Healthy in the Hills Network, West Virginia
Health Improvement Plan
October 11th, 2019 Draft

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VISION

As Appalachians look towards the future, many communities show a willingness to adapt to change in favor of finding solutions. A flexible attitude and growing trust in the belief that our goals can be attained will mark a cultural shift, one that happens predominantly through our interactions as we work together, intentionally making the time to navigate difficult hurdles. By understanding rural communities and striving to make improvements, our efforts over the next ten years will result in improved physical environments with greater opportunities and accessible support for all.

FOCUS AREA

The Healthy in the Hills Network (Network), established in 2012, is a team of cross-sector partners in southern West Virginia and eastern Kentucky who have developed a shared vision for improving rural health that may be replicable in rural areas across the United States and abroad.

This plan was developed as Network partners began to question how to build a culture of health and tackle community needs together. The Network recognized that leveraging resources from state and national partners and across county lines in Mingo County, West Virginia and Pike County, Kentucky could lead to creative solutions in building a culture of health.

The focus of the plan is to launch a collaborative, community-driven planning process to address the social determinants of health and health equity. The plan will provide our Network with a framework to make systemic improvements to address underlying issues that create health disparities. Network goals fall within four focus areas: engaged rural network, data-driven decisions, strong communications, and sustained improvement.

The Network recognizes that building a culture of health is an active and iterative process, and that by honing the skills of project partners through training and active participation in community projects, the results may be long lasting.

COMMUNITY CONTEXT

Poverty, unemployment, and lack of educational achievement affect access to care and a community's ability to engage in healthy behaviors. Without a network of support,

families struggle to thrive, and employers are hesitant to launch or expand businesses in the area. The Network exists to fill that gap by addressing the social determinants of health that residents face.

Currently, more than 29% of Mingo County residents live in households with an income below the Federal Poverty Level. Race disparities are apparent in the county; an estimated 40% of Caucasian children live in poverty compared to 72% of African American children. Roughly 13% (1,409 of 10,910) of all county households have no motor vehicles, based on the latest 5-year American Community Survey estimates. More than 10,000 people in Mingo County (42.4% of the population) receive SNAP benefits and 60.07% of public school students are eligible for free/reduced price lunch. There are 4,559 people, 25.63% of the total county population aged 25 and older, without a high school diploma. Just over 1,000 young people, ages 16-19, are not currently enrolled in school and are not employed[1].

Williamson Health and Wellness Center (WHWC) is a Federally Qualified Health Center (FQHC) founded in 2011 to serve an area known to be one of the unhealthiest and most distressed communities in West Virginia. WHWC serves as an anchor institution for the Network, providing financial and human capital to support the area's community health improvement journey.

In 2014, Williamson, WV was recognized as a Robert Wood Johnson Foundation Culture of Health prize winner. This recognition positioned the Network to learn from peer communities about strategies for health improvement and to share evidence-based approaches and promising practices with rural communities facing similar challenges.

In 2017, the WHWC helped to launch the Greater Williamson Community Development Corporation (GWCDC) to drive economic development, including broadband access for all. The GWCDC and WHWC participate in local and regional initiatives to align the substance use disorder and recovery community with workforce training and employment.

With a growing business community and increased access to broadband, we expect an increase in available job opportunities. The Network aims to address the social determinants of health and health equity barriers to ensure the changing local economy impacts the community at large.

[1] Center for Applied Research and Engagement Systems (CARES) at the University of Missouri (2019, February 15). *Health Indicators Report*. Retrieved from: engagementnetwork.org

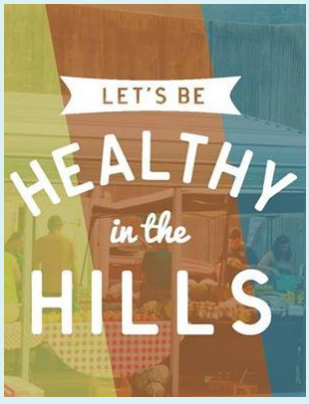
RECOMMENDATIONS FROM *COMMUNITIES IN ACTION*

The Network recognizes the value of participating in state and national efforts to build a culture of health, and leveraging lessons learned and resources to help develop our Network and reach our future aims. The following three organizations lead innovative programs or initiatives that provide evidence-based resources and tools.

1. The National Academy of Medicine Culture of Health Program (nam.edu/programs/culture-of-health/): A multi-year collaborative effort to identify strategies to create and sustain conditions that support equitable good health for everyone in America.
2. Center for Rural Health Development, Wild Wonderful Healthy WV (healthywv.org): An initiative to engage local communities to create healthy, economically vibrant communities to improve health and support economic growth.
3. Institute for Health Improvement, 100 Million Healthier Lives (100mlives.org): Peer to peer communities and support partners co-designed a "Community of Solutions" model to address challenges of achieving health, wellbeing and equity.

This plan is guided by a recommendation from the *Communities in Action: Pathways to Health Equity* report, released by the National Academies of Science, Engineering, and Medicine in January of 2017:

Recommendation 7-5: Public health agencies and other health sector organizations should build internal capacity to effectively engage community development partners and to coordinate activities that address the social and economic determinants of health. They should also play a convening or supporting role with local community coalitions to advance health equity.

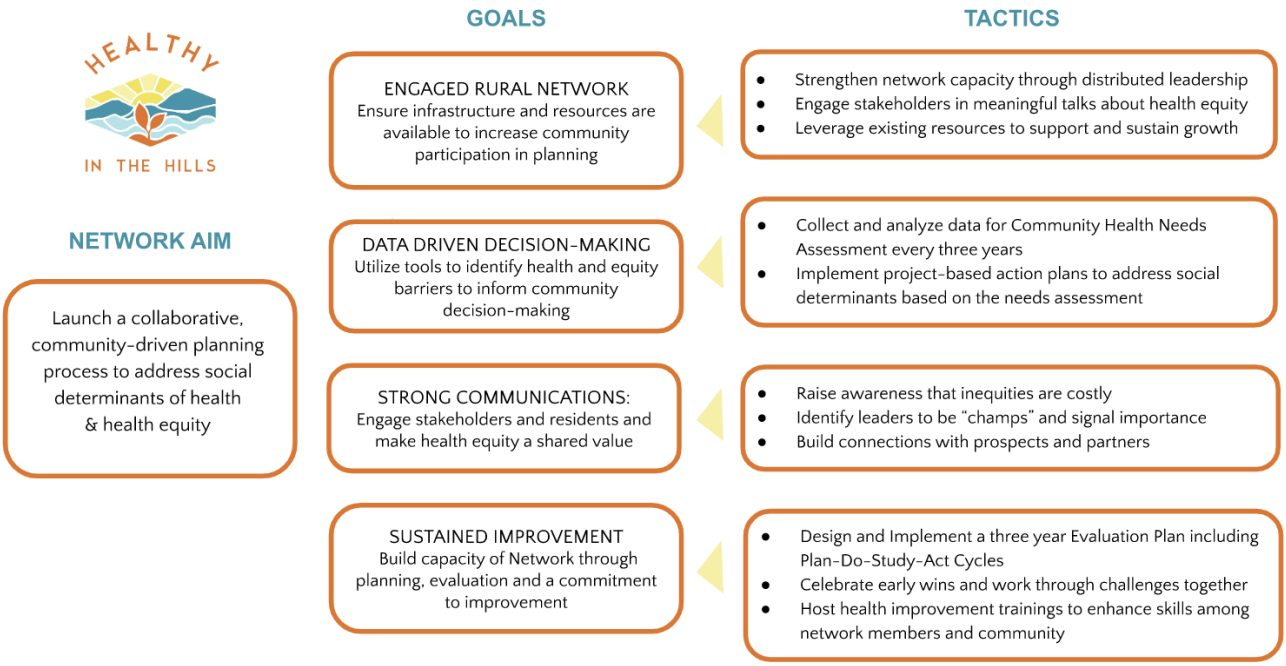


Changing Mindsets

At a local event called Community Conversations, partners and residents involved in the Healthy in the Hills Network expressed fatigue with working on long-term projects that may sometimes seem unattainable. They described a feeling of "meeting just to meet," and not getting enough done in terms of visible or measurable change. The Network realized that many may be motivated by early wins. By celebrating early wins, Network members may find within themselves a way to contribute to long-term efforts feeling a sense of accomplishment at each milestone. The approach could result in changing the way people stay engaged, contributing to a cultural shift where residents believe that change is possible.

STRATEGIES AND TACTICS

The Healthy in the Hills Network guides collaborative work on health improvement projects. The graphic below illustrates the aim, goals, and tactics of the health improvement plan.



Goal 1: ENGAGED COMMUNITY NETWORK Ensure infrastructure and resources are available to increase community participation in planning

Community voice is essential to ensuring that the Network selects health improvement projects that are representative of what the community wants. In order to truly engage with residents, the Network identified four tactics to ensure that the community is a driving force behind the projects, and that the collaboration is sustainable.

A. Strengthen capacity through distributed leadership

ENGAGED RURAL NETWORK

OBJECTIVE 1 Strengthen Network capacity through a distributed leadership model

	ACTIVITIES	TIMELINE			
A	Gather 3 year commitments from participants in the health improvement plan	YEAR	1	2	3
B	Set up remote meeting technology and hosts quarterly meetings	YEAR	1	2	3
C	Develop and share Network and community calendar	YEAR	1	2	3
D	Offer multiple ways for stakeholders to be involved with decisions and action plans	YEAR	1	2	3

The hallmarks of distributed leadership include shared responsibility, synergy among partners, an investigative culture and an equitable and ethical climate for decision making. A network agreement among partners represents the willingness to contribute time, data and other resources for the group to achieve results. Dividing tasks among Network members, and meeting regularly for accountability, strengthens the group's interactions.

In 2019, the Network created a governance body called the Leadership Council, which includes members who participate in Network planning, implementation and evaluation.

Network roles are spread across partners, achievements are recognized, and challenges are addressed as a team. The Network is inclusive of those who will be affected, acknowledging the feedback and perspective of residents throughout the planning process, which increases the likelihood that outcomes will be positive for the community.

B. Engage in meaningful conversations about health equity

ENGAGED RURAL NETWORK

OBJECTIVE 2 Engage stakeholders and the community in meaningful conversations about health equity

	ACTIVITIES	TIMELINE			
A	Administer the Racial Equity Map, a Coalition Self-Assessment Tool, annually and record results to inform the three year Community Health Needs Assessment	YEAR	1	2	3
B	Co-host monthly Community Conversations as a platform for the Network to share updates, celebrate, address barriers and gather community feedback	YEAR	1	2	3

It takes time to engage individuals, and it may take additional time to help get community members and rural stakeholders who are new to the process to feel involved. Reaching out to individuals to talk about interests outside of a meeting setting may help with gathering personal commitments.

Community Conversations is a meeting platform for community partners where everyone connects around a meal. This in-person setting is a place where the takeaways from formal network meetings can be shared with a larger community group to share knowledge or gather feedback. Community Conversations take place at a local restaurant, contributing to the local economy, or occur pot-luck style where everyone brings a dish. Gathering in both informal and formal settings encourages inclusivity and reduces meeting fatigue.

Among the essential rural Network partners are the individuals with "lived experience." Their personal perspective on community issues provide a firsthand account of experiences with barriers and solutions to achieving health equity. Lived experience will inform the entire planning process, from early at the onset of a project and throughout the implementation and evaluation phases. Individuals with lived experience will also be invited to learn about community planning and improvement at leadership trainings.

C. Leverage resources to sustain growth

ENGAGED RURAL NETWORK

OBJECTIVE 3 Leverage existing resources to support and sustain growth

	ACTIVITIES	TIMELINE			
A	Develop a stakeholder map of the community partners and residents working to address social determinants of health and health equity to use for Network recruitment	YEAR	1	2	3
B	Gain support from Network members specializing in healthcare delivery, including Williamson Health & Wellness Center and Appalachian Regional Hospital	YEAR	1	2	3
C	Gather financial contributions and human capital from Global Public Service Academy (GPSA) and Amizade Global Service Learning (Amizade) groups to engage visiting volunteers in helping to carry-out projects within the Plan	YEAR	1	2	3
D	Invite partners with common CHNA needs assessment requirements to collaborate	YEAR	1	2	3

In-kind contributions from The Healthy in the Hills Network members have sustained the Network since 2012. Starting in 2019, with a more defined focus and stronger commitments from partners, the growing Network requires a larger operational budget derived from diversified funding streams. Williamson Health & Wellness Center, as the anchor for the Network, will secure the financial resources and the staff to track project income and expenses.

Through stakeholder mapping together, the Network identifies the organizations and individuals who are working to address social determinants of health and invites them to be a part of health improvement planning. The Network engages cross-sector partnerships to address non-medical factors that impact health outcomes within the community. There is encouraging evidence that increasing the coordination of social services can improve health outcomes and reduce health care expenditures.

Global Public Service Academy (GPSA) and Amizade Global Service Learning (Amizade) organizations bring hundreds of visitors to Mingo County each year. By building on the established relationships with these service learning groups, the Network will leverage human capital and financial resources for project supplies required for the health improvement plan. With a clear health improvement plan in place, we open opportunities for visiting and local volunteers to not only contribute, but also to help tell our story as we grow.

Goal 2: DATA-DRIVEN DECISIONS Utilize tools to identify health and equity barriers to inform community decision-making

To develop projects that will ultimately benefit the community, the Network first identifies the issues that community members are experiencing. Using a data informed process gives a solid foundation to residents and stakeholders working to build projects together. The following tactics drive collaborative decision making for the Network.

A. Develop a Community Health Needs Assessment (CHNA)

DATA DRIVEN DECISION-MAKING

OBJECTIVE 1 Collect and analyze data to develop a Community Health Needs Assessment every three years

	ACTIVITIES	TIMELINE			
A	Gather publicly available data and community data from Network partners	YEAR	1	2	3
B	Gain perspective from stakeholders and individuals with lived experience through interviews and community forums	YEAR	1	2	3
C	Correlate data to identify priority areas of need	YEAR	1	2	3
D	Develop a Theory of Change (TOC) for the prioritized areas of need	YEAR	1	2	3
E	Publicly present the CHNA and TOC to the community for feedback	YEAR	1	2	3
F	Approve Community Health Needs Assessment every 3 years	YEAR	1	2	3

Building a culture of health in our community means understanding the needs of the people that the Healthy in the Hills Network serves. It means knowing what one another's day-to-day lives are like and celebrating when something good happens or troubleshooting when issues arise. We are committed to sharing resources and opportunities to improve community health and learning from the personal perspectives of residents about barriers to health equity that exist in the area.

To understand the communities where we live, work and play, the Network plans to conduct a Community Health Needs Assessment every three years.

In addition to the publicly available data, the sources for the CHNA will include:

- Community data from partners (ARH, Coalfield CAP, STOP)
- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) screening tool
- Race Equity Map Coalition Assessment Tool
- Forums and interviews with individuals with lived experience and partners

<u>Community Data</u>

In collecting data for the assessment, the Network will reach out to those in the area who are each separately committed to developing CHNAs in order to align efforts. These organizations include Appalachian Regional Hospital (ARH), Coalfield Community Action Partnership (Coalfield CAP) and Williamson Health and Wellness Center. The Network recognizes that it may benefit each of these separate organizations to combine resources in future years in order to produce a single robust needs assessment.

PRAPARE

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is a national effort to help providers understand the social determinants of health that impact patients. PRAPARE is a standardized patient risk assessment tool and a process of collection of resources to identify and act on issues related to the social determinants of health[2].

In 2018, the National Association of Community Health Centers connected with the West Virginia Primary Care Association (WVPCA) to select two West Virginia health clinics, including WHWC, to participate in a Train the Trainer program for PRAPARE. The WVPCA described the opportunity,

> "Along with the training and technical assistance from NACHC, the WVPCA and health center staff will have the opportunity to learn from health centers and PCAs across the country who have successfully implemented PRAPARE. Health Centers and PCAs are using the data to define and document the increased complexity of their patients, transform care with integrated services and community partnerships to meet the needs of their patients, advocate for change in their communities, and demonstrate the value they bring to patients, communities, and payers.[3]"

In January 2019, WHWC appointed a team to use the PRAPARE screening tool in gathering patient risk assessment data and committed to sharing PRAPARE data and analysis with the Network. The data collection began in June 2019, and preliminary data was shared with the Network in September of the same year.

Race Equity Map Coalition Assessment Tool

The Race Equity Map is a Coalition Self-Assessment Tool Assessment developed in collaboration with the 100 Million Healthier Lives (100MHL) initiative, the Wandersman Center and community partners from the 100MHL Race, Racism and Equity Workgroup.

The Race Equity Map was created to help community collaborations think about where they are in their journey to address race, racism and equity. In 2019, members of the Network were invited to participate in beta-testing of the tool which is divided into four sections: people and power, culture, systems change and financial resources.[i]

In our community, we see that equity discussions require trust, patience and active listening. Talking about equity can lead individuals to recognize their own biases, an important step in understanding systemic issues that drive health disparities and inequity.

Forums and Interviews

[2] National Association of Community Health Centers (2019, March 1). *PRAPARE Implementation and Action Toolkit*. Retrieved from: nachc.org

[3] West Virginia Primary Care Association (2019, October 4). *Association News*. Retrieved from: wvpca.org

The Network encourages data collection that includes perspective from people who have experienced social determinants of health and health equity barriers firsthand to tell the story of “where we are now.”

In 2019, WHWC will host two community forums to gather community input for the Network CHNA. One forum will be open to the public and another will be focused on understanding the needs of individuals struggling with substance use disorder who seek support from the community.

These community experiences, gathered at focus groups and via interviews, are used alongside other data in understanding the social determinants of health indicators that represent true barriers to achieving health equity.

Theory of Change

A theory of change will be developed by first identifying the change that the Network and community want to see, which is a question posed to the community and Network partners as the CHNA results are presented. The Network will work with partners from the University of Virginia to complete a literature review and research best practices to determine how to achieve change across the identified areas of need.

B. Co-design action plans

DATA DRIVEN DECISION-MAKING

OBJECTIVE 2 Co-design action plans to address social determinants of health

	ACTIVITIES	TIMELINE			
A	Host co-design sessions in the community to identify solutions and validate Theories of Change to address priority areas of need	YEAR	1	2	3
B	Develop project driver diagrams with community that include change ideas	YEAR	1	2	3
C	Employ an equity lens in project planning and evaluation by asking 3 key questions: Who will this work impact? Are there some who may benefit more than others? Who isn’t thriving and what will it take for that to change/improve?	YEAR	1	2	3
D	Create long term plans with distributed roles, tasks and deadlines; launch a 100-day action lab with stakeholders	YEAR	1	2	3

Co-design involves connecting with individuals in the community to understand the values and beliefs of residents. The Network will host co-design sessions with the community in the winter of 2019 to troubleshoot the barriers identified in the Community Health Needs Assessment and prioritize health improvement projects.

The Network members will engage with community residents to build connections around one another’s expectations and will discuss the types of support that all contributors involved in planning can provide to achieve common goals within the plan. A driver diagram will be used to drive evaluation and action planning.

Our Network believes that short-term measurable goals and action plans keep people interested, engaged and accountable. Leading together to reach common goals requires action plans that define a clear path with activities, roles, and deadlines and track progress. Action plans divide tasks among individuals and/or committees who are ready, willing, and able to tackle activities on their own.

The Network will launch a 100-day action lab to kick-off the first year and will revisits its action plans regularly to track progress, share accomplishments, discuss opportunities and barriers, and celebrate accomplishments.

C. Engage support from service-learning partnerships

DATA DRIVEN DECISION-MAKING

OBJECTIVE 3 Engage support from service-learning partnerships

	ACTIVITIES	TIMELINE			
A	Reach out to service learning partners at GPSA, Amizade and University of Virginia for support with evaluation, project supplies and human capital	YEAR	1	2	3

The University of Virginia supports data collection and analysis to drive improvement looking at the existing community data and socio-demographics to gauge overall health and wellbeing. The academic partners will help facilitate co-design workshops with the Network to align solutions to fit community needs as expressed in the community health needs assessment. The academic partners will also assist with evaluation plans based on the metrics formulated by the Network.

Service-Learning Partners including Global Public Service Academy (GPSA) and Amizade Global Service Learning (Amizade) increase investments of human capital and other resources to help with project implementation. The Southern West Virginia Area Health Education Center will assist with coordinating the service-learning efforts so that the contributions from visitors align with the Network plan.

Goal 3: STRONG COMMUNICATIONS Engage stakeholders and residents and make health equity a shared value

To address the social determinants of health and advance health equity we must first ensure that a shared value is developed to address these issues. It will be important to raise awareness about health inequities, identify leaders in the community who can communicate with community members, and that we develop a communication's plan that reaches diverse audiences to ensure engagement across our community.

A. Raise awareness that inequities are costly

Disparities in income, education, housing, race, gender and even geography impact the lives of families living in rural communities. The Network recognizes that inequities are costly and will share the Communities in Action report to raise awareness among stakeholders in public health, healthcare delivery and with community members.

The Network applies an equity lens to project planning. This means asking the right questions as our Network goals and actions are developed. The Network will ask questions such as: *Who will this work impact? Are there some who may benefit more than others? Who isn't thriving and what will it take for that to change/improve?*

B. Identify leaders to signal importance

The Healthy in the Hills Network believes in talking about health disparities is part of a process that leads to more effective health improvement outcomes. The network will identify local leaders to champion health equity and will strive to deliver a common message that resonates with the community. Resources including the Communities in Action sector briefing materials and REM tools will be shared.

C. Build connections with prospects and partners

STRONG COMMUNICATIONS

OBJECTIVE 3 Build connections with prospects and partners

	ACTIVITIES	TIMELINE			
A	Develop 2 page version of the Plan to engage Network and volunteers in the Plan	YEAR	1	2	3
B	Appoint Network representatives to participate in Greater Williamson Community Development Corporation and Broadband Enhancement Council meetings to share Network information and bring updates back that may inform Network decision making	YEAR	1	2	3
C	Appoint Network representatives to participate in Wild, Wonderful Healthy WV and CORE meetings to share Network information and bring updates back that may inform Network decision making; share information about Health Improvement Trainings	YEAR	1	2	3
D	Share the business case of the Plan with Healthcare Providers and Health Systems	YEAR	1	2	3

The Network will appoint representatives to share the Network updates with key state and local groups who are working on efforts that may align with the Network plan. The network will develop a condensed version of the plan for outreach to potential partners.

The Greater Williamson Community Development Corporation (GWCDC) and the Broadband Advisory Council are working to build a culture of health with a focus on economic prosperity. They envision a connected community featuring an active downtown that promotes healthy lifestyles, walkable streets and recreational access for all. Long-term community impacts expected after the broadband infrastructure is in place include the creation of new businesses and jobs and increased tourism to the area.

The Network will strive to remain informed about the community development initiatives, including efforts to enhance broadband access for all.

The Network serves as a regional training hub for the Wild Wonderful Healthy West Virginia (WWHWV) initiative to assist southern West Virginia counties in health improvement planning to address social determinants of health and to drive economic revitalization. The WWHWV trainings, coordinated by the Center for Rural Health Development, focus on community health needs assessments and other improvement topics for rural communities. The Network aims to send representatives to bring back the lessons learned from WWHWV health improvement trainings.

The Network will share a business case for working upstream to address social determinants of health and health equity with healthcare delivery and health system stakeholders. Outcomes of the plan, recognized by year three, will result in cost savings that may compel healthcare organizations to sustain involvement with the Network.

Goal 4: SUSTAINED IMPROVEMENT Build capacity of Network and community through planning, evaluation and a commitment to improvement

To ensure that the plan is carried out as planned and that desired milestones are reached, the Network will develop an evaluation plan that involves continuous improvement.

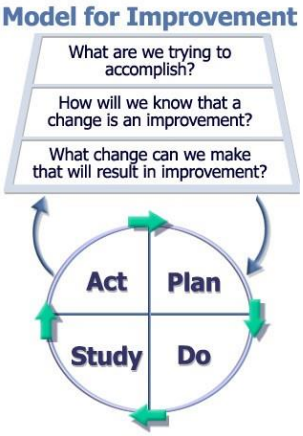
A. Design and implement a three-year Evaluation Plan

SUSTAINED IMPROVEMENT

OBJECTIVE 1 Design and implement a three year Evaluation Plan

	ACTIVITIES	TIMELINE			
A	Develop a Network committee to oversee evaluation	YEAR	1	2	3
B	Identify process and outcome metrics for the Plan and action plans	YEAR	1	2	3
C	Review progress at quarterly meetings and Community Conversations	YEAR	1	2	3
D	Identify change ideas with community to improve processes and outcomes	YEAR	1	2	3
E	Test change ideas using Plan-Do-Study-Act Cycles	YEAR	1	2	3

An evaluation committee will be made up of volunteers from the Network and will work with academic partners from the University of Virginia to oversee evaluation. Evaluation tools will be developed in 2019 and metrics will be co-designed with the community.



The Model for Improvement is a framework for data collection and analysis that asks: 1) What are we trying to accomplish? 2) How will we know when the change we see is an *improvement?* 3) What change(s) can we make that will lead to an improvement?[4] These questions help bring teams together to make sure the desired results are achieved.

The Model for Improvement framework outlines a process, or a repeatable set of steps, called the Plan-Do-Study-Act (PDSA) cycle. First, teams are formed and develop a plan to test a change idea (Plan), then carry out the test (Do), then observe and learn from the consequences of the test (Study), and finally determine what modifications should be made moving forward (Act). The illustration is used to show that the cycle is repeated until the change idea is recognized as a verifiable improvement.

Network participants involved in project planning and training will contribute feedback to drive improvement using the PDSA process based on the driver diagrams created

[4] Associates in Process Improvement (2019). Retrieved from http://www.apiweb.org/

collaboratively. The cyclical process allows for ongoing feedback from the community and stakeholders.

B. Celebrate and work through challenges together

SUSTAINED IMPROVEMENT

OBJECTIVE 2 Celebrate and work through challenges together

	ACTIVITIES	TIMELINE			
A	Recognize achievements and challenges at Network and community meetings	YEAR	1	2	3
B	Host community celebrations for reaching outcomes	YEAR	1	2	3

By experiencing successes and challenges together, the Network will build a collaborative culture that is strengthened overtime. Recognizing achievements at Network and community meetings is an essential component of the plan which supports motivation and sustainability.

C. Host health improvement trainings

SUSTAINED IMPROVEMENT

OBJECTIVE 3 Host health improvement trainings to enhance skills among Network members and community

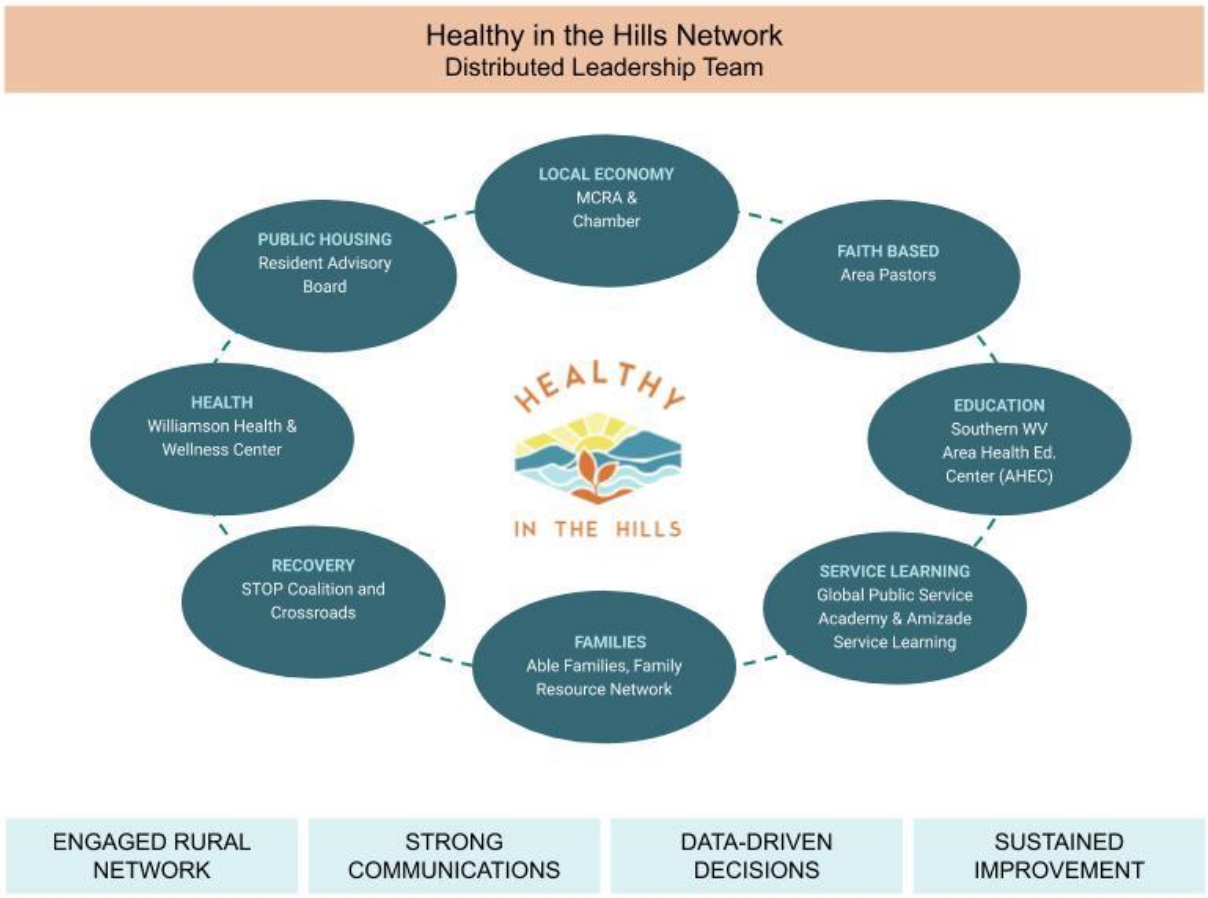
	ACTIVITIES	TIMELINE			
A	Develop a Network committee to coordinate training	YEAR	1	2	3
B	Schedule trainings with training providers based on Network and community needs	YEAR	1	2	3
C	Go public with registration and outreach materials	YEAR	1	2	3
D	Develop and assess training evaluations to inform future trainings	YEAR	1	2	3

The Network will leverage a combination of partnerships to host health improvement trainings to strengthen community leadership capacity. Health improvement trainings will involve developing skillsets and learning about tools that participants can use to design, implement and evaluate community projects. Interactive lessons will include topics on finding personal motivation, working collaboratively, employing an equity lens across projects, and striving for outcomes and sustainability.

Training participants will be encouraged to engage friends and family in health improvement planning. As more individuals become aware of the Network activities, the efforts may effectively drive culture change and create a sense of hope in the community.

STAKEHOLDERS

The organizational chart below showcases a distributed leadership model. Distributed leadership involves authentic engagement between organizations and the community served. Opportunities to be involved in the Network include serving on the Leadership Council or volunteering to assist with programs, projects or events. Volunteers and Leadership Council members contribute to Network sustainability and growth and help to spread messages within diverse community settings. Supporting partners also play a role by offering resources and technical assistance.



Stakeholders and residents are committed to planning, implementation and evaluation phases. While some Network roles have been defined upfront, other roles will be determined as part of the planning process.

Southern West Virginia Area Health Education Center will assist with coordination of service-learning teams and medical students to support the enhanced incubation plan. The University of Virginia will assist with facilitation of the co-design workshop to validate the CHNA and create action plans.

Training partners from the Center for Rural Health Development guiding the Wild, Wonderful, Healthy West Virginia initiative will collaborate with the Network to offer

community health improvement training. Service-learning partners including Amizade and the Global Public Service Academy will provide financial and in-kind resources including supplies and volunteers to implement community health improvement projects.

Williamson Health & Wellness Center (WHWC) will gather data using the PRAPARE standardized risk assessment tool. The Network team will assist with reviewing the data and establishing internal processes to streamline data collection and analysis, billing procedures, and referral processes. WHWC also offers administrative and outreach personnel to support network development.

SUSTAINABILITY

The sustainability of the Network involves ongoing communication to maintain relationships among network members. Sustainability also requires strategic healthcare and economic development partnerships and fundraising.

Efforts to address non-medical factors in community health align with current healthcare trends among healthcare providers shifting to adapt to value-based payment models. The healthcare providers in our community are looking for ways to address the social determinants of health for their patients to improve outcomes and achieve cost savings. The Network provides a unique service to the community by addressing the social determinants of health collaboratively.

As part of a sustainability plan, the Network will leverage support from healthcare partners who see a value in the Network health improvement plan as it relates to value-based care. Specifically, Network activities could affect no-shows, readmissions, care coordination, patient experience and bundled payments.[5]

The Greater Williamson Community Development Corporation and WHWC have partnered to launch a Broadband Advisory Council. The Network aims to align efforts with the Broadband Advisory Council to watch for opportunities to leverage resources and build on one another's planning efforts. The broadband planners are driving equity and inclusivity by expanding access to rural communities.

In addition to building healthcare and economic development partnerships, the Network will continue to fundraise for planning, implementation and evaluation.

The health improvement plan will require a combination of private, state and federal investment. In 2019, the Network (with WHWC as the fiscal agent) received sub-award from the Appalachian Regional Commission through the Wild Wonderful Healthy West Virginia initiative. The small grant will support the development of the health improvement

[5] Health Leaders Media (December 27, 2018). Five ways social determinants of health affect the revenue cycle. Retrieved from: https://www.healthleadersmedia.com/finance/5-ways-social-determinants-health-affect-revenue-cycle

action plans for the Network. WHWC will continue to fundraise to support Network activities and sustainability as the plan is carried out over the next three years.

ACKNOWLEDGEMENTS

The Race Equity Map is a Coalition Self-Assessment Tool developed in collaboration with the 100 Million Healthier Lives (100MLives) initiative, the Wandersman Center and community partners from the 100MLives Race, Racism and Equity Workgroup.

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