

Massachusetts  
Fairview Hospital  
Rural Health Network  
#P10RH31096-01-00

## Strategic Plan

### 1. Network Statement

South Berkshire County (SBC) is part of America's Premier Cultural Resort. We have theater and dance. We have an abundance of natural resources – mountains, streams, ponds and lakes. We have fresh air, hiking, biking. We have access to organic produce, farm-to-table restaurants and alternative and complementary health care practitioners. However, SBC struggles with a multitude of issues that impact the health of our community. We have significant poverty, poor health status markers, significant opioid abuse, children who experience ACEs. The winters are cold and long, public transportation is not available, the distances to health care and supermarkets, community centers and faith communities can become insurmountable. And, unfortunately, access to resources often depends on who you know. This is not a recipe for meeting the needs of *all* our residents.

SBC has an abundance of resources in the form of caring individuals, service organizations, a critical access hospital, a federally qualified community health center, and a free volunteer clinic to meet the health care needs of our residents. However, we still have too many people suffering with obesity, diabetes, depression, anxiety, cardiovascular disease, autoimmune disease, dementia, and addictions.

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

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

## 2. Organizational Overview

In the spring of 2017, Fairview Hospital took advantage of the opportunity to apply for funding to create a network dedicated to understanding and improving health in South Berkshire County (SBC). The Berkshire Health Systems **2015 Community Needs Assessment** gave us the following starting point:

- Target populations include the medically underserved, the uninsured, our aging population, growing racial and ethnic populations, the economically vulnerable, youth, pregnancy and childbirth and populations with health disparities.
- Community benefit priorities include access to medical professionals, particularly for the un- and under-insured, infectious disease, obesity, smoking, cancer, cardiovascular health, diabetes, maternal/child health, mental health, stroke/blood pressure.
- The community health initiative priorities were healthy weight/nutrition/exercise, mental health/depression, motor vehicle accidents, substance abuse/excessive drinking, teen pregnancy and tobacco use.
- “There is also an overarching goal to improve the health status of the community through integrative health and prevention.”

This is county-wide and does not necessarily reflect the strengths and challenges unique to SBC; it does give us a sense of where we should be looking for more local data. Of these areas of focus, we gathered anecdotal input highlighting mental health/depression, motor vehicle accidents and substance abuse/excessive drinking as areas of need in our community.

The trends we are experiencing from a state and national perspective that are motivating factors are the changes in health care financing that are shifting the risk from the insurer to the practitioners and hospitals. We are seeing greater support for a focus on prevention and are inspired to identify what preventive activities are most appropriate for SBC.

The **Rural Health Network (RHN)** was created to engage community health and service organizations in anticipating these and other trends in health and health care delivery to effectively assure that the health needs of the residents of SBC are met. The original structure of the network is a core of the *three major health care providers* in SBC – Fairview Hospital, Community Health Programs and East Mountain Medical Associates. The *full network* includes Volunteers in Medicine, Multicultural Bridge, Berkshire VNA, BMC Psychiatry Department (South County outreach position), Berkshire South Regional Community Center, Railroad Street Youth Program, Grace Church, Berkshire Hills Regional School District, Elder Services of the Berkshires, Berkshire Community Action Council. With a clear definition of the goals, activities and responsibilities of the network, we anticipate changes in structure and membership moving forward.

### Vision for the network

- A trusting group of organizational representatives and community members, emotionally invested and in touch with the strengths and needs of the community.
- A group that is sustainable, adaptive and successful in accomplishing agreed upon goals.  
A group that can leverage its strengths for the common good.

## Vision for the community

- A sense of community and ownership.
- Residents feel empowered, understand what is available and how to access it, and find it navigable.
- Residents feel they can change or add to what is available, that there is mutual respect, and people are treated with a sense of dignity and equity.

## Mission

To develop and sustain an adaptive network of community service providers that works to improve the health and well-being of individuals and families in the South Berkshire community.

## Core Values

Empowerment	Connection
Respect	Sustainability
Dignity	Honesty
Community	Transparency
Pride	Adaptiveness

## Governance and Decision-Making

- The group stated that it would like a strong organizational structure with requirements for participation; those in leadership roles need to make a commitment to that leadership role.
- The governance board will be comprised of 6-12 individuals who will make a commitment to monthly meetings, taking responsibility for the direction and the fiscal solvency of the network.
- The network coordinator will take responsibility for convening the network, coordinating meetings and activities and integrating the meeting proceedings into an action plan. The coordinator may offer direction based on expressed needs of the group and available funding mechanisms.
- For now, the network will continue to exist under the umbrella of Fairview Hospital. Over the next 2 years, the board will explore possibilities that include becoming an independent 501c3, as well as continuing under a larger organization (not necessarily Fairview) with its own governance board. This would allow for the benefits associated with an established organization, while maintaining the objectivity and impartiality necessary for a true partnership.
- The goal of the Network will be consensus decision-making among the members of the governance board with accommodation made for the rare situations in which this may prove impossible. Input from the larger community will be solicited on a quarterly basis, and this input will inform the decision-making of the governance board.

### 3. Strategic Planning Process

#### Early Stages

Our strategic planning process started with simply getting to know each other and what services we each provide for the community; in a small rural area such as ours, it is important to get to know all the players. We used our monthly core team meetings to hash out our mission and vision, define health and ideal health care systems and used this time to process and sort through the information and activities that took place at the full network meeting; this allowed us to form a strong core. We worked on the parameters of our work with our consultants, HCI Conduent, to help us formalize our data collection and built the bases for the work we did with the larger group of network partners.

#### Quarterly Meetings

Our quarterly full network meetings were incredibly exciting as partners engaged in learning about each other, understanding each other's perspectives, and identifying ways we could begin to work together, even as we worked to create the network structure. The partners engaged in defining the terms, identifying needs and identifying what would make the network valuable to them. This work is reflected in every aspect of this strategic plan.

#### Techniques

The techniques used contributed greatly to the effectiveness of the time we spent together. The coordinator did formal key informant interviews that were collated by our consultants; this allowed the coordinator to get to know the partners better and painted a much clearer picture of the resources and needs in our community. The other information that fed our consultant's report came from an on-line capacity survey sent out to as many other health, educational and service organizations as we could identify, to make sure we had not missed any needs, or any services/tools available to meet those needs.

#### Small Group Discussions

At our meetings, we made a point of having small group discussions anytime the group was larger than 5 to make sure that people got to know each other and everyone had ample opportunity to be heard. An effort was made to separate individuals from the same organizations so there was a diversity of perspective in each group. The richness of what came from these groups was amazing, as these groups of caring and capable individuals amplified what each other brought to the table.

#### The Community

The last, but probably the most important contribution to our strategic planning process came from the community. We held 2 community forums. Using the small group model, we facilitated conversations among a diverse group of participants, to hear what they felt the needs are in this community and potential solutions. We also sent out a community survey, both on-line and in hard copy, to get broader input from the community itself. At the time of this writing, we received over 200 responses to the survey, with more coming in. We view this as a good continuing surveillance tool.

## 4. Organizational Assessment Summary

### Process

Members of our core group (Fairview Hospital, Community Health Programs, East Mountain Medical Associates) were asked to fill out the assessment form in anticipation of our meeting. They arrived partially prepared for the meeting, due to confusion about whether they were assessing their own organizations, the core network group, or the network of all 13 partners. After some discussion, it was agreed to assess the full network, which led some people to change some of their ratings. Each of the 5 participants shared their ranking and reason, as well as differences. We had discussion and quite easily arrived at consensus. This became easier as the questions got more complex. Overall, we managed the process well, particularly since we are in the early stages of our development as a network.

### Results

The completed overview was distributed electronically to the full network and their input was requested at our April network meeting. We reviewed the conclusions with the group. There was not further input and a general acceptance of the conclusions we had reached was acknowledged.

We were pleasantly surprised with the progress made, particularly in engaging our partners and the community. This feeds our optimism about the value of the network to the community. We agreed we have also made progress in our clarity of mission and movement toward sustainability. These are significant accomplishments for a young network of 8 months.

### Next Steps

The areas we plan to work on are:

- Communication concerning the network's role and its value.
- Identifying our first projects and strategies, so we can begin to utilize our cooperative strength and learn how to work together most effectively.
- Continued discussion regarding authority and membership criteria. This discussion is serving as the backdrop for our membership criteria for the governing board of the organization.
- We plan to review the assessment again in 6 months to evaluate continued progress as a network.

## 4. External Environmental Scan

Data is difficult to gather for South Berkshire County because of our sparse population of 26,000 people covering 350 square miles, for a population density of 73 people per square mile. Often times, data is collected on the entire Berkshire County region.

Data was collected from the following resources:

### **BHS 2015 CHNA : (county-wide data)**

- Cardiovascular diseases, cancers, respiratory diseases (other than lung cancer), nervous system diseases and psychological disorders - leading cause of death in adults.
- Lung cancer - leading cancer.
- Pneumonia and influenza deaths - decreasing.
- Alzheimer's disease - increasing, higher than diabetes, breast, prostate or colon cancer.
- Motor vehicle and suicide deaths - higher than expected.
- Smoking during pregnancy - increasing.
- Opioid-overdose deaths - trending up since 2004, higher than statewide average.
- Food insecurity - 17% of county children, 30% are obese.

### **Berkshire United Way :**

- Families in poverty - 20% or more of the population in parts of Great Barrington, Stockbridge, Sheffield.
- Families in poverty - 5% to 20% of the population in parts of New Marlborough, Monterey, Tyringham, Great Barrington, Stockbridge and Lee.
- 3<sup>rd</sup> grade English proficiency - dropping county-wide.
- Children in DCF caseload - above its previous 2008 peak in 2015.

### **Be Well Berkshires: (county wide data)**

- Food insecurity - 15% of Berkshire County residents, 16.6% are children.
- Eligible for SNAP - 32% of Berkshire County residents eligible and not receiving it.
- Residents seeking food assistance- average of 15,000 residents.
- Obese - 19.9% of Berkshire County residents.
- Children - 18.3%.
- Eating less than 5 servings of fruit and vegetables/day - reported by 70% of residents.

### **Berkshire Regional Planning:**

- Population division - 4,500 under 18; 15,100 between age of 19 and 64; 6,500 are 65 and older.
- Largest cohort - between \$25,000 - \$50,000 (often the working poor); more people making under \$25,000/year than \$150,000/year.
- Poverty - 8.3% of individuals and 4.5% of families.

### **Mass Office of Rural Health:**

- HPSA designation (South Berkshire County) - for primary care, mental health, and dental health.

### **Berkshire Hills Regional School District :**

- Social and emotional disabilities (since 2012) - 700% increase in students; 125 families with complex medical and behavioral needs connected with services in 2016.

### **HCI Conduent Report: (our network consultant)**

- 3 most common health needs are mental health, substance abuse, obesity/overweight.
- 3 most critical social determinants are transportation, social infrastructure/connectivity, economy/housing/employment.
- Concerns for our low-income population include food security, stress and delayed health care
- We have identified populations who are experiencing discrimination, isolation and lack of opportunities.

### **Community Meetings:**

- We have a powerful caring community.
- There are many resources but it is not always easy to find them.
- We need better mental health resources, especially for children.
- We need better resources to deal with addiction.
- We have a shortage of health care providers, especially specialists of certain kinds.
- There is a need for specialized care and care coordination for people with special needs.
- We need economic development.

### **Community Surveys (sent out in English and Spanish):**

- The most identified health concerns were high blood pressure, high cholesterol, cancer, asthma and tick-borne infections.
- Participants identified availability and cost as the most common reasons for not getting health care needs met.
- 58% of respondents leave Berkshire County to get their health care needs met.
- Other than medical care, our respondents use mental health, physical therapy, nutrition, chiropractic and massage most often.
- 93% of respondents have health insurance but only 66% consider it adequate; 49% state it covers the services they need.
- Only 34% of respondents have insurance that covers their mental health needs or dental care.
- We plan to delve more deeply into these responses and to identify groups that are not represented.

### **Identified Issues:**

We were pleasantly surprised by the consistency of identified issues and that we did not have disagreements about what is right and not right in our community. There are two comments that provide a nice summary of how to approach the issues important to us.

1. “We are good at responding to need but not as good at changing the need to respond”. This is not a criticism of the good work any of us are doing. Rather a frustration with the band-aid approach we sometimes take due to external constraints. It also provides an important reminder to look at the underlying causes of the problems and address those. This is where our focus on social determinants of health shows its importance.
2. “What you know depends on who you know”. This statement reminds us of the inequity in distribution of resources and the importance of engaging the *whole* community in addressing problems. Resources should be universal rather than a privilege.

### **Primary Focus Areas: (for improving the health of our community)**

- Mental Health and Mental Disorders.
- Substance Abuse.
- Obesity/Overweight.

### Social Determinants of Health identified:

- Transportation.
- Social Infrastructure and Connectivity.
- Economy/housing/employment.
- Access to health services.
- Income, race and ethnicity are hallmarks of the communities most affected.
- Age and sexual orientation impact access to services.

### Highest Priority Needs:

- Increased opioid dependency.
- Continued alcohol misuse.
- Lack of access for marginalized groups – immigrant, LGBTQA, poor, mentally ill, chronically ill.
- Lack of transportation.
- Isolation.

### Trends Now:

- Change to ACO model for Medicare and Medicaid.
- Increased emphasis on prevention.
- Unaffordable educational costs for communities due to state funding formulas and decreasing school age populations.
- Aging South Berkshire population.
- Uncertainty in the public and private healthcare marketplace due to volatility in Federal health care delivery reform.
- Health insurance costs driving municipal and school department budgets and limiting resources available for services.
- Recognition of complementary and alternative health care services as valuable, with minimal insurance coverage for them.
- More locally grown food, with more in food pantries; SNAP benefits and other food subsidies.

### Prioritization of Activities:

- Pilot programs that can be expanded to the rest of our population.
  - ✓ Network members felt it was important not to lose successful programs.
  - ✓ These successful programs can serve as a point of entry for other high risk populations.
  - ✓ We all liked these models because they have the potential for broader application in the community.
  - ✓ We believe that intervention at an early age will serve a preventive function in our community, as it reaches families as well as children.
  - ✓ Encompass many of the priorities we felt important to decrease opioid dependency, alcohol misuse and lack of access.
  - ✓ For success, it will require our attention to transportation, other social determinants of health, and working to decrease the sense of isolation that drives some of these dangerous behaviors.



## 5. Network Programming Goals & Objectives

### Goal:

- **Create a Culture of Caring in our Community** recognizing the variety of experiences that impact different individuals and groups.

### Objective:

- Create a **Coordinated Community Collaborative Care model** for all population groups, from children to seniors.

### Activities Year 1: July 2018- June 2019

- 1. Maintain the existing Collaborative Care program between Muddy Brook Elementary School and MACONY Pediatrics and begin its expansion through engagement of other pediatric providers (CHP GB and Lee) and other school districts (Lee, Southern Berkshire Regional School District, Farmington River Regional School District). This will lay the foundation for expanded implementation in Year 2.**
  - Assure appropriate staffing for the existing collaborative care program.
  - Secure mental health resource referral list.
  - Create Telehealth access in the school to connect to medical practice.
  - Bring other providers and schools together to introduce the concept and create buy-in.
  - Determine practitioner need in the school.
  - Connect with new ACO teams to coordinate services.
- 2. Create a unified role for community health workers and make cultural competency an integral part of all activities.**
  - Identify all existing CHWs in South Berkshire County and their job descriptions.
  - Convene all organizations using or desiring to use CHW's.
  - Look at both the state and BCC CHW training programs.
  - Refine CHW job descriptions and requirements.
  - Engage Multicultural BRIDGE as well as other providers of cultural competency training.
  - Include an understanding of disparities.
  - Assure we are working from a shared vision of health.
  - Create an implementation plan.
  - Identify funding sources.
- 3. Develop an electronic referral system and create a centralized resource directory and establish a long-term strategy for maintenance:**
  - Review what BCAC has in place already; review how it is working for existing partners.
  - Develop a list of criteria for a usable system.
  - Engage as many South County and South County serving organizations as possible in participation.
  - Monthly monitoring for glitches and efficiencies.
  - Gather all existing resource directories.
  - Identify agency resources for maintaining/updating.
  - Create a plan.
  - Identify roles and implement.

## Activities Year 2: July 2019 through June 2020

1. **Implement Collaborative Care with other pediatric providers (CHP- GB and Lee), other ages and other school districts (Lee, Southern Berkshire Regional School District, Farmington River Regional School District) :**
  - Identify and find resources for staffing needs.
  - Provide training and support.
  - Reinforce mental health resources.
  - Create Telehealth access in all participating school and provider offices; this can be used for family meetings as well as professional collaboration.
  - Continue work with ACO teams to avoid duplication of services.
  
2. **Build a peer network connecting people of all ages:**
  - Meet with community leaders to identify existing support systems and needs.
  - Meet with existing groups to identify strengths and needs.
  - Engage leaders in creating locally appropriate solutions.
  - Begin the expansion of existing programming/services to meet these needs.
  
3. **Create a plan, based on our first year of experience, to build collaborative care communities for all population groups.**

## 6. Adaptive Capacity Goals & Objectives

Our Organizational Assessment helped us recognize the progress we have made, and gave us a roadmap to reach the benchmarks of progress.

**Timeline for these goals and objectives-** to direct us toward a year of further building the credibility of the Network, as well as to demonstrate its effectiveness.

Activity	Timeline
1. Reach out to towns, school districts, other organizations to engage them in identifying needs and becoming part of the solution	Summer and Fall 2018
a. Schedule visits at each town hall and council on aging to identify the individuals to engage	
b. Connect with existing town services	
2. Promote our vision and activities to increase visibility and get more people engaged.	Summer 2018
a. Engage the PR staff of participating organizations to create a plan	
3. Establish criteria and commitments of governance board members to assure that the group can make actionable decisions.	Summer 2018

a. Schedule a half-day retreat with the network governance board.	
b. Hold a series of meetings with network governance board.	
4. Work with the goals identified above and create a minimum of 3 projects to focus on the first year.	
a. Form project teams	Summer 2018
b. Create evaluation format, criteria, timeline for projects	Fall 2018
5. Identify squeeze points in the process and address	Fall 2018/ Winter 2019
6. Repeat Organizational Assessment Overview	December 2018
7. Identify process benchmarks for our success	Summer 2018
8. Identify what community resources can provide support/training to make our processes more effective	Winter 2018-2019
9. Create an environment where people see hiccups as opportunities, not punishable offenses	Ongoing
a. Evaluate periodically	September 2018 and quarterly
10. Maintain fiscal viability of organization	Ongoing

## 7. Use of the Strategic Plan

The **Strategic Planning process** is an immensely helpful process for defining who we are, what we are capable of, and how we want to reach our accomplishments.

The **Network Statement** is a way of introducing ourselves to our neighbors as well as our funders. It is a statement that should draw positive attention and can headline any event where we are introducing ourselves. Combined with the **Organizational Overview**, it is a tool that directors can bring to their Boards to demonstrate the value of membership and the potential of collaborative work.

The **Data** we have collected will serve as background for understanding the 'why' of our goals and objectives and will also be a baseline to compare ourselves to as we move forward. Its combination of hard data with the anecdotal experiences of people in the field allows us to see where the reality on the ground. The experience of life here in South Berkshire county is not necessarily reflected in the data, and the data often does not mesh with our perceptions of the area. The difficulty of life for many people is invisible. The combination of data and anecdotal evidence paints a broader picture than is usually seen.

The **Details of the Plan** set out a strategy for addressing the most obvious needs. It is apparent that as we start to address some of these, we will be identifying more needs. The first year of the grant will be a test for us, to see how well we can work together to find creative ways to address the needs. Our plan is innovative and exciting and at the same time, cautious and incremental, allowing us to build the relationships and trust to accomplish big things. It reflects an understanding of the realities of collaborative work combined with our

shared vision. We are careful to start with lean staffing to assure that we do not have too large a burden for the community to support, with the capacity to enlarge the staff as activities and funding are identified. The strategic plan is the checkpoint for our decision-making to assure that we are moving in the direction the larger network and community are expecting. By keeping as large a community as possible engaged, we can refer back to the strategic plan and use it as a template as the world around us changes. It is a working document that is subject to change, with the process for change outlined in the network structure.

The process of building the **Governance Board** is our first step towards strengthening the network. Creating a structure for individuals and organizations to identify their place in, will allow each one to use their strengths and appreciate the synergy created when we all come from a place of strength. As we are able to meet with a larger group, the plan is to meet quarterly, we will be better able to use everyone's resources most effectively. This may entail focus-shifting within an agency's mandate to allow for more collaborative work, or resource sharing to facilitate more comprehensive services. The adaptability will come from a powerful sense of shared mission.

We are starting with a concerted effort to maintain an **Existing Pilot** for which we have the baseline data and the data after a year of implementation. This Pilot began as a response to a 700% increase over 4 years in students with social and emotional disabilities in one of our school districts. By building strong relationships among families, schools, health care providers and community services, they were able to build a therapeutic program, track cases to identify effective supports and establish protocols to access Collaborative Care. This resulted in a significant increase in families connecting with the services they need and an accompanying increase in BAS Assessment reading scores. The school classrooms are increasingly calm and productive.

**Community Health Workers**, previously funded through the Prevention Wellness Trust Fund, have been a valuable resource. This plan recognizes their value and will be used to demonstrate the continued need for these workers. We look forward to bringing our goals and objectives to the organizations which provide training and certification for these workers to assure that the needs of our community can be met by the upcoming graduates of these programs.

We are excited to have the experience of the work that some of our network partners have done with **Benefits Hub**, a communications/referral tool, to lay the groundwork for creating a more comprehensive tool. This Strategic Plan will guide our continued work with Berkshire Community Action Council, who houses the Benefits Hub. to find ways that this program can facilitate an improved referral system.

The **next steps** this team has identified are, work that needs to happen within the schools on policy and protocols and expansion of the program to our other schools and health care providers. This will require protocols, training, staffing and support. We see this model as transferable to other population groups as a powerful tool in the implementation of our goal to be a Community of Caring.

We will continue with the **metrics** collected thus far. As we expand the pilot in the same setting (schools and pediatric offices), we can collect the same metrics over a larger number of organizations and students. When we move forward to build the system for a more diverse audience, we will use additional data about use of health and social services and disease incidence to measure our performance and look for areas to improve efficiency and/or effectiveness.

Creating a uniform and dynamic resource list, improving our use of Community Health Workers, assuring cultural competency, and developing an electronic referral system are the things that will support our **Collaborative Care Coordination**. Creating systems that are transferable to any population, that will address that population's unique needs, will enable us to reach all those in need. It will also allow us to offer these systems to other rural areas where they are grappling with similar problems. *When we are sure that everyone who lives in South Berkshire County has a way to be connected to the resources they need, we will have fulfilled our mission.*