Network Development Planning (NDP)

Grant: P10RH31839 **Start Date:** 07/01/2018 **End Date:** 06/30/2019 **Report Date:** 07/31/2019

Organization: JEFFERSON, COUNTY OF

Submitted Date: 07/12/2019

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0384. Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10C-031, Rockville, Maryland, 20857.

Network Infrastructure

Network

Please provide information about the network members and network operations. Network members are defined as members who have signed a Memorandum of Understanding or Memorandum of Agreement or have a letter of commitment to participate in the network.

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Non-Profit Organization Identify the types and number of organizations in the consortium or network for your project.Please check all that apply (at least one Non-Profit Organization or For-Profit Organization is required):	**Number**
Area Health Education Center (AHEC)	
Behavioral/Mental Health Organization	1
Community College	
Community Health Center	
Faith-based Organization	
Free Clinic	
Emergency Medical Services	
Federally Qualified Health Center	
Government	
Law Enforcement	
Public Health	
Health Department	1
Hospice	
Hospital - Other than a Critical Access Hospital	
Hospital - Critical Access Hospital	1
Migrant Health Center	
Private Practice/Physician’s Clinic	
Rural Health Clinic	
School District/System	
Social Services Organization/Agency	
University	
Other - Specify: EMS	1

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For-Profit Organization Identify the types and number of organizations in the consortium or network for your project.Please check all that apply (at least one Non-Profit Organization or For-Profit Organization is required):	Number
Critical Access Hospital	
Hospice	
Private Practice	
Rural Health Clinic	
Other - Specify:	

Member Organizations	Number
Total number of NEW member organizations that joined the consortium/network during this project period (after the start date of the grant):	0

Meeting Type Indicate the total number of full-member (all members that signed MOU, MOA, or letters of commitment) network meetings conducted during the reported budget year by meeting type. Please check all that apply (at least one is required):	Number
Meeting conducted face-to-face	12
Meeting conducted via teleconference	
Meeting conducted via webinar	
Meetings conducted with combination of face-to-face and teleconference/webinar	
Meeting conducted in a manner not listed above - Specify type:	

Type of Network Benefit	Type of Change
From the beginning of this budget year, assess the following overall Network activities (check one answer for each type of network activity): The "Other" field is optional. If checked, add an explanation for "Other" in the Comments field at the bottom of this page.	
Financial Cost Savings	No Change
Access to Educational Opportunities	Increased
Access to Equipment	Increased
Access to Subject Matter Experts	Increased
Understanding of community health needs	Increased

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Staffing Capacity	Increased
Other	No Change

Focus Area(s) What area(s) was the network focusing on for this project period?Please check all that apply (at least one required):	
Cardiovascular Disease (CVD)	
Behavioral Health - Both Mental Illness and Substance Use	✔
Network Organization/Infrastructure Development	✔
Oral Health	
Reimbursement for Health Services	
Substance Use	✔
Substance Use - Opioid Specific	✔
Chronic Disease - Diabetes Specific	
Chronic Disease - Chronic Obstructive Pulmonary Disease Specific	
Chronic Disease - Asthmas Specific	
Chronic Disease - Other	
Hospital Closure	
Care Coordination	✔

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Focus Area(s) What area(s) was the network focusing on for this project period?Please check all that apply (at least one required):	
Children / Adolescent Health	
Diabetes	
Elderly / Geriatric / Older Adult Health	
Emergency Medical Service	✔
Health Information Technology	
Mental Health / Mental Illness	
Obesity - Child/Adolescent	
Obesity - Adult	
Primary Care	
Telehealth / Telemedicine	
Workforce Development	
Other - Specify:	

Network Infrastructure Form Comments

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Is Network Infrastructure Form Complete?	Y

Network Infrastructure Form File Attachment			
File Name	**File Type**	**File Size**	**Upload Date**

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Network Collaboration

Collaboration

Please provide information about collaboration and/or integration among the network members. Refer to the activities listed in the project work plan for this project period.

Activity	Number
Number of activities initiated *How many activities from the project work plan were initiated by at least two or more network members?*	11
Number of activities completed *How many activities from the project work plan were completed by at least two or more network members?*	9

Development Plan	Type of Change
Did the network develop the following (this does not include a needs assessment)?Please provide a type of Development Plan description if Development Plan is not listed below.	
Business Plan	No
Sustainability Plan	Yes
Other - Specify:	Strategic Plan

Network Planning Activities What type of Network Planning activities were done during the project period?Please check all that apply (at least one required):	
Conduct needs assessment	✔
Develop network bylaws	✔
Develop network mission statement	✔
Develop network governance structure	✔
Develop of network charter	

Develop incorporation document(s)	
File/Submit incorporation document(s)	
Develop Network Partner Memorandum of Understanding (MOU) and/or Memorandum of Agreement (MOA)	✔
Conduct community engagement activities	✔
Other - Specify: Developed Strategic Plan	✔

Network Collaboration Form Comments

Is Network Collaboration Form Complete?	Y

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Sustainability

Sustainability

Please provide information about the contribution by network members and the network's sustainability efforts.

Funding Revenue	Number
Annual Program Award *Please provide the annual program award based on box 12a of your Notice of Award.*	100,000
Additional funding secured to assist in sustaining the network *Please provide the amount of additional funding secured for sustainability of the program or network during this current project period, as a result of leveraging the grant.*	200,000
Estimated amount of cost savings due to participation in the network during this current project period	0

Sources of Revenue Please check all that apply (at least one required):	
Network Revenue	
In-kind Contributions (In-Kind contributions are defined as donations of anything other than money, including goods or services/time.)	✔
Member fees	
Fundraising	
Providing contractual services	
Other - Specify:	

In-Kind Services How many of the network members have provided the following in-kind services:	Number

Goods (Ex: equipment, food)	2
Services (ex: meeting space)	3
Staff support	2
Expertise (ex: legal, business, website/marketing development)	2
Other - Specify:	

Network Policy	
How many network policies or procedures were created during this budget period:	N
How many network policies or procedures were amended during this budget period:	N
How many network policies or procedures were implemented during this budget period:	N
As a result of being part of the network, how many network member organizations were able to integrate joint policies/procedures within their respective organizations during this budget period?	N
Will the activities of the Network/Consortium continue to operate after the Federal grant funding period?	Y

Sustainability Form Comments

Is Sustainability Form Complete?	Y

Sustainability Form File Attachment			
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Network Assessment

Network Assessment

Please provide information regarding the network's assessment during this project period.

Assessment	
Does the network have a process or tool to assess effectiveness of network performance after the Federal grant funding period?	Y
If yes, how will the network performance be assessed?	We found the tools provided by HRSA to be very effective in understanding our network performance and were used by us in our daily operations. We will continue to use these. We also carried out a Community Health Assessment which, when assessed, will give us further insight into network performance.
Does the network include a process or tool to assess effectiveness of network director (or the person tasked with leading the network)?	Y

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If yes, how is the network director (or the person tasked with leading the network) assessed?	Joint Network Directors were and continue to be subject to continuous assessment by a CHIP Oversight Committee comprising representatives from Jefferson County Public Health and Jefferson Healthcare. Network Directors also made formal presentations on the goals, objectives and outcomes of the project to Jefferson County Joint Board, Jefferson County Board of Health, and Jefferson County Commissioners. Finally, they participated in monthly coaching and oversight meetings with CRL coach & HRSA PO.
Did the network meet its program objectives outlined in the Network Planning grant work plan?	Y

Network Assessment Form Comments

Is Network Assessment Form Complete?	Y

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