofit
Albemarle Regional Health Services	Windsor, NC	Public Health
Bertie County Cooperative Extension	Windsor, NC	Other
Bertie County Council on Aging - Senior Center	Windsor, NC	Senior Center
Bertie County Schools	Windsor, NC	School System
Bertie County Sheriff's Office	Windsor, NC	Law Enforcement
Bertie County YMCA	Windsor, NC	Nonprofit
Bertie Rural Health Association	Windsor, NC	Federally Qualified Health Center
Blue Cross and Blue Shield of NC	Durham, NC	Other
CareNet Counseling	Greenville, NC	Behavioral Health
East Carolina University Brody School of Medicine	Greenville, NC	College/University
Eastern Area Health Education Center	Greenville, NC	Area Health Education Center
ECU Health Bertie Hospital	Windsor, NC	Critical Access Hospital
ECU Health Chowan Hospital	Edenton, NC	Critical Access Hospital
Eustress - The Good Stress Company	Windsor, NC	Behavioral Health
Family Support Network of Eastern North Carolina	Greenville, NC	Nonprofit

Member Organization	Location	Organizational Type
Galileo Health	Greenville, NC	Other
Greater Wynns Grove Baptist Church	Colerain, NC	Other
Mid-East Commission	Washington, NC	Government
NC Agromedicine Institute	Greenville, NC	Other
NC Farm and Ranch Stress Assistance Network	Greenville, NC	Other
NC Office of Rural Health	Raleigh, NC	Government
Pittman's Pharmacy	Windsor, NC	Other
Retired Governmental Employees Association	Raleigh, NC	Other
Roanoke Chowan Community Health Center	Colerain, NC	Federally Qualified Health Center
Roanoke Chowan Community College	Ahoskie, NC	College/University
Trillium Health Resources	Greenville, NC	Medicaid Managed Care Organization

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Garnet Health Medical Center - Catskills

Sullivan Transportation Health Access & Reliability Taskforce

P10RH45762

Project focus area:
Transportation

Other focus areas:
Network Organization/ Infrastructure Development

Network Statement

Sullivan County is known for its rich history, the natural beauty of its lakes, rivers, and mountains, and of course, the people. The population is unique in that it includes families who have been here for several generations, as well as those who come for seasonal stays or day trips. However, Sullivan County is ranked 60th out of 62 counties in New York state for health status according to county health rankings, establishing it as one of the least healthy counties in the state. Among the top issues that affect health in Sullivan County are access to affordable, reliable personal transportation; access to affordable, decent, and safe housing; and access to affordable, reliable public transportation, making transportation an important area of interest to improve health access.

The Sullivan Transportation Health Access & Reliability Taskforce (STHART) is addressing the gap in medical transportation services by developing a robust transportation network focused on historically excluded residents. The dedicated experts that compose STHART have a shared vision to improve health outcomes by creating access to quality medical services. With community support, the network hopes to establish long-lasting solutions to make transportation resources more accessible to all Sullivan County residents.

Network Development

The STHART Network has enjoyed the process and valued the network development component of the Rural Health Network Development Planning grant. While partner members have remained committed to the network throughout the grant cycle, there were several staff changes within the partner agencies that required re-orientation and adjustments to the work plan. Despite these minor setbacks, the STHART members stayed focused on data collection and analysis to further the work of the transportation planning program. Thanks to the tools provided for the network development process, STHART has established a strong vision and mission and has developed a plan for the future of the partnership. The STHART Network will merge with the Sullivan County Transportation Steering Committee to avoid duplication of efforts between the two organizations. Formal agreements and defined responsibilities will help guide the continued efforts to provide medical transportation in Sullivan County.

Programmatic Development

The programmatic progress included a comprehensive strategic plan composed of literature reviews, best practice reviews, and review of health care-specific data for Sullivan County including census-based data, as well as current and future conditions reporting. The challenge has been to determine the network's final scenario planning and implementation strategy. The network's work has been led by the consulting team, Urban Design 4 Health. Through trial and error, network members began to look at transportation from a different perspective and explore the option of bringing services to where patients are located rather than transporting patients to where services are located. Additionally, the network is in the process of developing alternative solutions to complete a strategic plan.

Sustainability

After the Network Planning grant period, the STHART Network will join the transportation steering committee of Sullivan County to continue the work addressing the gaps in medical transportation services for historically excluded residents. The steering committee currently only consists of the county transportation department and has a primary focus of transporting residents for work and shopping needs. The network will join the steering committee and work together to engage more like-minded agencies to participate on the committee. The STHART strategic plan will be used for future funding opportunities and the STHART members will support the process by continuing to provide in-kind services and pursuing additional funding sources to complete the goals of the program.

Region Covered

- Sullivan County, NY

Network Partners

Member Organization	Location	Organizational Type
Garnet Health Doctors	Monticello, NY	Physicians' Clinic
Garnet Health Medical Center-Catskills	Harris, NY	Hospital
Rolling V Bus Corporation	South Fallsburg, NY	Transportation
Sullivan County Division of Community Resources	Monticello, NY	Government

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Good Samaritan Hospital

Rural Community Healthcare System

P10RH45767

Project focus area:
Transportation

Other focus areas:
Behavioral Health

Network Statement

The Rural Community Healthcare System's mission is to carry out planning activities to effectively address local behavioral health, primary care, care coordination, and care integration needs, resulting in the eventual creation of an integrated health care network. Knox County and the surrounding four-county community is composed of a population who typically shy away from addressing mental health needs. The Rural Community Healthcare System was formed to lead the way in eliminating the stigma of, and barriers to, behavioral health, and improve accessibility to health care.

Rural health care needs are important. Transportation and access to medical care was identified as a focus area for the community. The team focused on access to medical care, utilizing current methods and resources available in the four-county area. With input from various team members from the area, the problem was examined, and potential solutions proposed. All members are serving from a background focused on the health of the community. The team's fluidity is a strength as it seeks to attract the appropriate members at the appropriate time, discussing potential solutions and identifying additional personnel or resources that will be needed. The varied backgrounds of members, while similar in scope, represent the network's strengths and its ability to be successful and responsive to the problem at hand.

Network Development

The Good Samaritan Hospital Network initially convened in 2022 to implement planning activities addressing local behavioral health, primary care coordination, and care integration needs. Each entity in the network has achieved success on an individual basis and has proven its longstanding commitment to public health through longevity and public acceptance. While the members had always worked together tangentially, this network is the first formal collaboration of the entities and the first attempt at focusing on a single subject matter — a stated commitment to a health network. The partners were selected based on their individual access and attention to a wide variety of patients and their needs. The network has worked together to develop a network statement, an organizational assessment, and an external environmental scan, with transportation being the primary focus. The lack of a skilled workforce and lack of knowledge in the general population were also identified as potential areas where improvements could be made. The organizational assessment also found that members had different concepts of the network and differences in opinion, including the current reality

and the aspirations of the network. Daviess County Health Department and Martin County Health Department were recently added to the network and will be utilized for continued growth and discussion. The Daviess County Health Department has reached out with a need for mobile health clinics for its underserved immigrant population. The network will continue to utilize these partners in the future, as the hospital has re-purposed the mobile unit to be available for primary health needs, rather than only for mental health needs. As future opportunities arise and interest is voiced by other organizations in the community, Good Samaritan Hospital and the Knox County Health Department will work together to ensure availability of this resource.

Programmatic Development

A 2020 community needs assessment in the service area indicated a need for increased access to primary care services, transportation, and accessibility to care and was identified as a focus early on in network discussions. The network has focused primarily on examining the possibility of expanding the current Good Samaritan Hospital Mobile Wellness Unit to deliver care to outlying areas. The Mobile Wellness Unit did increase the number of communities served (from five to six communities – Loogootee, Shoals, Winslow, Bicknell, Oaktown, and Washington) since the inception of the network. More importantly and impactful for the transportation issue, the hospital has partnered with the local YMCA in providing public transportation and increased hours of operation.

Local funding for a public transit route is a possibility and will be further investigated. Future plans being discussed include joining with other networks and groups in the community to continue conversations regarding transportation. The recent addition of the Daviess County Health Department will improve services to the immigrant population of Daviess County. Ultimately, utilizing the Mobile Wellness Unit in these neighboring counties will provide assistance in unconventional settings, granting health care to the populations in most need.

Sustainability

Major changes to the network will soon occur, beginning with the transitioning of the Samaritan Center to the Family Health Center. Good Samaritan Hospital will continue to communicate with partners (Family Health Center and Good Samaritan Physician Network), through the network formulation, with no major funding needs anticipated. Transportation and accessibility to health care will remain a focus of Good Samaritan. The Mobile Wellness Unit will continue to be utilized and will be operated under the auspices of the hospital. The hospital is looking to expand a paramedicine program and the mobile unit could become a vital part of that program, further enhancing access to care in the local community.

In addition, the Knox County Health Department has contracted with Good Samaritan to lease the Mobile Wellness Unit for various days throughout the coming year and will be delivering services in Daviess County, to the large population of Haitian and migrant workers there. The funds obtained through this contractual agreement will help alleviate the costs of the unit and will assist in maintaining its viability in the community.

Region Covered

- Daviess County, Indiana
- Knox County, Indiana
- Martin County, Indiana
- Pike County, Indiana

Network Partners

Member Organization	Location	Organizational Type
Daviess County Health Department	Washington, Indiana	Public Health
Family Health Center	Vincennes, Indiana	Federally Qualified Health Center
Good Samaritan	Vincennes, Indiana	Hospital
Good Samaritan Physician Network	Vincennes, Indiana	Physicians' Clinic
Knox County Health Department	Vincennes, Indiana	Public Health
Martin County Health Department	Loogootee, Indiana	Public Health

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HOPE for a Drug-Free Stephens

Stephens County Wellness and Recovery Network

P10RH47171

Project focus area:
Population Health/
Social Determinants of Health

Other focus areas:
Behavioral Health
Integrated Health Services
Network Organization/Infrastructure Development
Substance Abuse/Addiction

Network Statement

The HOPE for a Drug-Free Stephens Network reaches into high-poverty and medically underserved neighborhoods, schools, and workplaces to strengthen and expand prevention, treatment, and recovery services for individuals with alcohol and substance use disorders. Now, there is HOPE for individuals who have been historically underserved, marginalized, and adversely affected with little or no access to care and at risk and in need of treatment and recovery solutions. Through the "Unite Us" social referral platform, one of the key systemic disadvantages is now being addressed with an equity-based approach that ensures everyone will have a fair chance to live in recovery.

HOPE for a Drug-Free Stephens, a registered rural nonprofit 501(c)3 network, unites thirty public and private partners from diverse sectors, including the medical community, mental health services, school system, local industries, community-based organizations, law enforcement, peers in recovery, recovery organizations, and the court system. Since 2018, the dedicated members have collaborated to develop innovative solutions to combat fatal overdoses and address the mental health and substance use crisis that impacts vulnerable individuals in the community.

Leveraging the collective resources of the network, the Center for Wellness and Recovery of Northeast Georgia opened in May of 2021 after local leaders with health care experience stepped up to form a nonprofit 501c3 and open a 12-bed detox and treatment center in response to the opioid overdose crisis. The center provides a range of essential behavioral health services, including a 30-day residential detox and treatment program, medication-assisted treatment, outpatient counseling, social services, and peer recovery support. The ultimate goal is to ensure equal access to quality treatment and support individuals in achieving sustainable long-term recovery in a recovery community where individuals have a safe and sober environment to live, work, and play.

Network Development

The planning of the Stephens County Wellness and Recovery Network has been instrumental in the development of a more formal network to provide integrated health services for Stephens County residents. Services include detox and treatment services, addiction and behavioral health counseling, social health needs, recovery services, and primary and preventive care delivered live and via telehealth. A network manager/care

coordinator was hired to coordinate care among network partners with the help of the Unite Us social health platform. The members of the network have been onboarded into the Unite Us platform where they refer patients and receive referrals to provide services to meet physical, behavioral, and social health needs. This value-driven approach has resulted in increased access to care, reduced cost, and improved lives and long-term outcomes.

Programmatic Development

Programmatic development of the network has been achieved through the following steps:

1. Developing a plan with network members to integrate behavioral health care and treatment for opioid/substance use disorders with primary care
2. Expanding access to patient-centered psychiatric care and counseling and to recovery support through the use of telehealth and secure facetime encounters
3. Coordinating and improving the quality of essential services through a network manager/care coordinator to manage transitions of care and track patient follow-up and outcomes
4. Developing a community-wide integrated behavioral health strategy that includes the rollout of the Unite Us social health platform with data analytics to track quality and outcomes
5. Completing a network organizational assessment at the end of year one to identify network strengths and areas for improvement that need to be addressed with an action plan
6. Completing a sustainability plan that identifies long-term strategies for operationalizing the activities with quantifiable metrics to assess the short-term and long-term impact

Sustainability

Major changes to the network will soon occur, beginning with the transitioning of the Samaritan Center to the The network sustainability plan provides a complete picture of the comprehensive strategy of the Stephens Wellness and Recovery Network's long-term sustainability outlined below:

1. Sustain the network membership and support through continued engagement, monthly network meetings and communications.
2. Secure target population support and engagement through collaboration with partners that serve these populations.
3. Leverage partnerships at the local/community, state, and regional levels. These partners may include entities like rural counties and municipalities, health plans, law enforcement, community recovery organizations, faith-based organizations, and others with effective and successful programs and services that meet the needs of those with substance use disorders in the community.
4. Support network members in the implementation of the Unite Us software platform to refer clients or patients to network resources to meet their physical, mental, and social health needs.

Region Covered

- Stephens County, GA

Network Partners

Member Organization	Location	Organizational Type
Avita Community Partners	Toccoa, GA	Behavioral Health provider
Georgia Partnership for Telehealth	Toccoa, GA	Other
HOPE for a Drug-Free Stephens	Toccoa, GA	Collaborative
Northeast Georgia Physicians Group – Toccoa Clinic	Toccoa, GA	Physicians' Clinic
Stephens County Hospital	Toccoa, GA	Hospital
The Center for Wellness and Recovery	Toccoa, GA	Behavioral Health provider

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Indiana Rural Health Association

Indiana Transfer of Care Network

P10RH45768

Project focus area:
Increase Health System Efficiencies

Other focus areas:
Health Equity
Network Organization/Infrastructure Development
Quality Improvement
Transportation

Network Statement

For hospital patients in need of a rapid and efficient interfacility transfer offering specialized care, emergency medical services (EMS) are the critically important connection to that higher level of care. These interfacility transfers (IFT) ensure that patients have adequate transport to another health care location to receive appropriate medical care. Without access to timely EMS transfers, hospitals can face full emergency rooms and negative health outcomes for patients, including death, which affect the community at large. Yet many communities are struggling to provide timely IFTs due to limited funding and a decreasing workforce.

The Indiana Transfer of Care (InTOC) Network strives to empower local hospitals and their communities to ensure the highest level of care is always available. Under the leadership of the Indiana Rural Health Association, InTOC partners joined together in 2022 to ensure easy access to health care services through inter-facility transfers. A community action network made up of state leadership, local EMS providers, and local health care providers are working together to achieve an equitable, available, and timely hub-and-spoke model for interfacility transfers, thus increasing access to appropriate and timely care for rural Indiana citizens. Working towards change, the InTOC Network continues to identify solutions to EMS workforce challenges and advocate for change in EMS models, workforce, reimbursement, and communication. Ultimately, the InTOC Network intends to achieve the necessary connections that will provide greater access to advanced care for families, friends, and the community.

Network Development

Focusing on network development over the past year has allowed the InTOC Network to build relationships, create formal, signed agreements, create an organizational structure and a formalized board, and hold monthly planning meetings. The network conducted a network organizational assessment, which identified opportunities for formalization. As a result, the network created formal bylaws, policies, and procedures.

A challenge in network development is getting participation from partners when partners are not currently receiving funds for their participation. The Indiana Rural Health Association did much of the initial

development of network deliverables, including network statement and environmental and organizational assessments, and then solicited partner feedback and approval.

Programmatic Development

Programmatic development over the past year was focused on creating a more efficient and equitable system of health care for interfacility transfers. The network collaborated to create and define a shared, regional motor pool that will be housed in Terre Haute, Indiana. Decisions were made based on GIS mapping, data collected from an initial needs assessment, and preliminary data records from each hospital for interfacility transfers. Preliminary data records detailed how often a transfer occurred, how long it took to get a transfer, and where the patient was transferred and reason for the emergency transfer. Overall, there is a lack of data on IFTs and historically, IFT data has been tracked by hand. Additionally, there is currently no streamlined way to track IFT data. This ultimately affects the rural community health care system at large.

Responding to the data has presented challenges specifically related to finances and the workforce. Securing an outfitted vehicle to do the transfers as part of EMS start-up is expensive. The InTOC Network plans to identify community grants and other grant opportunities to cover these upfront costs. After the initial upfront costs, the network partners will budget to pay into the IFT service line for not only maintaining supplies but also the workforce.

Sustainability

To sustain the network, InTOC has worked together to strengthen partnerships and has discussed continuing to sustain the network through building capacity and diversifying funding streams. Hospital groups within the network will contribute to sustainability through financial contributions on a yearly basis to the non-emergent interfacility transfer line of service. The network has also identified community grants to assist in funding items like location, trucks, medical equipment, and more.

Further, the InTOC Network has also focused on building capacity, both with staffing and location for the IFT service line. Regarding the EMS workforce, InTOC will gain insight into the EMS staff and paramedic needs through an EMS workforce study conducted by the Bowen Center for Health Workforce Research and Policy. Based on the study's findings, this presents an opportunity to address and better support the EMS workforce. The IFT service line will be stationed in Terre Haute, at a location selected by partners. Finally, there are already existing services that provide IFTs, however, they are not able to adequately support the current volume. To ensure these services are able to continue to support IFTs, the IFT service line will utilize existing transport services on a rotating monthly basis. Lastly, the network will initiate a formal board and formalize a structure to contribute to decision-making and sustainability in regard to workforce, location, and diversifying funding.

Region Covered

- Putnam County, Indiana
- Sullivan County, Indiana
- Vermillion County, Indiana

Network Partners

Member Organization	Location	Organizational Type
Putnam County Hospital	Greencastle, IN	Critical Access Hospital
Sullivan County Community Hospital	Sullivan, IN	Critical Access Hospital
Union Hospital Clinton	Clinton, IN	Critical Access Hospital

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Louisiana Rural Health Association

Rural Health Care Coordination Network

P10RH47172

Project focus area:
Network Organization/ Infrastructure Development

Other focus areas:
Care Coordination
Community Health Workers
Health Information Technology

Network Statement

Every day, Louisiana residents live with and die from chronic illnesses like heart disease at astronomical rates – rates exceeding their counterparts in nearly all other states. Social determinants like high poverty rates, low graduation rates, racial inequality, and a lack of health care resources are threatening the lives of proud, hardworking Louisianians. The hardest hit are those living in rural areas, like the Acadiana region, due to limited access to health care specialists and social support resources. The results are even higher levels of chronic illness and even poorer outcomes.

The Rural Health Care Coordination Network has evolved over the past three years from a nascent idea to having a solid role in chronic care management performance improvement, data analytics, and regional strategic planning for improved telehealth care coordination. The network aims to support telehealth integration and health information exchange engagement to build and maintain a framework that accompanies technical support and evaluative methods. This strategy and framework support better health outcomes and make measuring program impact and cost of care more accurate. In turn, health care can be more efficiently and effectively delivered. The program is now bringing more clinicians into the health information exchange fold and expanding its reach to community health workers. By growing the health care network while addressing the “whole person,” Louisiana will be healthier and more equitable.

Network Development

The Rural Health Network Development Planning Grant was used to build upon previous collaborative work that the Louisiana Rural Health Association (LRHA) engaged in with Louisiana Technical University (LaTech) and the Louisiana Public Health Institute (LPHI) separately. Bringing the three organizations together for the first time leveraged the relationships of LRHA, the analytics capacity of LaTech, and the health information exchange software of LPHI. The group has identified its next strategic steps and potential additional members of the network, who have expressed interest.

Initial challenges included narrowing the focus of the initiative to a specific region. The group established criteria which included: existing relationships, existence of primary care clinics, and lack of participation by

primary care providers in the rural health information exchange. In the end, the group decided that having a regional hospital anchor that also participated in the health information exchange was important.

Working through these issues was facilitated by initial mapping of regional assets as well as needs. This provided a visual representation of existing infrastructure as well as areas with the highest health disparities. Leveraging the regional hospital anchor also helped define the service area. Finally, a close analysis of existing need data showed that strategies to address social determinants of health were critical to a strong implementation of the care coordination software since individual rural health clinics do not necessarily have the resources to hire dedicated care coordinators or community health workers.

Programmatic Development

The network has designed a program that will integrate care coordination and social determinants of health navigation with primary care sites through community health workers (CHWs) and a Medicaid-focused health information exchange. Instead of housing the CHWs within the rural health clinics, the network will use a horizontal integration model that is more suited to a rural community where it is not realistic to have a CHW embedded with each primary care clinic. Instead, the Louisiana Department of Health's local public health unit has an existing CHW program, and they have agreed to participate in the network once funds are available. The group has identified its next strategic steps as follows:

- **Goal 1:** Engage in a one-year planning process to identify, finalize, and pilot the health information technology, policies, procedures, staffing, and communication systems necessary to expand the HIE sites and link patients and providers with Community Health Workers to conduct care coordination and address social determinants of health.
- **Goal 2:** Expand the pilot program in years two through four to a new parish each year.
- **Goal 3:** Institutionalize care coordination strategies within partner policies, procedures, staffing, services, and communication systems.
- **Goal 4:** Implement a multidisciplinary and multi-sector referral system.
- **Goal 5:** Identify cost-savings and financing mechanisms to continue integrated care coordination.

The most significant challenge now is identifying funding to implement the next phase of the network and pilot the proposed horizontal integration model. In absence of funding, the group is also developing an alternative path forward that does not require additional funding.

Innovations that might be helpful to other communities include leveraging a Medicaid-focused HIE to participate in the network as well as working with local public health units and their existing programs. Although there is precedent for linking CHWs with HIEs through care coordination, an example of the planned horizontal integration was not found during a literature review.

Sustainability

Planning the path forward without knowing the status of funding has been the most difficult. The network has submitted an initial grant funding request and identified other potential grants. The final steps for this planning year involved identifying strategies to continue forward with momentum. Having Louisiana Technical University as a partner means that the network can generate strong analytical data to demonstrate its impact on health care costs, which will facilitate future financial sustainability.

While funding is pending, the network will integrate itself into other existing collaborative efforts such as the Louisiana CHW Workforce Committee and the Louisiana CHW Network. Other affinity groups that the network can explore include those that conduct education and awareness for CHWs and rural providers about the health information exchange. Network education efforts will continue to be statewide with a special focus on areas where there is a health-care organization in the health information exchange network. The goal of education efforts would be a deeper and more permanent understanding of care coordination strategies and available resources in rural settings.

Region Covered

- Acadia Parish, LA
- Avoyelles Parish, LA
- Evangeline Parish, LA
- St. Landry Parish, LA

Network Partners

Member Organization	Location	Organizational Type
Louisiana Public Health Institute	New Orleans, LA	Nonprofit
Louisiana Rural Health Association	Napoleonville, LA	Nonprofit
Louisiana Technical University Computer Science Department	Ruston, LA	College/University

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Missouri Alliance of YMCAs

NEMO Strong

P10RH45769

Project focus area:
Integrated Health Services

Other focus areas:
Behavioral Health
Care Coordination
Health Education
Health Equity

Network Statement

Mark Twain once said, "...the elastic heart of youth cannot be compressed into one constrained shape long at a time." Hannibal, Mark Twain's boyhood home, and the surrounding region of northeast Missouri are deeply committed to the health and well-being of the youth, the community's greatest asset. Young people have the potential, enthusiasm, energy, and optimism to strengthen the communities and make them more vibrant long-term. Unfortunately, the communities face many challenges — high rates of suicide, drug abuse, food insecurity, smoking, and obesity – that threaten the kids and their families.

Multiple anchor institutions are joining forces to respond to these challenges and create healthy and nurturing communities in northeast Missouri (NEMO) so kids can flourish and thrive. Known as NEMO Strong, this cross-sector coalition will leverage its combined strengths and relationships to build the region's capacity to make programs and information more accessible to its residents. This includes intentionally engaging youth, whose ideas and voices will help shape NEMO Strong's efforts and increase buy-in and involvement by youth and their families. United, NEMO will build a healthier region that promotes physical and mental health and strengthens the resources and opportunities for the next generation.

Network Development

NEMO Strong started with a group of 11 network members. The group kicked off the work with an in-person network meeting to get to know each other and added 15 additional members. This resulted in more collaboration but also required the creation of a steering committee to maintain effectiveness and focus on work outcomes.

The network will remain a coalition of partners working on "improving our community's wellness one person at a time." The primary challenges faced during network development and planning were 1) getting the full group together in-person for group learning and discussion, consensus building, and planning decisions and 2) sustaining momentum for change in an environment that is full of staffing challenges, budget shortages, and overloaded health systems. The network worked to overcome these challenges by modifying the meeting schedule to include more one-on-one meetings for check-ins and two network retreats where members

could spend more time building relationships and diving deeper in network planning. Defining quick wins during the planning stages has partners excited for implementation and the network is ready to move beyond planning and get to work. Specifically, NEMO Strong is moving forward with regularly scheduled meetings and communication strategies to stay engaged as a network and to identify opportunities for integration, to leverage funding and development, and enhance services.

Programmatic Development

NEMO Strong has focused on two areas that will support program development:

The first area for program development is integration of existing services. The network worked to identify and share existing programs, targeting their strategic goals. There are existing opportunities to advance the health and wellness of youth through cross-referrals, transportation, and more intentionality around programming and education within current services. To advance positive change in the health and wellness of youth in northeast Missouri, the network has laid out objectives around increasing youth engagement and improving systems such as transportation and referrals. Additionally, to improve the mental health of youth, the network has identified objectives around increasing youth knowledge and skills and strengthening the mental health infrastructure.

Secondly, the network will work as a group to identify new financial resources to support program implementation. The network has also identified several objectives, including establishing dedicated staffing, strengthening the governance, securing resources, implementing education and communication to increase awareness, engagement and support, and developing a dashboard to measure success.

Sustainability

NEMO Strong identified a steering committee that will continue to serve the network. The chair has been identified and will serve for one year. Additionally, goals around building infrastructure and capacity were identified and include establishing staffing, building and strengthening governance, and securing resources. Lastly, the network will develop bylaws to provide leadership into the future.

Region Covered

- Marion, MO
- Pike, MO
- Ralls, MO

Network Partners

Member Organization	Location	Organizational Type
Blessing Health System	Hannibal, MO	Hospital
Bowling Green Schools	Bowling Green, MO	School System
Clopton Schools	Clopton, MO	School System
Douglass Community Services	Hannibal, MO	Behavioral Health
Gateway Region YMCA	St. Louis, MO	Nonprofit
Hannibal Regional Hospital	Hannibal, MO	Hospital

Member Organization	Location	Organizational Type
Hannibal School District	Hannibal, MO	School System
Hannibal YMCA	Hannibal, MO	Nonprofit
Louisiana Schools	Louisiana, MO	School System
Palmyra Schools	Palmyra, MO	School System
Preferred Family Healthcare	Hannibal, MO	Behavioral Health
Pike County Health Department	Louisiana, MO	Health Department
Pike County Memorial Hospital	Louisiana, MO	Hospital
Marion County Schools	Philadelphia, MO	School System
Mark Twain Behavioral Health	Hannibal, MO	Behavioral Health
Twin Pike YMCA	Louisiana, MO	Nonprofit

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North Country Healthy Heart Network, Inc.

North Country Chronic Disease Prevention Coalition

P10RH45770

Project focus area:
Network Organization/ Infrastructure Development

Other focus areas:
Chronic Disease Prevention/Management

Network Statement

Chronic diseases are the leading causes of death, disability, and skyrocketing health care costs in the United States and in North Country, yet these conditions are largely preventable. Early detection, coordinated interventions, and management of symptoms can reduce costs and improve people's chances of staying well and feeling good as they age.

The North Country Chronic Disease Prevention Coalition is a network of medical and behavioral health care providers, public health units, area offices of aging, social care agencies, and other chronic disease prevention program stakeholders that collaborate to offer coordinated, comprehensive, evidence-based products and services designed to reduce the burden of chronic disease. In doing so, the health and social care delivery system will emphasize prevention — not treatment — which offers every North Country resident equal opportunity to live their healthiest life.

Network Development

Progress: The coalition made great strides toward formalizing the network. Specifically, the coalition's network lead entity (NLE), North Country Healthy Heart Network, Inc.'s board of directors formalized the coalition's steering committee by chartering it as the Integrated Network Development Committee and making it a standing committee of the board. At the same time, the board updated its bylaws, organizational chart, and certificate of incorporation to reflect its expanded purpose and new governance structure. In addition to formalizing the governance structure, the NLE and coalition participant roles were further clarified. To that end, the coalition memorandum of understanding was updated and signed by 29 organizations. Further, service agreements were developed and executed among the NLE and the coalition's lead training and technical assistance partner and several evidence-based program delivery organizations. Finally, the coalition concluded its work on several plans intended to promote network sustainability. This includes finalizing an evaluation and data collection plan, strategic plan, and business (sustainability) plan.

Programmatic Development

Challenges: Planning on the heels of the COVID-19 pandemic presented numerous challenges for the coalition. Most participating organizations provide direct care and support. As these organizations began to emerge from the COVID crisis, they were confronted with an accumulation of unaddressed "other" patient, client, regulatory, and financial needs. This was unfortunately at a time when staff were burnt out and leaving in search of less stressful situations. Although the coalition had a good core group of organizations that were able to consistently participate, staff remaining at many coalition participant organizations had little bandwidth to engage in planning. The turnover in staff assigned to represent participant organizations at planning meetings was also a challenge. Another challenge facing the coalition during this planning year was uncertainty around a 1115 waiver that New York state proposed in the fall of 2022. The proposal included strategies that, if employed, would impact coalition decision-making — specifically, decisions about business structure and potential information technology investments. Until an announcement is made and the regional plan for implementation is defined, the coalition's position will be to continue communicating its intention to be the lead chronic disease management network to all potential 1115 regional lead entities. Finally, staffing for this project was a challenge — partly because funding for the proposed project manager position was not guaranteed beyond the one-year planning grant period, and partly because qualified applicants required a salary higher than the contract could afford. Fortunately, an exception was made to allow for the engagement of a consultant to support the planning work.

Innovation: The coalition is organized as a shared-services model network, a model that is unique and necessary. The current region is large — about the size of Massachusetts — with small-town population centers that are often separated from each other by distances of at least 40 to 60 miles. Health care organizations supporting these communities are, for the most part, small and have very limited resources. To deliver ongoing, year-round chronic disease prevention and self-management services in a community requires dedicated staff and systems, none of which any one organization in this region can afford. By working together and sharing resources, the coalition can collectively help one another's communities increase access to these important services. Specifically, participating organizations sharing programs, organizational strengths, expertise, and access to high-need populations collectively create a regional structure with the capacity to sustain ongoing support for chronic disease prevention services. Each member has a role (or two or three) to play. Whether that role is to support program delivery, offer staff expertise to help solve an operational challenge, or help promote community awareness, each member's contribution helps the coalition achieve its mission and get closer to the future it has envisioned for the North Country.

Progress: Although the purpose of this contract was not focused on program development, the coalition did use other funds to support activities intended to increase delivery of, and enrollment in, its members' evidence-based chronic disease prevention and self-management programs. The coalition established "recruitment strategies" and "referral performance improvement strategies" teams to focus on monitoring and implementing plans to increase program enrollment via either self- or provider-generated referrals. The coalition also secured funds to support the development of a pilot contractual structure through which organizations can be reimbursed for providing self-management education programs.

Finally, the North Country Chronic Disease Prevention Coalition began exploring opportunities for integration of its members' existing education and self-management services with other chronic condition management services such as care management, community health workers, and meal delivery programs.

Challenges: The most significant challenge programmatically was a lack of provider-referred enrollment. During the first three quarters of this 12-month grant, providers made 176 referrals. That represents 34 percent of the 525 referrals targeted by June 30, 2023. Further, an overwhelming majority of those referrals (80 percent) came from just one provider. Despite best efforts to simplify the referral process and convey the value of engaging patients in these evidence-based programs, provider offices are not yet consistently and systematically identifying and referring patients who could benefit. Moving forward, the NLE aims to secure funds that will support the addition of dedicated staff to work with provider practices.

Innovation: Delivering chronic disease prevention and self-management programs as a network rather than as individual organizations is an innovative way to ensure rural communities have access to these lifesaving services. First, no single organization alone has the capacity to dedicate full-time staff to providing a year-round calendar of programs, let alone staff to coordinate the systems needed to get people connected to those programs. However, many organizations have prioritized supporting efforts to reduce the burden of chronic disease in their communities and are able to dedicate a few hours of staff time each week to assist. The network brings these organizations together so that they can collectively offer programs throughout the year.

Sustainability

The future of the coalition is bright. Functionally, the NLE will continue to provide leadership and administrative staff support to the network. The coalition will continue pursuing foundation, New York state, and federal grant opportunities to help sustain that core function. Additionally, the North Country Chronic Disease Prevention Coalition will begin outreach to payers to introduce coalition services and value propositions. Simultaneously, the coalition will continue cultivating relationships with other payer intermediary organizations such as the Adirondacks Accountable Care Organization, Northwinds IPA, and Fort Drum Regional Health Planning Organization — and advocating for inclusion of its members' services in value-based or shared savings contracts those organizations are negotiating.

Programmatically, the program delivery participants in the coalition are anticipated to continue offering programs as long as:

1. there is a continued demand
2. they have access to ongoing training and technical assistance, and
3. funding to offset the cost of hosting a program is available.

To ensure ongoing demand for programs, the NLE, in partnership with the regional chronic disease self-management training and technical assistance center, will continue to facilitate the "recruitment strategies" and "referral performance improvement" teams so that the broader coalition remains engaged in activities to promote program participation. Sustainability of the training and technical assistance center function, as well as funding to support program delivery, will be accomplished through the mix of strategies described in the previous paragraph.

Region Covered

- Clinton County, NY
- Essex County, NY
- Franklin County, NY
- Hamilton County, NY
- St. Lawrence County, NY
- Warren County, NY
- Washington County, NY

Network Partners

Member Organization	Location	Organizational Type
Adirondacks ACO	Plattsburgh, NY	Other
Area Agencies on Aging (Clinton, Essex, Franklin, Warren/Hamilton, Washington Counties; St. Regis Mohawk Tribe)	Potsdam, Hogansburg, Malone, Plattsburgh, Elizabethtown, Glens Falls, & Fort Edward, NY	Area Agency on Aging
Adirondack Health Institute	Glens Falls, NY	Other
Behavioral Health Services North	Plattsburgh, NY	Behavioral Health
Champlain Valley Family Center	Plattsburgh, NY	Behavioral Health
Claxton-Hepburn Medical Center	Ogdensburg, NY	Hospital
Clifton-Fine Hospital	Star Lake, NY	Critical Access Hospital
Community Health Centers of the North Country	Ogdensburg, NY	Federally Qualified Health Center
Cornell Cooperative Extension of Essex County	Elizabethtown, NY	Nonprofit
County Public Health Agencies (Clinton, Essex, Franklin, Hamilton, Washington, St. Lawrence)	Potsdam, Malone, Plattsburgh, Elizabethtown, & Fort Edward, NY	Public Health
Fort Drum Regional Health Planning Organization	Watertown, NY	Other
Glens Falls Hospital	Glens Falls, NY	Hospital
Hudson Headwaters Healthcare Network	Glens Falls, NY	Federally Qualified Health Center
Northwinds IPA	Plattsburgh, NY	Behavioral Health
Prevention Team	Ticonderoga, NY	Nonprofit
St. Lawrence County Health Initiative	Potsdam, NY	Nonprofit
St. Regis Mohawk Tribe	Hogansburg, NY	Tribal Nation
UVM-Alice Hyde Medical Center	Malone, NY	Hospital
UVM-Champlain Valley Physician's Hospital	Plattsburgh, NY	Hospital
UVM-Elizabethtown Community Hospital	Elizabethtown, NY	Hospital

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New Mexico

Rio Arriba County

Rio Arriba County Rural Housing Task Force

P10RH45764

Project focus area:
Housing

Other focus areas:
Behavioral Health
Substance Abuse/Addiction

Network Statement

The Rio Arriba County Rural Housing Task Force (RAC-RHTF) was created to identify and illuminate unmet needs relating to housing programs, housing development, and substance use disorder (SUD) in the Española Valley and surrounding areas, subsequently developing and implementing solutions to meet those needs. The task force has laid the foundation for addressing future housing and SUD related crises in the community by bringing tenants, property owners, community activists, service providers, first responders, and local and national politicians together to address the affordable housing crisis in Española, NM. The RAC-RHTF has convened these relevant stakeholders, conducted an initial environmental scan, and are developing a methodology that will work in the community to accomplish a tangible product: housing coupled with direct services. The RAC-RHTF will help the community to develop housing and shared spaces that embrace traditional knowledge while recognizing the connection between past harm and multi-generational SUD. Services provided will utilize a restorative justice response to emphasize life skills training and reintegration. Services will be designed to be trauma-informed and culturally sensitive in order to provide regenerative housing and holistic support for all community members.

Network Development

RAC-RHTF recognizes that formality would lend important credibility to the work already underway and impact resource eligibility, such as grant funding, or future programs. RAC-RHTF is working to determine the degree of formality that will be most effective to achieve goals and programs into the future. There is a significant challenge in finding the reliable resource streams needed to sustain a formal network long-term. RAC-RHTF is currently looking to examples of housing collaboratives in the region to assess if their structures or models would be appropriate to consider as a continuation for RAC-RHTF. RAC-RHTF has begun to work with S3 Santa Fe Housing Initiative (S3), an established collective impact initiative in a neighboring community, to learn from them and see how they formed and continue to serve their community. S3 accepts public donations and receives contributions from community foundations and organizations, which may be an option for the continuation of RAC-RHTF.

Members of the task force had to dedicate time and effort to preventing the displacement of many individuals and families due to the imminent closure of an affordable housing complex in the community. This unexpected housing crisis took time and energy away from formalizing the network, but also united partners in action. The task force immediately mobilized to amplify awareness regarding the devastating impact this closure would have on the community, worked to make connections between agencies and local governments, engaged the affected community, and brought relevant parties together to stop the displacement of involved families and individuals. RAC-RHTF continues to coordinate long-term solutions, and community groups have come together to clarify needs and find resources to improve the entire complex and ensure it is a vibrant community for residents and neighbors.

Finding functional precedent organizations to look to as examples has been difficult, as RAC-RHTF is the first network looking to apply the health care-focused "Rural Healthcare Network" model to a housing collaborative group for those experiencing or affected by SUD. Also, applicability and language of the stages of the defined network development process requires translation for many members who are familiar with housing, but not health care. RAC-RHTF leaders have worked to understand the background of each member and have been able to rephrase discussions and tasks to best engage each member. If other communities undertake the creation of a similar network aimed at housing as an element of health, a recommended innovation is to clarify language used in all guiding documents and templates. This would reduce confusion among members and enable productive progress in reaching decisions and organizational milestones.

Programmatic Development

Shortly after forming the task force, the community faced an affordable housing crisis, which became a driving force for the development of advocate-based coordination amongst network members. The Santa Clara apartment complex was condemned on November 22, 2022, leaving the residents displaced. A second complex, La Vista Del Rio apartments (LVDR) was then under threat of closure in March 2023. If LVDR closed, the city would lose a total of 96 affordable housing units in the Española Valley in under six months. RAC-RHTF coordinated to provide services and support to displaced residents and spoke at city council and other community meetings about the housing crises.

RAC-RHTF members, along with community providers, residents and government officials worked to support the residents while the closure seemed imminent. Efforts resulted in the complex remaining occupied, and the RAC-RHTF collaborated with consulting firms, Project Moxie and Luz del Sol, to aid in the transition of ownership of the LVDR apartments to the city of Española for the safety and security of current and future residents. RAC-RHTF spearheaded an event at Española Pathways shelter, which was an opportunity for agency members to collaborate with each other and to raise community awareness of all participating agency programs.

RAC-RHTF members have also made efforts to bring local and national media attention to the housing and substance use disorder crisis taking place in the area, with several articles being published in two local papers and one article in the Los Angeles Times. Members have begun to plan for potential clients to utilize the services of member agencies, with the assistance of two designated navigators. The RAC-RHTF is working toward the adoption of a cross-agency referral platform and advocating for local government support to fund the two navigator positions. Ongoing discussions of the RAC-RHTF include plans for housing options, renovation of buildings, and the construction of new buildings e.g, a tiny house village. The network has faced the challenges of a lack of affordable housing and a lack of funding, but partners are forming a team to secure various funding options.

Sustainability

The RAC-RHTF plans to remain connected to Rio Arriba County by requesting funding and support from the Health & Human Services Department. The task force intends to continue to encourage participation from any interested community member, with active invitations directed to service providers, involved agencies, and community organizations.

In order to ensure proper compliance and fiduciary responsibility for any funding resources, the task force will prepare and adopt bylaws and operational procedures. Task force leadership will be determined by the adopted bylaws. The task force will continue to operate on a primarily voluntary nature, but there is a need to staff a part-time position to ensure continuity of coordination and operation. Rio Arriba County has agreed to continue to support the task force while it is still in the planning and development phase. Funding for Task-force development and for continued coordination will be able to be sponsored by the county if this is determined to be the most feasible path forward.

Beyond the task force mandate of addressing the impact of SUD on the housing crisis and homelessness, partners believe that by teaming with city and county governments to identify solutions to their climate response or adaptation plans, of which housing is a critical component, projects can be identified to address needs of the community and prepare for future challenges. With this collaboration, the taskforce will be able to apply for and access national funding through programs addressing community resilience to climate change.

Region Covered

- Northern Santa Fe County
- Rio Arriba County, NM

Network Partners

Member Organization	Location	Organizational Type
Barrios Unidos	Chimayo, NM	Nonprofit
Breath of My Heart Birthplace	Española, NM	Nonprofit
Bridge to Health	Española, NM	Nonprofit
Dreamtree Project	Taos, NM	Nonprofit
Española Pathways Shelter	Española, NM	Nonprofit
Heart of Taos	Taos, NM	Nonprofit
Los Alamos JJAB	Los Alamos, NM	Nonprofit
Mesa to Mesa	Española, NM	Nonprofit
National Latino Behavioral Health Association	Cochiti Lake, NM	Nonprofit
New Mexico Coalition to End Homelessness	Santa Fe, NM	Nonprofit
New Ventures Community Building	Rio Rancho, NM	Consultant
North Central RTD	Española, NM	Government
Ohkay Owingeh Housing Authority	Ohkay Owingeh, NM	Tribal Nation
Self Help, Inc	Los Alamos, NM	Nonprofit

Member Organization	Location	Organizational Type
Sen. Ben Ray Luján (D-NM) Office	Santa Fe, NM	Government
Taos Alive	Taos, NM	Nonprofit
T.O.R.A.H Works Ministries	Española, NM	Nonprofit
The Mountain Center	Española, NM	Nonprofit

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Rural Health Association of Tennessee

Tennessee Rural Health Clinic Network

P10RH45771

Project focus area:
Network Organization/ Infrastructure Development

Network Statement

Strengthening access to quality primary care in rural communities is essential for the physical, mental, and economic well-being of rural communities. Despite being Tennessee's largest group of safety net providers, federally designated rural health clinics (RHCs) have not had an association to provide them with voice and support. Over the years, the lack of an established RHC network has resulted in serious consequences. For example, during the 2018 TennCare moratorium on wraparound payments, many clinics were forced to close, including birth centers. Later during the COVID-19 pandemic, the absence of an RHC network made it difficult for state agencies to connect directly with rural providers and patients.

In 2022, the Rural Health Association (RHA) of Tennessee brought independent and provider-based RHCs together to establish the Tennessee Rural Health Clinic Network (TN-RHC). Network leaders connected with more than 200 RHCs through surveys, site visits, and a rural health clinic virtual summit with speakers from TennCare and the National Association of Rural Health Clinics. The physicians and nurse practitioners who operate these clinics have shared that as the health care industry becomes increasingly difficult to navigate, they want an organized network to facilitate peer learning, provide timely and accurate information, and to advocate for the needs of their providers and patients.

Network leaders plan to continue developing the network to achieve their collective mission to improve the health and well-being of rural Tennesseans by strengthening and supporting the rural health clinics that serve them. By setting goals related to expanding capacity and services and improving patient outcomes, the network has the potential to strengthen not only this provider group, but also the rural health care system as a whole.

Network Development

The TN-RHC Network began with representatives from four organizations who recognized a void in advocacy and support services for Tennessee's more than 200 rural health clinics. Throughout the planning process, the network has grown to include 20 RHCs and five non-RHC partners. The founding members of the TN-RHC network have signed a formal memorandum of agreement committing themselves to participation in network

activities including data-sharing, peer-to-peer learning opportunities, and advocacy toward mutual goals. The TN-RHC network will be formalized as a member group under the umbrella of the RHA of Tennessee. The founding members have agreed to an advisory committee structure that will include an inaugural group of 12 advisory committee members with leadership that will include a chair, co-chair, recorder, finance chair, and advocacy chair.

While RHC leaders have been enthusiastic about the idea of the TN-RHC network, engaging members to commit their time and presence to network activities is and will continue to be a challenge. Barriers include geographic distances between RHCs and the nature of operating clinics on slim margins with few staff. Many of the RHC leaders and staff are meeting one another for the first time. Establishing strong collegial relationships will take time. To overcome these barriers, the Rural Health Association of Tennessee has adopted a "We'll come to you" approach, finding success in visiting RHCs in their own communities. The most engaged members are those who received an in-person visit from RHA leaders.

Programmatic Development

One of the challenges for RHCs has been securing reliable information and guidance on regulatory requirements, program compliance, and reimbursement. To overcome this challenge, network leaders reached out to state agencies, managed care organizations, and regional federal agencies to learn about their resources and identified contacts. The TN-RHC Network is serving as an important connector between RHCs, their peers, and state agencies.

Currently, the RHA of Tennessee is developing RHC resources for promoting patient access to care, improving clinical quality, and addressing workforce needs. Specifically, the RHA of Tennessee is collaborating with clinics and partners to develop tools including a policy manual template, a National Health Service Corps certification guide, DATA 2000 waiver resources, and resources for a closed-loop referral system to support referrals for patients' social drivers of health needs. These tools will be made available on the RHA's learning management system.

Sustainability

To sustain the TN-RHC Network beyond the term of the network planning grant, the RHA of Tennessee and the advisory committee are deploying a multi-pronged strategy. This includes formalizing the structure of the advisory committee and installing its inaugural leaders. Network leaders are also prioritizing member recruitment and engagement to cultivate a strong connection among RHCs. Additionally, network leaders have already begun identifying funding sources to support the network's infrastructure as well as funding for clinics wishing to enhance their operations. The RHA of Tennessee has applied for the Health Resources and Services Administration (HRSA) Rural Health Network Development grant that will enable the network to hire a full-time network director. Over the period of the grant, the network director will be responsible for recruiting enough members and sponsors to sustain network director and RHC coordinator positions. Lastly, the RHA of Tennessee has developed a grant procurement and management strategy aimed at bringing additional value to clinics through the provision of professional development stipends, resources to address workforce needs, data benchmarking, and opportunities for mini grants.

Region Covered

All fully rural counties as in Tennessee defined by HRSA, plus all "partially rural" census tracts as defined by HRSA that have a RHC.

- Bedford
- Benton
- Bledsoe
- Campbell
- Cannon
- Carroll
- Cheatham
- Chester
- Claiborne
- Cocke
- Coffee
- Crockett
- Cumberland
- Decatur
- DeKalb
- Dickson
- Dyer
- Franklin
- Gibson
- Giles
- Grainger
- Greene
- Grundy
- Hancock
- Hardeman
- Hardin
- Haywood
- Henderson
- Henry
- Hickman
- Houston
- Humphreys
- Johnson
- Lake
- Lauderdale
- Lawrence
- Lewis
- Lincoln
- Obion
- Marshall
- Maury
- McMinn
- McNairy
- Meigs
- Monroe
- Perry
- Polk
- Putnam
- Rhea
- Scott
- Smith
- Stewart
- Tipton
- Union
- Van Buren
- Warren
- Wayne
- Weakley
- White

Network Partners

Member Organization	Location	Organizational Type
Cumberland Family Care	Spencer, TN	Rural Health Center
East Tennessee State University-Center for Rural Health Research	Johnson City, TN	College/University
Hometown Health Clinic	McKenzie, TN	Rural Health Center
Rural Health Association of Tennessee	Decaturville, TN	Nonprofit
Servolution Health Services, Inc	Speedwell, TN	Rural Health Center
Three Rivers Hospital/St. Thomas	Waverly, TN	Critical Access Hospital
TN Department of Health, Office of Rural Health	Nashville, TN	Government

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HSHS St. Clare Memorial Hospital, Inc.

Northland Telehealth Network

P10RH45772

Project focus area:
Telehealth

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

Network Statement

Rural communities in Wisconsin are experiencing a perfect storm of health crises compounded by provider shortages in 11 counties serving more than 325,000 lives. The Northland Telehealth Network's (NTN) communities represent rural dwellers that experience a significant "rural penalty" that requires travel for long distances just to access specialty health care. NTN member sites include ten primary care Health Professional Shortage Areas (HPSAs); all 14 sites are mental health HPSAs; five are medically underserved areas and populations. These counties and local communities collectively represent a health care service environment of significant need. In 2018, the focus counties only had 216 primary care physicians and 267 mental health providers serving a population of 325,654.

By recognizing the gaps that exist in rural health care, telehealth can be deployed as a way of exploring alternatives to in-person care. Network partners came together in 2017 to deploy small pilots. However, an absence of telehealth equipment, a lack of capital funding, and limited resources to seek philanthropy or grants led leaders to explore economies of scale and shared telehealth services. Advancements in technology have led to the expansion of telehealth services and are recognized as an equivalent providing the standard of care. Programs such as teleStroke and teleNICU allow for robot placement by the bedside within minutes of arrival connecting patients and families to specialty board-certified physicians for timely decisions on course of care. This specialty support provides rural health more options with the goal to ultimately keep the patient close to home. For example, NTN is able to support infant patients who may just need a little more time and avoid taking them away from their parents to access treatment. Being able to determine whether a baby can remain at the hospital they're born in or if they need to be transported elsewhere for additional care is a huge benefit of technology. NTN can support infants born in the neonatal intensive care unit, keep grandma at home, and rapidly expand access to substance-use disorder treatment in the individual's local community.

Network planning produced a roadmap to adopt standardized telehealth protocols for new pilots, streamline processes, identify economies of scale, and combine efforts to secure telehealth equipment through grant and other philanthropy efforts. Having established relationships and familiarity with current network members allows collaborators to pursue telehealth opportunities that would benefit the communities served.

Network Development

NTN has had several discussions guided by the grant documents on how formal the network should be. While the network has decided not to institute bylaws or a formal structure, partners will continue to meet on a quarterly basis with a formalized agenda led by HSHS St. Clare Memorial Hospital and Prevea Health (HSHS/Prevea). It will be a fluid process where the members can bring needs to the network for discussion and collaboration. The network has highly engaged members who see value in keeping the network going for the benefit of their communities.

The biggest challenge in network development has been participation from all members. At the first meeting, one of the asks for the network members was to verify that the contact listed was the most appropriate person to represent their organization in this project, realizing that most of the network member contacts were high level executives. The intention was to engage the right people as partners moved to formalize the network. As participation decreased, individual emails were sent in an effort to understand the circumstances and see what could be done to re-engage partners in the network.

A future action to overcome the participation and engagement issue is to have the network members rotate through the quarterly meetings and give an update on their organizational needs and their work.

Programmatic Development

Throughout the planning process, members have not yet developed any specific programs related to individual telehealth service lines. However, during this planning process, the groundwork has been laid for how partners would like to see specific program development look. The network wants to see individual members' telehealth needs be brought to the attention of the NTN so that partners can brainstorm next steps and possibly offer up equipment and contract advice, bring that member onto an existing telehealth contract, look for available grants, etc. The goal is to provide members with the ability to bring care to their rural communities without the burden of high costs.

Even though partner participation is sometimes limited, the network leadership has been thoughtful throughout the process and completely transparent to all NTN members. All partners receive updates on progress and feedback is solicited along the way.

Sustainability

Beyond the planning grant, the network has decided as a group to keep meeting quarterly with email communication as needed. The network is exploring the idea of bringing in outside speakers for education at a quarterly meeting so that network members are getting the resources they need to implement services in their communities. HSHS/Prevea will continue to serve as the organizer for the network to keep initiatives going forward. The network is still in the planning phase of the network and has not yet developed any services or programs. Partners have had conversations regarding what services the network hopes to engage in as part of the completed needs assessment and environmental scan. Once the network is fully established with a strategic plan, members can begin to implement and engage in the programs needed in the communities.

Region Covered

- Barron County, WI
- Buffalo County, WI
- Chippewa County, WI
- Delta County, MI
- Dunn County, WI
- Jackson County, WI
- Marinette County, WI
- Oconto County, WI
- Rusk County, WI
- Washburn County, WI

Network Partners

Member Organization	Location	Organizational Type
Advent Health Durand Hospital	Durand, WI	Critical Access Hospital
Black River Memorial Hospital	Black River Falls, WI	Critical Access Hospital
Cumberland Healthcare	Cumberland, WI	Critical Access Hospital
Door County Medical Center	Sturgeon Bay, WI	Critical Access Hospital
HSHS St. Clare Memorial Hospital	Oconto Falls, WI	Critical Access Hospital
Indianhead Medical Center	Shell Lake, WI	Critical Access Hospital
LE Phillips Libertas Treatment Center	Chippewa Falls, WI	Behavioral Health
Libertas Treatment Center	Marinette, WI	Behavioral Health
OSF HealthCare St. Francis Hospital	Escanaba, MI	Critical Access Hospital
Prevea Health	Rice Lake, WI	Rural Health Center
Prevea Health	Ladysmith, WI	Rural Health Center
Prevea Health	Cornell, WI	Rural Health Center
Prevea Health	Mondovi, WI	Rural Health Center
Spooner Health	Spooner, WI	Critical Access Hospital

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Sullivan County Memorial Hospital

Sullivan County Health Improvement Network

P10RH45773

Project focus area:
Network Organization/ Infrastructure Development

Other focus areas:
Chronic Disease Prevention/Management
Health Equity
Increase Health System Efficiencies
Workforce Development

Network Statement

Sullivan County is a small county with a population of 5,840 located in northeast Missouri. The diverse and aging residents provide unique opportunities for health care needs. The town of Milan — the county seat — has a population of 1,801, with a substantial proportion of Hispanic and Congolese people. The patient-to-primary care provider ratio is 3,110 to 1. Increasing challenges to access to care as well as chronic disease, lack of transportation, and low health literacy further prove the need to enhance services in this area. Current areas that provide opportunities to increase economic growth include two large functioning processing plants in Sullivan County and the incoming Roy Blunt Reservoir which will produce major positive demographic and financial changes for the region.

To ensure residents of Sullivan County are not without health care and have access to quality health care, the Sullivan County Health Improvement Network (SCHIN) is composed of five area health care organizations with the goal of improving efficiencies, expanding access, and strengthening the health care system within the rural areas they serve. To do this, SCHIN works together to research, design and implement new and improved models of care and service delivery. Because the goal of this program is to expand access to care, sustaining a viable infrastructure is an absolute need for Sullivan County. The current hospital building is in jeopardy as well as the capacity of providers. The focus is to leverage existing providers, facilities, and partnerships to maximize rural resources.

Network Development

Local organizations were contacted regarding the need for a network to strengthen health care access in Sullivan County. Each organization was chosen for their ability to affect and be affected by the declining health care within the county. To formalize the partnerships, each organization signed a letter of commitment to the SCHIN.

Additionally, with the ever-busy nature of the local health care system and the consistent shortages overall, there was concern regarding time management and the amount of time required to participate in this network. Members, however, understood the dire need for a network such as this and overcame their concerns to move forward to improve health care in Sullivan County. Monthly meetings were scheduled to

keep the network moving forward and were offered in various formats, including in person, phone, and video to assist with participation.

Further, for communities wishing to establish a network within their area, it is helpful to use previous successful network models as groundwork for their network. For instance, Sullivan County Memorial Hospital used the Mercer Putnam Sullivan Rural Health Network for guidance. Lastly, collaborative efforts to date include reviewing data collected by two partnering organizations, completing an external environmental scan, and as a group, determining the top challenges and opportunities of the SCHIN.

Programmatic Development

Thus far, quite a few program objectives have been accomplished, including examining various health care models and collecting community data. With help from a consulting group, the network explored micro-hospital vs. critical access hospital designation, mobile-integrated health care, and an at-home direct care program (utilizing community paramedics and health care workers) health-care models. The options explored were not conceivable due to the current capacity of the organization and the level of difficulty the service would inflict on the provider organization. Additionally, SCHIN completed a community health needs assessment. Additional time was taken to promote the assessment and its importance to the community in an effort to receive a high completion rate.

Further, SCHIN is currently in the process of exploring services that have required the residents of Sullivan County to seek care outside the county. Capturing this leakage would increase the volume of services provided locally, increase the availability of specialty services, and increase the revenue stream for partners. This, in turn, would assist in assuring the viability of core health care organizations in Sullivan County. SCHIN is working closely with the Hospital Industry Data Institute to gather this data. By examining this data, the Sullivan County Health Improvement Network will be able to assess and address the needs of county residents.

Sustainability

After the Rural Health Network Development Planning Grant concludes, the Sullivan County Health Improvement Network will remain an option for those who wish to continue improving and developing the county's health care services. The Network learned that in order to continue to improve, health care organizations must work together to ensure greater coordination of care. Regarding financial sustainability, dues may be required from members in the future to continue in the network. Lastly, workforce development and securing funds for a new facility will continue to be top priorities to maintain and expand services in the area.

Region Covered

- Sullivan County, MO

Network Partners

Member Organization	Location	Organizational Type
Northeast Missouri Health Council	Kirksville, MO/Milan, MO	Federally Qualified Health Center
Northeast Regional Medical Center	Kirksville, MO	Hospital
Sullivan County Ambulance District	Milan, MO	Emergency Medical Services
Sullivan County Health Department	Milan, MO	Public Health
Sullivan County Memorial Hospital	Milan, MO	Critical Access Hospital

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Thrive Allen County

Southeast Kansas Social Isolation & Suicide Prevention Network

P10RH45774

Project focus area:
Network Organization/ Infrastructure Development

Other focus areas:
Mental Illness/Mental Health Services

Network Statement

The Southeast Kansas Social Isolation and Suicide Prevention Network (SEK-SISP Network) brings together community members in Allen, Anderson, Bourbon, and Crawford counties to remove barriers for those at risk for suicide to seek help. The SEK-SISP network believes that through collaboration, education, and awareness, it can save lives.

The SEK-SISP Network's goal is to increase training among community partners who serve populations that have proven to be vulnerable to social isolation and suicide — more specifically, the agricultural field, LGBTQ+ individuals and individuals who are home-bound.

SEK-SISP Network is excited about the collaboration within this group and believes southeast Kansas could become a model for other rural regions that are affected by these life-altering health determinants.

Network Development

The SEK-SISP Network has made progress in formalizing the network by reaching out to key organizations in the community that showed interest in discussing local suicide prevention efforts. Relationships were already established with these organizations, as they are all members of the Allen County Rural Health Initiative. A representative who would serve as the primary contact from each of the four participating organizations was identified and invited to attend meetings. The first SEK-SISP meeting was held in February 2023 and continued to meet bi-weekly to create a network statement and discuss opportunities, challenges, and goals for the network.

Challenges to network development include the lack of staff availability to attend meetings and creating buy-in for staff to participate in network activities when their time is limited. The network is overcoming this challenge by Thrive staff making time for one-on-one meetings with network members when needed and allowing network members to take ownership of the group. Members were encouraged to participate in creating the network statement, creating goals for the group, and providing time during meetings for feedback.

Programmatic Development

SEK-SISP has worked together to plan the Trauma-Informed Care Summit, which was held in Spring 2023 in Iola, Kansas. This day-long training was facilitated by the Center for Trauma Informed Innovation at University Health in Kansas City, and taught participants the basic principles of trauma-informed care, how that relates to work being done in the community, especially related to health and wellness, and how to avoid compassion fatigue when working with individuals in crisis.

SEK-SISP and Thrive Allen County worked with Akesa Health to beta test a mobile application which helps individuals transform anxiety and stress into resilience. Thrive and partners allowed staff to download the app and then provide feedback to Akesa.

SEK-SISP faced challenges in developing direct services for the community due to staff turnover at Thrive Allen County during the grant period. Time was needed to train new staff on the project. Because of this and the time it took to identify and organize community partners, SEK-SISP did not start formally meeting until February 2023. The network is still in the early program planning phase, identifying opportunities for programs and activities regionally.

Sustainability

SEK-SISP will continue to meet on a monthly basis with current members beyond the grant period. Thrive Allen County will continue to seek funding, including federal grant funding, to provide suicide-prevention services and community education and will look at how SEK-SISP can partner with other local and state organizations on suicide prevention activities.

At this time, SEK-SISP plans to operate as a subgroup of the Allen County Rural Health Initiative, which is made up of Southeast Kansas health and prevention-focused organizations. Members of SEK-SISP will continue to be involved in the Kansas Suicide Prevention Coalition and will identify ways that the network can create opportunities for the statewide organization to facilitate outreach and education in southeast Kansas.

Region Covered

- Anderson County, KS
- Allen County, KS
- Bourbon County, KS
- Crawford County, KS
- Neosho County, KS
- Woodson County, KS

Network Partners

Member Organization	Location	Organizational Type
Allen County Regional Hospital	Iola, KS	Hospital
Community Health Center of Southeast Kansas	Pittsburg, KS (Multiple Locations)	Rural Health Center
Hope Unlimited	Iola, KS	Nonprofit
Southeast Kansas Mental Health Center	Iola, KS (Multiple Locations)	Rural Health Center
Thrive Allen County	Iola, KS	Nonprofit

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Union Hospital, Richard G. Lugar Center for Rural Health

Illiana – Survivor Milestones Improving Lives Everyday

P10RH45775

Project focus area:
Cancer Care

Other focus areas:
Care Coordination
Chronic Disease Prevention/Management
Increase Health System Efficiencies
Integrated Health Services

Network Statement

Cancer impacts everyone. Cancer survivors — those who have been diagnosed with cancer — and their caregivers walk the unexpected journey in hopes of living longer and healthier lives. The diagnosis and treatment of cancer is unique to each survivor, leaving lasting effects on their physical, emotional, and spiritual lives. Although each journey is unique, there is a uniting theme: No one is the same during and after their journey. Cancer diagnosis and treatment for today's cancer survivors have advanced, resulting in many lives being saved and extended life expectancy for many survivors. Unfortunately, survivorship support and resources have not been as much of a focus as diagnosis and treatment for cancer survivors.

Cancer survivors and their caregivers in the Wabash Valley have little to no support outside their cancer treatment at cancer centers. The Illiana - Survivor Milestones Improving Lives Everyday (I-SMILE) Network came together in 2022 to identify ways to improve the quality of life for cancer survivors and their caregivers in the Wabash Valley. The network has brought together many stakeholders who work with cancer survivors, have listened to cancer survivors with their caregivers, and are working to establish a new strategic plan that will help improve support and resources for cancer survivors in the Wabash Valley. The I-SMILE Network is excited about working with communities to help cancer survivors live healthier and more fulfilling lives during and after cancer.

Network Development

The I-SMILE Network is a multi-organizational health care and community network whose mission is to identify and implement strategies and activities to improve the quality of life and quality of care for cancer survivors in rural Indiana and Illinois. Since its inception in 2022, the I-SMILE Network has formalized agreements with a range of community partners who have not traditionally been represented in the cancer space. The network has found that these types of partners are fully invested in the work and bring some of the most innovative ideas to the table. The team has also made efforts to continuously onboard new partners such as additional local health departments and the regional YMCA.

One of I-SMILE's biggest challenges has been transitioning from a collaborative partnership to a fully functioning rural health network. As the grant holder, the Lugar Center is seen as leading the entire I-SMILE

effort. However, all I-SMILE partners are equal in creating and moving the strategic agenda forward. The hope is that as time goes on, all network members continue to have open and transparent conversations about the trajectory of the I-SMILE Network.

Programmatic Development

Over the last year, I-SMILE has made significant progress towards achieving established goals. A significant achievement took place when the I-SMILE project team and advisory board hosted three focus groups in rural communities composed of cancer survivors and their support persons and attended multiple listening sessions with cancer survivor organizations and health-care workers. All cancer journeys are unique, but these conversations allowed the I-SMILE Network to identify similarities in gaps of resources and support. This qualitative data helped the I-SMILE Network identify and prioritize areas of focus for the strategic plan. Prioritized areas of focus include 1) improving the quality of life for cancer survivors in rural communities by expanding access to support groups, resources and education and 2) increasing access to cancer prevention, screening, oncology navigation, and survivorship strategies for health care providers servicing rural populations.

Additionally, the I-SMILE Network was able to connect with other local and state partners who play an important role in serving cancer survivors. These entities serve as great examples of the type of all-purpose cancer survivor-focused organization that the I-SMILE Network strives to become. Additionally, a couple of network members were able to attend the Indiana Cancer Consortium annual meeting where they had the opportunity to meet with other state and federal partners.

Sustainability

I-SMILE Network partners are all fully invested in pursuing the actions outlined in the strategic plan in order to better serve cancer survivors in the Wabash Valley. All partners have invested many hours and immeasurable effort to collect the essential data necessary to make a true impact on the lives of cancer survivors and their support people.

The I-SMILE Network intends to formalize a governing structure and/or nonprofit organization to oversee, sustain, and evaluate I-SMILE activities. If additional funds are awarded, the I-SMILE advisory board will become a governance body. To do this, each network organization will select one representative from a leadership position to sit on the governing board. It is pivotal that I-SMILE partners establish a governing board to complete the activities, but it is also crucial to achieve partner buy-in and ownership of the network's activities on a scale that the advisory board is not equipped to do.

The governing board will work to ensure sustainable operations of the network by exploring additional funding for I-SMILE operations and programming as well as exploring the opportunity to transition I-SMILE Network into its own organization. Sustainability from the governing board level will require either decreasing costs or increasing revenue.

Region Covered

- Clark County, IL
- Parke County, IN
- Sullivan County, IN
- Vigo County, IN

Network Partners

Member Organization	Location	Organizational Type
Clark County Health Department	Martinsville, IL	Clark County Health Department
Cork Family Medicine	Marshall, IL	Rural Health Center
Marshall Public Library	Marshall, IL	Government
PINK of Terre Haute	Terre Haute, IN	Nonprofit
Richard G. Lugar Center for Rural Health	Terre Haute, IN	Public Health
Sullivan County Public Library	Sullivan, IN	Government
Union Family Medicine	Rockville, IN	Rural Health Center

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University of Montana (UM)

UM Health Extension Office Network

P10RH45776

Project focus area:
Network Organization/
Infrastructure Development

Other focus areas:
Behavioral Health
Care Coordination
Population Health/Social Determinants of Health
Workforce Development

Network Statement

The residents of Flathead and Lake Counties are experiencing strain on their local health care and public health systems due to limited access to services, increased demand for behavioral health support, and the community effects of substance use disorders. Professionals working in these systems face challenges filling high-need positions, understanding available resources for patients, and coordinating services across different systems.

In response to the complex issues faced by the Flathead and Lake County communities, a collaborative network was established in 2021. This network, composed of the University of Montana, Flathead County, and Lake County health care and public health leaders, conducted a thorough needs assessment and landscape analysis to develop a comprehensive health perspective for each county. This information and perspective guided the implementation of an innovative pilot health extension network with offices in both counties. The health extension offices, inspired by New Mexico's successful Health Extension Regional Offices program, will collaborate with various community sectors to identify high-priority health needs and develop local solutions by connecting those needs with university resources in education, clinical services, and research.

Network Development

The University of Montana (UM) Health Extension Office Network has engaged in several different tactics to further formalize its development. The network worked together to apply for funding to fully implement the network plan. As part of this process, partners were involved in developing a memorandum of understanding (MOU) that outlined the roles, responsibilities, and expectations for each key stakeholder. This has helped in holding network members accountable and engaged during the development process. Additionally, to make progress towards formalizing the network, members discovered it is important to have a clear vision and plan for the network, identify and engage key stakeholders, and establish communication channels to share about the network. The UM Health Extension Office Network identified several community stakeholders and met with them to receive input about community needs and how to better formalize the network. This input has been used to refine the network's vision and strategic plan to ensure that the network is being responsive to community needs. These stakeholders have also helped raise awareness about the UM Health Extension Office Network.

Some of the challenges the UM Health Extension Office Network faced during this process was turnover in the organizations that were participating in the network's development; helping new members gain clarity on the mission, vision, and goals of the network; and sustaining engagement throughout the process. While hosting meetings via teleconference platforms allowed for flexibility and convenience, the network found it was also contributing to many of the challenges. As a response, the network hosted several planning meetings in person to allow new members to ask questions and get clarification on the work the network was doing. These in-person meetings also helped sustain engagement because network members were better able to have robust discussions face-to-face. Also, during these in-person meetings, members were able to review the network's vision, mission, and goals to ensure they reflect the new members' input and to adapt them to the changing needs of the communities the network serves.

One innovation UM Health Extension Office Network found to be incredibly helpful was the use of a tribal liaison. Specifically, the network worked with partners from the Confederated Salish Kootenai Tribe (CSKT). To ensure the network works with these partners in a culturally responsive way, a tribal liaison was hired to serve as a network member. The tribal liaison is a member of the CSKT and is also a community member . This allows the network to gain a different perspective about community needs since the tribal liaison is not part of a health care or public health entity.

Programmatic Development

One of the initiatives the network has completed to support programmatic development is a comprehensive needs assessment for the communities the network serves. The needs assessment identifies the top five priority areas for each county. Since the top priority for both Lake and Flathead Counties is behavioral health, a landscape analysis was completed as part of the needs assessment process to identify behavioral health resources in each county. The network members decided to further refine the needs assessment data by meeting with other stakeholders such as K-12 school district staff, local nonprofits, and local tribal college staff to narrow the programmatic focus. From these discussions, the network has identified three potential areas for programmatic implementation:

1. HUB Pathways Model or care coordination
2. Supporting local initiatives to establish a mobile support unit, and
3. Deploying community health workers into the K-12 setting to help address behavioral health needs

The biggest challenge the network has faced with programmatic development is narrowing the focus to one or two specific projects. While it was easy for network members to identify behavioral health as the biggest health concern in both counties, behavioral health concerns in both counties are many, and tackling all concerns at first is unmanageable for the network. This is why utilizing other stakeholder input was invaluable for helping guide the network's decision-making process. The stakeholders outside the health care and public health systems had different perspectives on health priorities and were able to guide the network in what would be most helpful in addressing behavioral health concerns.

Sustainability

The network members have decided to use a braided funding model to sustain the network's efforts. The network has applied for a grant that would support program implementation in Lake and Flathead Counties. Additionally, during the network organizational assessment process, network members identified sources of funding other than grant funding (e.g., philanthropic organizations, third-party payors, and community-based organizations). The network members will continue to meet and carry out network functions as outlined in the

formalized MOU. Part of the network functions will be to identify funding sources to continue the programs and services the network provides. Furthermore, network members will continue to assess community needs to adapt the programs and services the network provides.

Region Covered

- Flathead County, MT
- Lake County, MT

Network Partners

Member Organization	Location	Organizational Type
Confederated Salish Kootenai Tribal Health	St. Ignatius, MT	Tribal Health Clinic
Flathead County Health Department	Kalispell, MT	Public Health
Lake County Health Department	Polson, MT	Public Health
Logan Health	Kalispell, MT	Hospital
St. Joseph Medical Center	Polson, MT	Critical Access Hospital
St. Luke Community Healthcare	Ronan, MT	Critical Access Hospital
University of Montana	Missoula, MT	College/University

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UPMC Kane

Chronic Illness Care Redesign Services Network

P10RH45778

Project focus area:
Chronic Disease Prevention/ Management

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

Network Statement

The University of Pittsburgh Medical Center (UPMC) Kane's Chronic Illness Care (CIC) Redesign Network is composed of UPMC Kane and community partners. The network focuses on bringing to bear vital prevention, chronic illness and disease management, and increased access to services to improve our rural community's health. For years, our community has struggled with being a "health care desert." This community experiences inadequate access to primary and specialty care services, travel burdens to receive care, and significant gaps in community health services. The goal of the CIC Services Redesign program is to improve the health of individuals with chronic obstructive pulmonary disease, heart disease, and substance abuse issues.

The program partners are working together to develop a targeted "non-traditional" approach for meeting health care needs where few options have existed. The network's approach collectively increases alternatives to care and in settings that allow individuals to enter preventive care, chronic disease programs, and treatment programs more easily. The "redesign" includes a community health coordination program that consists of separate services that are linked through a more formal, consistent message across several community providers and related social-service agencies. A significant step towards a solution is a plan for the use of telemedicine services to provide much-needed access and reduced costs to benefit patients who have ongoing chronic health needs. By utilizing telehealth, community agencies, social services, and other partner agencies that span the age spectrum, services can be linked to acheive better health outcomes for this community.

Network Development

UPMC Kane enlisted a group of community partners, including leaders in prevention and health care education, to form a network that serves individuals with chronic illnesses. In initial planning discussions, partners identified gaps in health services for the rural service area. Participants determined that the best approach for the network was to bring various social services, community center services, home health services, and long-term care services into the discussions of gaps and possible solutions for change. In turn, this created a broader network in which various levels of involvement and action will bring meaningful contributions to the overall goal. The network has a shared goal and program concept that will sustain services and also establish a community health coordinator service. The network also realized that members' levels of involvement may vary based on the gaps identified.

The resulting network reflects varying levels of involvement and capabilities of agency partners. The network also received a Health Resources and Services Administration Rural Health Network Development grant, with UPMC Kane as the lead agency. As the CIC Redesign Network moves forward in implementing the network development grant, the network has a better understanding of partner agencies and their capacity to participate. Governance and decision making, including collaboration, consensus, policies, and procedures, will be developed based on the responsibility and participation of network members.

Programmatic Development

The greatest asset resulting from the planning effort is a shared awareness that standardization across care systems is possible. A community health coordinator program will assist in delivering standardization in prevention and disease management efforts across patient services. Patient care, transitions, and services standardization will bring real-time programmatic change and meet the needs of the patient population. The Rural Health Network Development Planning Grant also laid the groundwork for the community health coordinator messaging to be consistent across all partner agencies. For example, reminder calls and requests for appointments will have similar messages with a referral to the community health coordinator if needed. Providing a consistent message throughout the system will ensure patient retention of information.

Additionally, telehealth is a new service offered by UPMC Kane as a result of receiving a USDA funded grant in 2021. During this planning year, the introduction of telehealth with mid-level providers allowed UPMC Kane to provide dramatically increased services access for more patients. Specifically, utilizing telehealth as a mode to deliver health care services has streamlined costs and improved the affordability of coordination, thus increasing access to care. The network also intends to utilize telehealth to better integrate care coordination for direct services among agencies and deliver standardizations in health services. Lastly, the program has adapted to change, which has enhanced satisfaction scores for the hospital. These changes include establishing a partnership with long-term and acute care to save on system costs and improving care via direct-to-consumer telehealth, which has reduced transportation barriers and patient-care costs.

Sustainability

A services pathway using a community health coordinator (CHC) will be a sustainable effort across the health care services network. The network will function as a hub-and-spoke system, with UPMC Kane as the lead entity. The CHC program will be sustained by focusing on the top three needs as determined by previous needs-analysis and planning efforts. Formal referrals have been identified to complete the planning process and establish standardization and referrals between home health, long-term care, and social services. In addition, the recent award of the Rural Health Network Development grant will provide funding for a designated CHC program. The grant will also support continuing efforts to establish long-term care options within the community utilizing telemedicine.

Region Covered

- McKean County, PA

Network Partners

Member Organization	Location	Organizational Type
Alcohol & Drug Abuse Services, Inc.	Allegany, PA	Other
Area Agency on Aging- Kane Senior Center	Kane, PA	Area Agency on Aging
Kane Area Community Center	Kane, PA	Social Services Agency
The Lutheran Home at Kane	Kane, PA	Skilled Nursing Facility
UPMC Home Healthcare Kane	Kane, PA	Home Health
UPMC Kane	Kane, PA	Hospital

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University of North Dakota

North Dakota Rural Health Clinic Network

P10RH45777

Project focus area:
Network Organization/
Infrastructure Development

Network Statement

Imagine being 60 miles from the nearest health-care provider. The vast geographic expanse of North Dakota often makes access to health care a challenge for residents living outside metropolitan areas. Many rural North Dakotans are older, live with multiple chronic diseases, and have lower income rates than their urban counterparts. Accessible, equitable health care in rural North Dakota means meeting North Dakotans where they are, when they need it, and with the most appropriate resources. This places heavy responsibility on the state's 55 rural health clinics (RHCs) that are owned by North Dakota's 37 Critical Access Hospitals.

The ND RHC Network was developed in 2021 to support ND RHCs through knowledge, tools, and resources necessary to provide quality health care, sustainability, and patient access in rural North Dakota. This vision is actively progressing by establishing an advisory committee of engaged ND RHC leaders and creating an implementation plan supportive of the network's vision. The ND RHC Network is connecting peers, forging partnerships, and building excitement amongst ND RHCs as the network begins providing the desired resources. Ultimately, the ND RHC Network is confident in its ability to unite RHCs in the state so that rural North Dakotans may continue to live where they desire without sacrificing their health.

Network Development

The Change to ND RHC Network was established in 2021 through the Center for Rural Health at the University of North Dakota School of Medicine & Health Sciences to provide a platform of support and resources to the RHCs in North Dakota. The first year was spent reaching out to all RHCs across North Dakota to sign a memorandum of understanding (MOU) agreeing to participate in the ND RHC Network, which achieved 100% participation. As new RHCs are formed, they will be invited to become members. Once the MOUs were completed, an advisory committee was created that included RHC managers from across the state who provide valuable feedback and expertise in all RHC-related matters and activities. Throughout the year, the ND RHC Network provided technical assistance, identified RHCs' needs across the state, and provided educational webinars that supported, educated, and promoted resources for ongoing performance improvement.

One of the challenges the ND RHC Network faced was RHC manager turnover. As new managers were identified, the project coordinator for the ND RHC Network reached out to set up a one-on-one orientation to inform them of what the ND RHC Network is and the resources and support it provides to RHCs in North Dakota. Another challenge faced was fluctuation in participation in meetings and activities that the network provided. With most of the RHC managers being working managers, many found it difficult to break away from work duties. Ongoing efforts to increase participation included scheduling quarterly network meetings during the lunch hour, hosting in-person meetings throughout the year for networking, conducting individual site visits, and promoting upcoming activities or meetings via diverse modes of communication.

These steps were taken to develop the ND RHC Network, which followed the process predetermined by the ND Critical Access Hospital Quality Network — ND RHC Network's sister network established 15 years prior — for the desired level of formality. The ND RHC Network recommends other communities discern their level of network formality prior to engaging in the creation of a network.

Programmatic Development

Each year, the ND RHC Network project coordinator will disseminate a survey to the RHCs to identify current statewide or individual needs. As a result of the survey conducted this year, in combination with discussions with the advisory committee and feedback from individual RHCs, various educational programs and resources were developed. For example, several RHCs discussed the desire to become more financially and operationally efficient to keep costs low, or to maintain that efficiency. The ND RHC Network worked with a subject matter expert (SME) to perform financial and operational benchmarking for the RHCs in the state. This allowed them to see high and low performers of each benchmark and how they compared to other RHCs in the state. Once the benchmarking was completed, the SME presented the information at a quarterly network meeting. A few months later, two in-person meetings were held across the state to review the benchmarks and discuss strategies for improvement. Following the in-person meetings, technical assistance hours were then provided to RHCs with the SME to discuss specific benchmarks they want to improve at their clinic.

Challenges experienced included low participation in virtual meetings and educational webinars as well as the extensive travel time managers incurred for in-person meetings. To overcome this, reminder emails and calendar invites were sent to managers regarding upcoming meetings. The meeting materials and recording were uploaded to the virtual library that is accessible only to network members. This allowed those unable to attend to still have access to the materials. Additionally, in-person meetings were held on the eastern and western sides of the state to alleviate the travel burden. This was proven to work as attendance increased overall.

Sustainability

Currently, the ND RHC Network does not charge a membership fee for RHCs to participate. The Medicare Rural Hospital Flexibility Program and the North Dakota State Office of Rural Health are committed to financially covering staffing costs and educational activities of the ND RHC Network, including SME fees, meeting room costs, etc. Additionally, network members are willing to serve as the lead to submit grant proposals that will benefit and support the network. The University of North Dakota Center for Rural Health will also pursue funding on an ongoing basis that advances the overall goals of the ND RHC Network.

Region Covered

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Network Partners

Member Organization	Location	Organizational Type
First Care Health Center	Park River, ND	Critical Access Hospital
Jacobson Memorial Hospital	Elgin, ND	Critical Access Hospital
Northwood Deaconess Health Center	Northwood, ND	Critical Access Hospital
Tioga Medical Center	Tioga, ND	Critical Access Hospital

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Westchester-Ellenville Regional Hospital

Ellenville Regional Rural Health Network

P10RH45779

Project focus area:
Population Health/
Social Determinants of Health

Other focus areas:
Chronic Disease Prevention/Management
Community Health Workers
Health Equity
Telehealth

Network Statement

A community is only as strong as its most vulnerable. Empowering the seniors in Orange, Sullivan, and Ulster Counties is essential to caring for the wellness of our region's residents. Chronic diseases, such as diabetes and cancer, and mental health challenges are prevalent among our senior population and require access to comprehensive medical care. Unfortunately, the lack of transportation and the current medical infrastructure put seniors' well-being at risk.

The Healthy Aging Committee of the Ellenville Regional Rural Health Network is working to address the challenges seniors experience within our community. Focusing on telehealth and expanding access to care and care coordination will close the gaps in the health care system. Bringing resources together and developing a united front will support the needs of our seniors and assist them to safely, healthily, and independently age in place.

Network Development

The Healthy Aging Committee, a subcommittee of the Ellenville Regional Rural Health Network, brings together a group of providers with a vested interest in the health of the region to create solutions to the disparities faced by those seniors. With the help of the Rural Health Network Development (RHND) Planning Grant Program, the group has been able to define themselves as a collaborative partnership that is working towards becoming a network of its own. Furthermore, the Healthy Aging Committee intends to develop a formal action plan that will guide the work the group will continue to do toward addressing barriers to health and health care.

Additionally, challenges the group experienced working towards network development included being tied to a specific project, and therefore feeling limited in the specific problems the Healthy Aging Committee could focus on. This challenge was overcome by utilizing the RHND Planning Grant to assess the partnering organizations' ability to work together in identifying and addressing problems. Lastly, conducting a network organizational assessment helped the Healthy Aging Committee to identify the group's status in terms of network development and informed next steps towards becoming a formalized network.

Programmatic Development

At the beginning of the grant, the Healthy Aging Committee aimed to create senior-focused "Tele-Wellness Hubs" that would increase access to care for seniors within the community. However, after receiving feedback from the community, it was determined that there needed to be a shift from this original aim as a majority of the community did not believe they would be comfortable utilizing telehealth, especially not in a public setting. Keeping the goal of increasing health care access in mind, "Wellness Hubs" have been redefined as easily accessible places where community members can talk with professionals from various health and wellness fields, attend classes and workshops, and learn how to utilize technology to more comfortably access telehealth at home.

The Healthy Aging Committee has also employed strategies to continue to receive feedback from community members in order to gauge the types of services residents would feel comfortable receiving in a public setting. In turn, this has created the need to be adaptable and persistent in recruiting new partners who can offer services that correspond to the community's interests.

Sustainability

Following the completion of the Rural Health Network Development Planning Grant Program, the Healthy Aging Committee plans to continue to work together to identify and address the pressing health challenges faced by the senior population within the region. The committee will continue to meet on a regular basis to develop a coordinated action plan detailing the specific health and health care access issues within the community. Utilizing this plan, the committee will recruit new partners as appropriate, develop programs to address the identified issues, and continue to solicit feedback from the community to guide the committee's work. Although the Wellness Hubs specifically will be implemented based on the availability of funding, the Ellenville Regional Rural Health Network will continue to develop other programs regardless of new sources of funding.

Region Covered

- Orange, NY
- Sullivan, NY
- Ulster, NY

Network Partners

Member Organization	Location	Organizational Type
Alzheimer's Association Hudson Valley Chapter	Poughkeepsie, NY	Nonprofit
Catholic Charities of Orange, Sullivan, Ulster	Goshen, NY	Nonprofit
Ellenville Regional Hospital	Ellenville, NY	Critical Access Hospital
Institute for Family Health	Ellenville, NY	Federally Qualified Health Center
Jewish Family Services of Orange County	Middletown, NY	Nonprofit

Member Organization	Location	Organizational Type
Jewish Family Services of Ulster County	Kingston, NY	Nonprofit
Orange County Department of Health	Goshen, NY	Public Health
Orange County Office for the Aging	Goshen, NY	Area Agency on Aging
Ulster County Department of Health	Kingston, NY	Public Health
Ulster County Office for the Aging	Kingston, NY	Area Agency on Aging

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