ADDRESSING THE HIV WORKFORCE CHALLENGES IN RURAL COMMUNITIES: UNIVERSITY OF VIRGINIA COMMUNITY HEALTH WORKER PROGRAM

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ON BEHALF OF OUR TEAM

HIV Care Challenges Rural VA

- Stigma
- Transportation
- Poverty
- Isolation
- Alcohol/drug use
- Mental health challenges

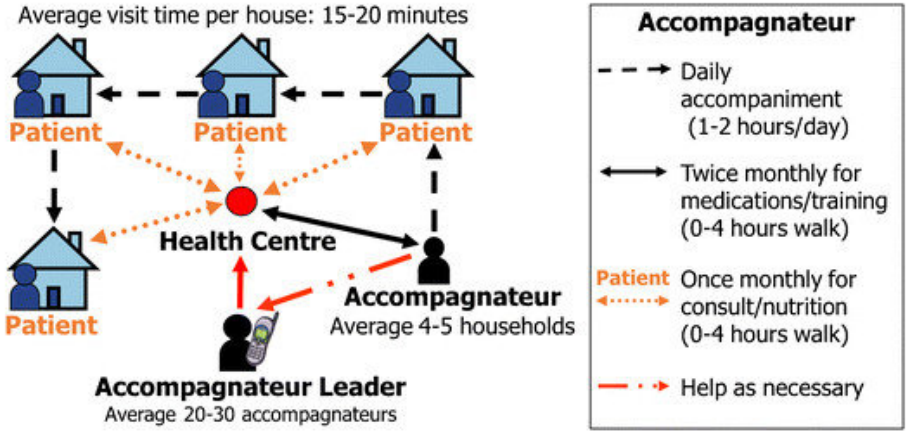
Accompagnement

Curr HIV/AIDS Rep
DOI 10.1007/s11904-016-0335-7

THE GLOBAL EPIDEMIC (SH VERMUND, SECTION EDITOR)

Community-Based ART Programs: Sustaining Adherence and Follow-up

Joia S. Mukherjee[1,2,3] · Danika Barry[2,3] · Robert D. Weatherford[2,3] · Ishaan K. Desai[1,2] · Paul E. Farmer[1,2,3]



Books & Arts | Published: 29 June 2017

Medicine: Heroes of global health

Amy Maxmen

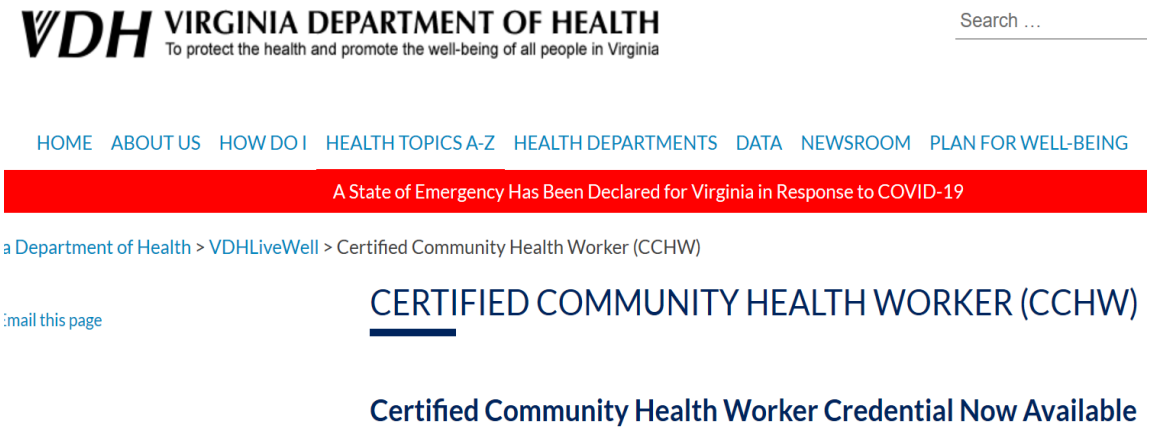
Nature **546**, 598(2017) | Cite this article

Amy Maxmen assesses a documentary on medical pioneer Paul Farmer and colleagues round the world.

UVA Ryan White Community Health Worker Program

- **Community Health Worker Program (2013)**
  - CDC funded Care and Prevention in the United States project (CAPUS)
- **Community Health Worker Certification (2018)**

CHW Training Topics	
Equity: Perspective Transformation	Health Education and Prevention
Disease Self-Management and Chronic Core Disease Review	Resource Identification and Organization
CHW Scope of Practice: History, Roles, Professionalism, Team Integration.	Teaching and Capacity Building Skills and Clinical Practice
Public Health Knowledge Base	Communication and Counseling Skills
CHW Legal and Ethical Issues	Outreach and Advocacy
Data Collection and Medical Record Review	



UVA Health

UVA Ryan White Community Health Worker Program (2)

- **Referral Process**
- **Intake**
- **Strengths-Based Case Management**

Stigma

"(I received) negative feedback from some of the agencies … being denied the opportunity to test at a housing project development that was predominantly Black residents and being told those services were not necessary. Also when providing free testing at a health fair being told, "We do not have Gay people here."

- CHW

Stigma

"I grew up in a rural (county) and prior to this position and learning about HIV, I contributed to the stigma …. Two years ago when I started and met some of my first client's with HIV, all I could think was, "They have HIV!!" Now I am not concerned … and have to remind myself sometimes of their status, as its easy to get so engrossed in their other needs."

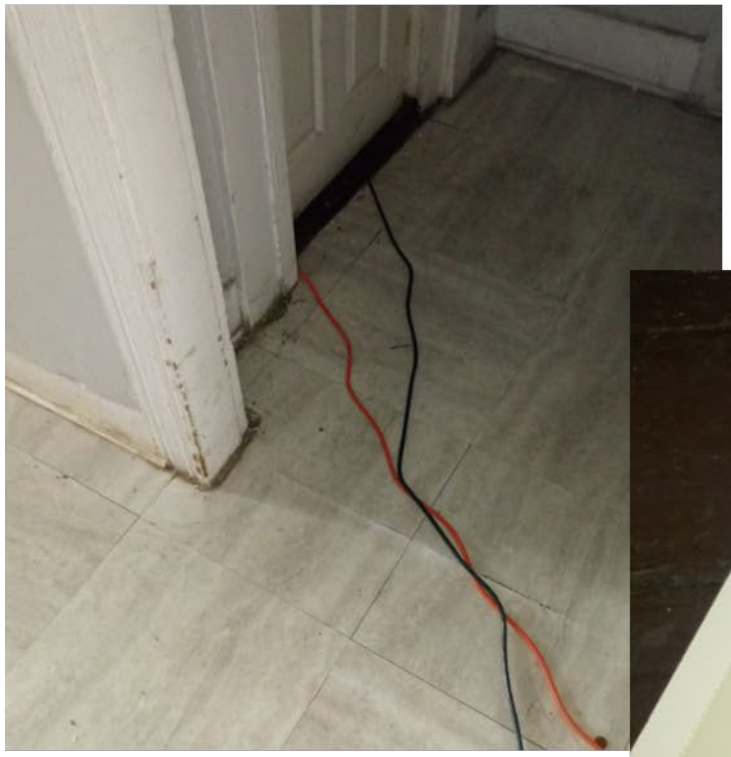
-CHW

Adherence

UVA Health

Transportation

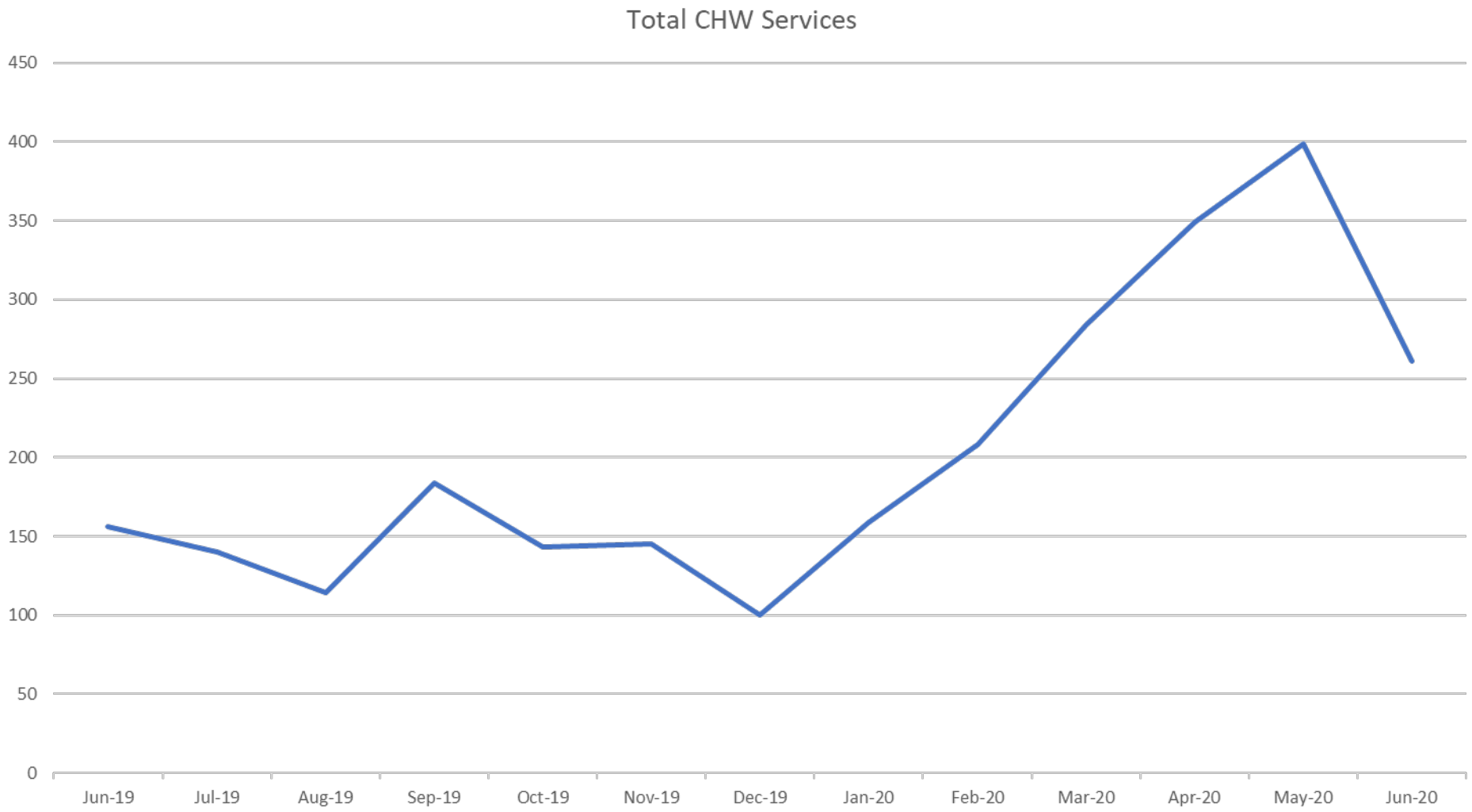
Housing



Substance Abuse Services

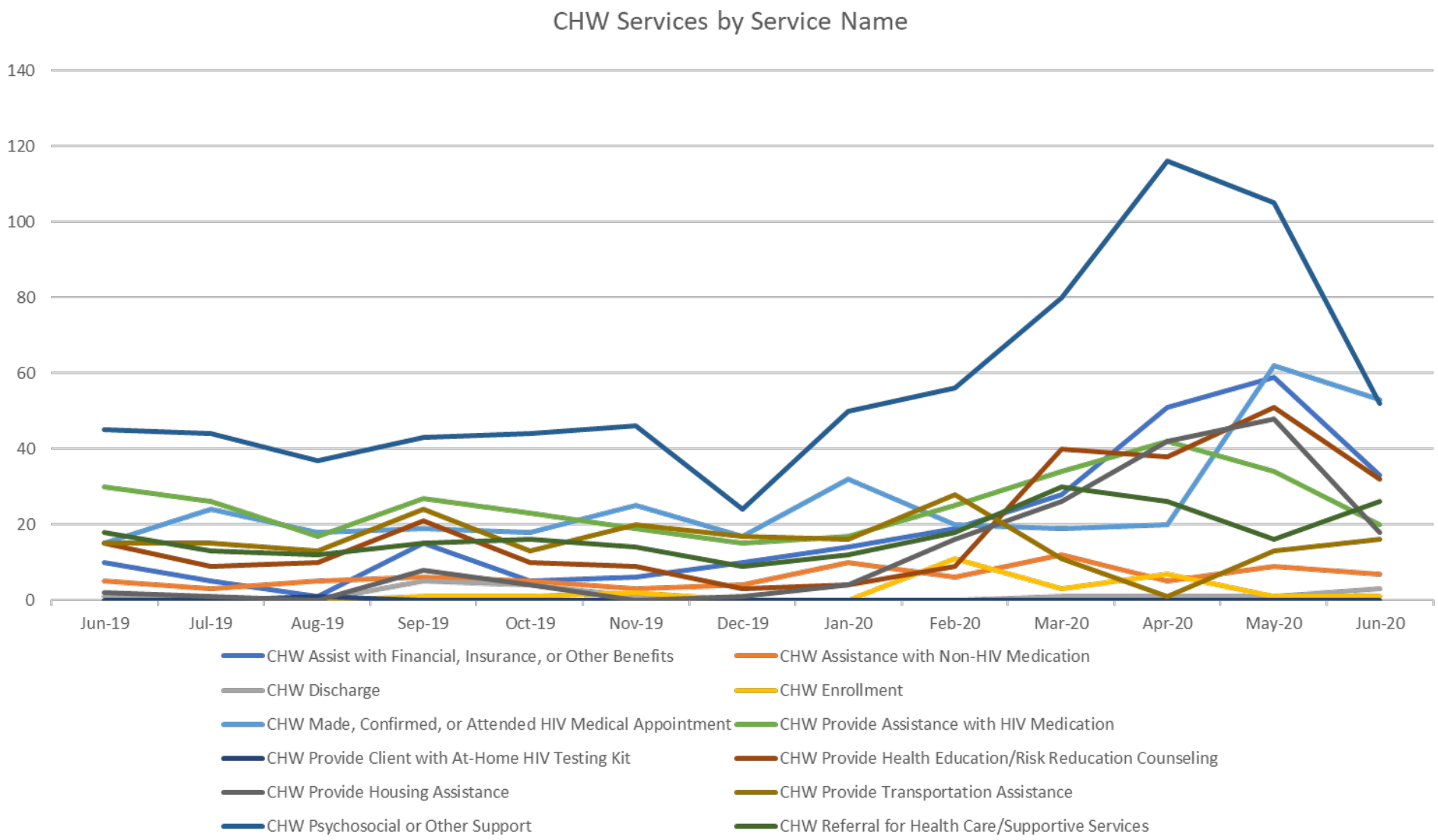
UVA Health

A Year of Services and… COVID-19



UVA Health

A Year of Services and… COVID-19 (2)



UVA Health

HRSA
Health Resources & Services Administration

Priorities and Opportunities for the Rural Health Workforce

National Ryan White Conference on HIV Care & Treatment

August 14, 2020

CAPT Sheila Pradia-Williams
Senior Advisor
Bureau of Health Workforce (BHW)

Vision: Healthy Communities, Healthy People

Agenda

- BHW Overview
- BHW in Rural Communities
- Telehealth Training
- BHW Resources

BHW Overview

The U.S. Health Workforce

Demand for health care occupations is growing.

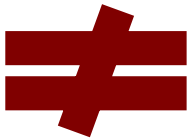
- Health care jobs to increase by 14% from 2018 to 2028
- Growth rate is much faster than the average for all occupations

Shortages of health professionals currently exist.

- Over 20,400 current shortage designations
- Majority in rural communities

The United States is projected to be short more than:

- 23,600 primary care physicians by 2025 and
- 15,600 dentists by 2025.



The challenges:

- Aging population and health care workforce
- Not enough clinicians to meet demand
- Maldistribution of many providers, including nurses

HRSA Health Workforce

Bureau of Health Workforce (BHW)

MISSION: Improve the health of underserved and vulnerable populations by

- strengthening the health workforce and
- connecting skilled professionals to communities in need.

EDUCATION **TRAINING** **SERVICE**

HRSA Health Workforce

BHW Priorities

Access	Make it easier for people to get health care.
Supply	Add health care workers to the workforce.
Distribution	Help health care providers work where they are needed.
Quality	Train the health workforce to use evidence-based techniques proven to help patients.

HRSA Health Workforce

BHW in Rural Communities

BHW's Footprint in Rural Communities

Rural Background

Students and trainees from rural backgrounds

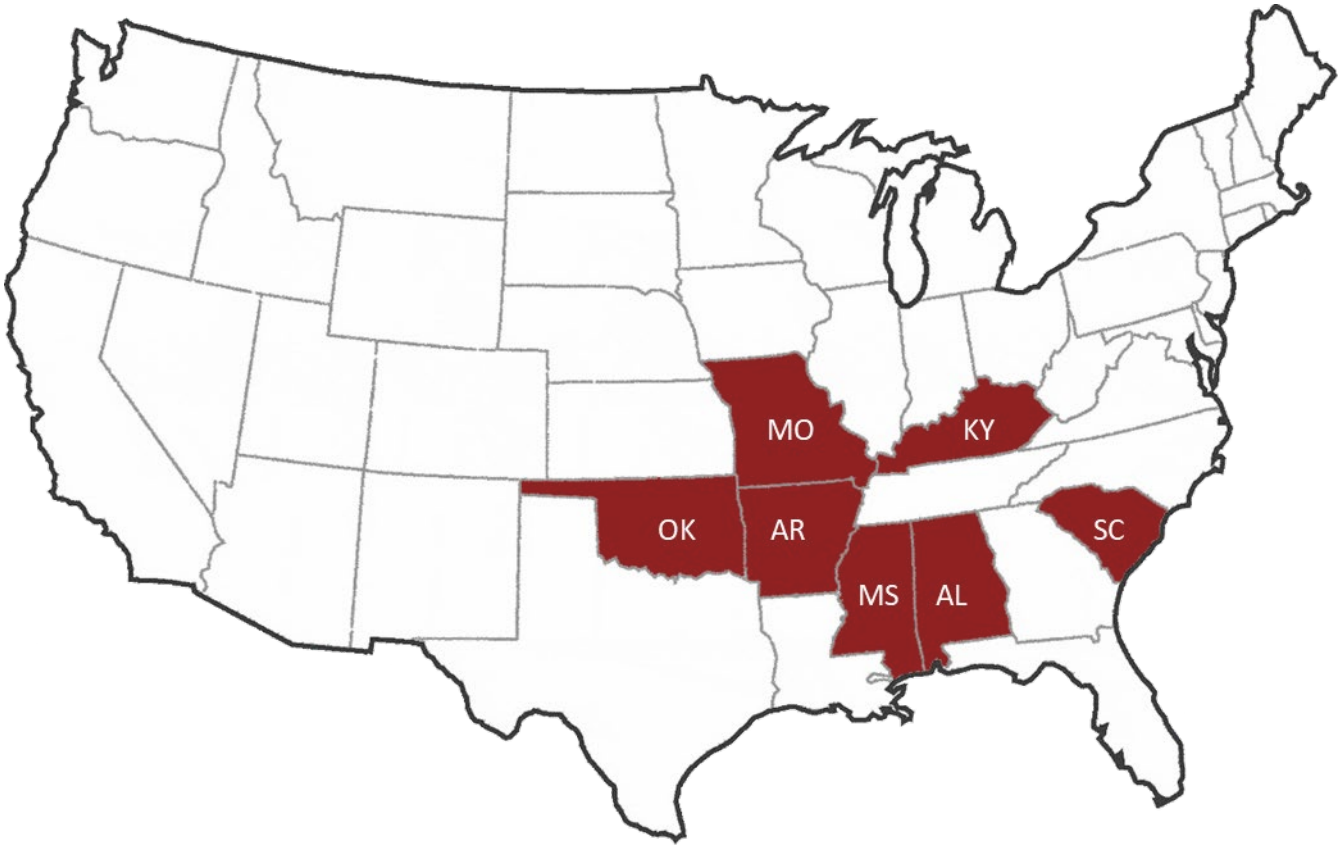
Training Sites

BHW-sponsored programs in rural training sites

Rural Residencies

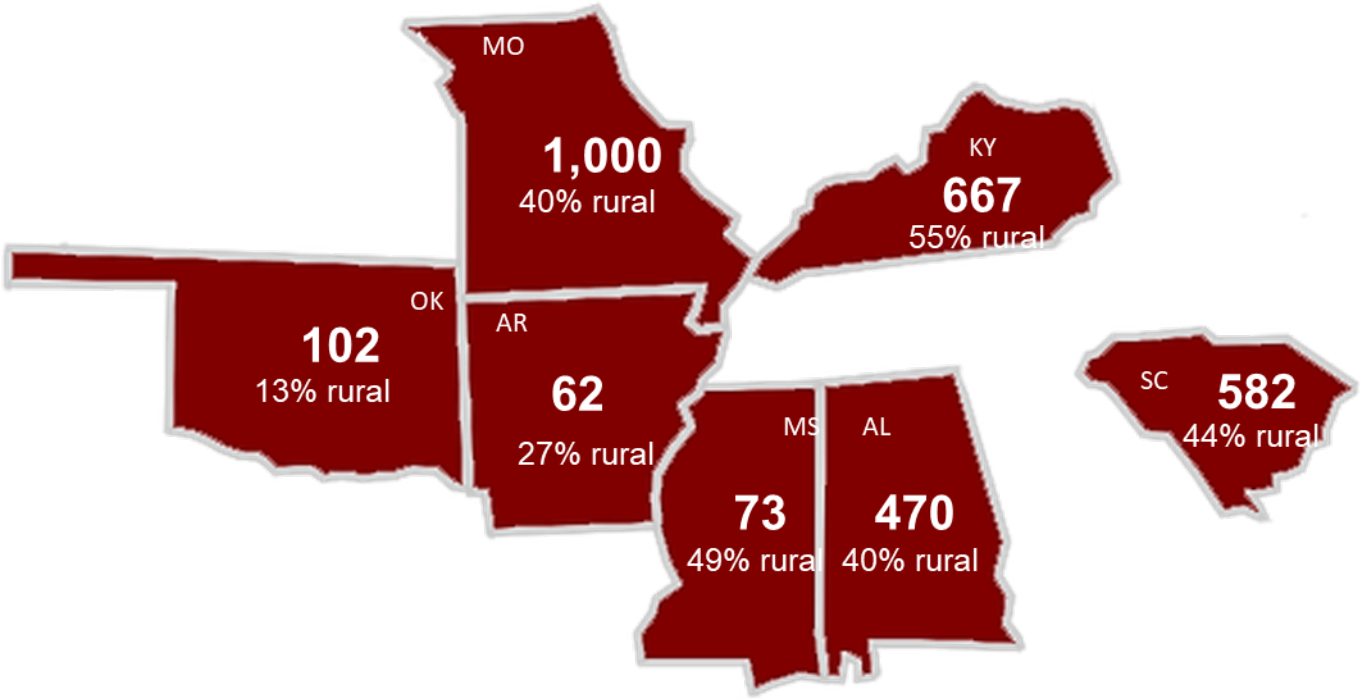
In family medicine, internal medicine, and psychiatry

HIV in Rural Areas: Seven States



BHW's Presence: Health Professions Training Program Sites

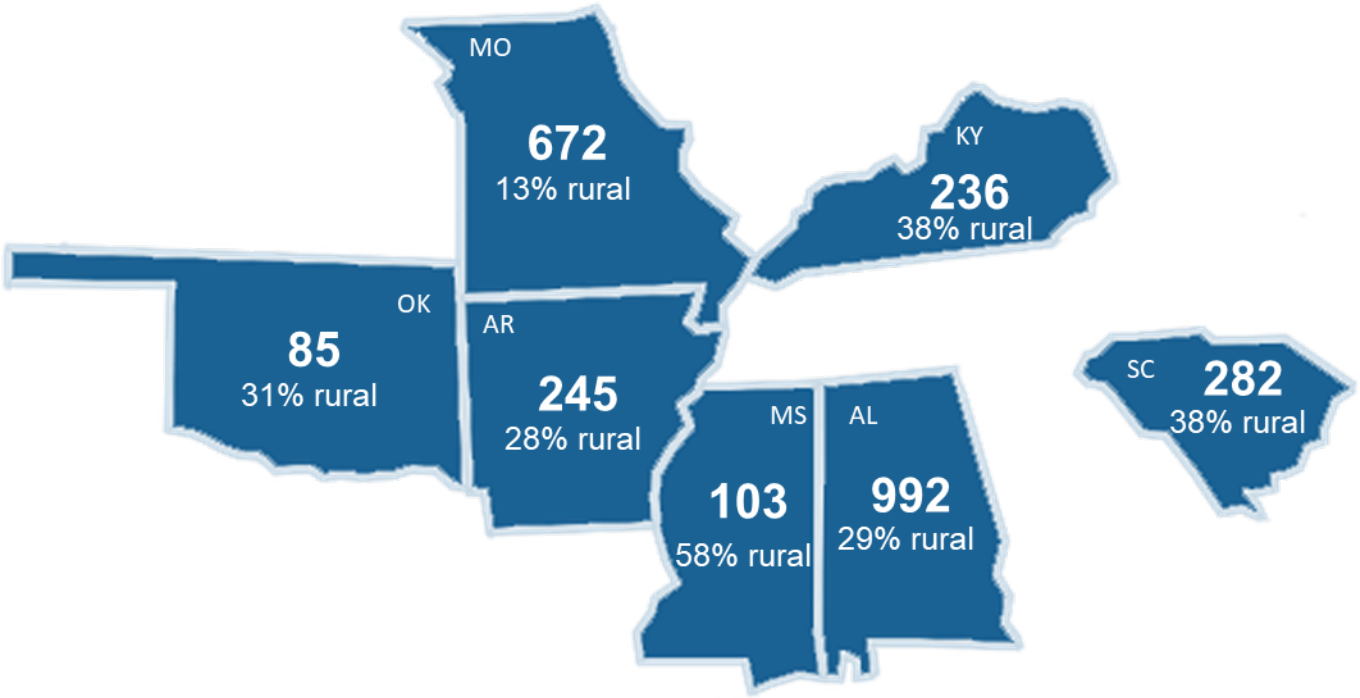
Nationwide: 20,726 sites
28% rural location



FY 2019 data

BHW's Presence: Health Professions Training Program Participants

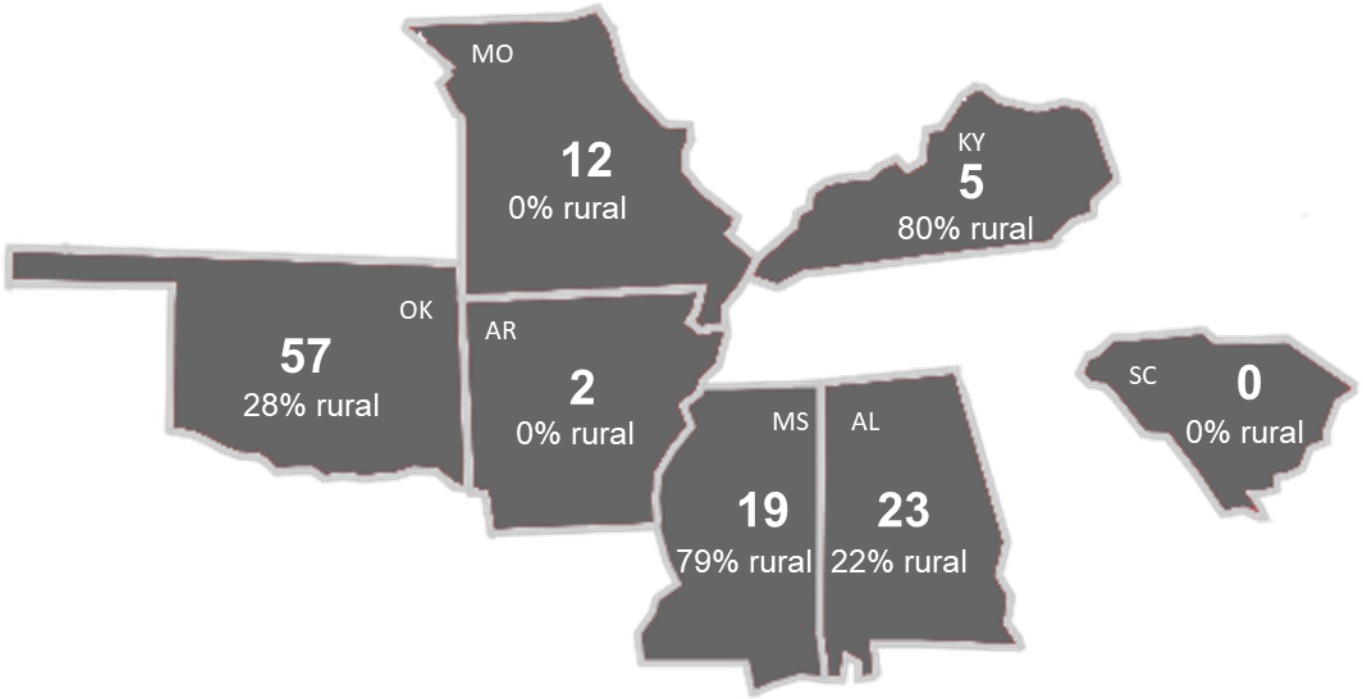
Nationwide: 29,769 clinical trainees
19% rural background



FY 2019 data

BHW's Presence: Teaching Health Center Graduate Medical Education

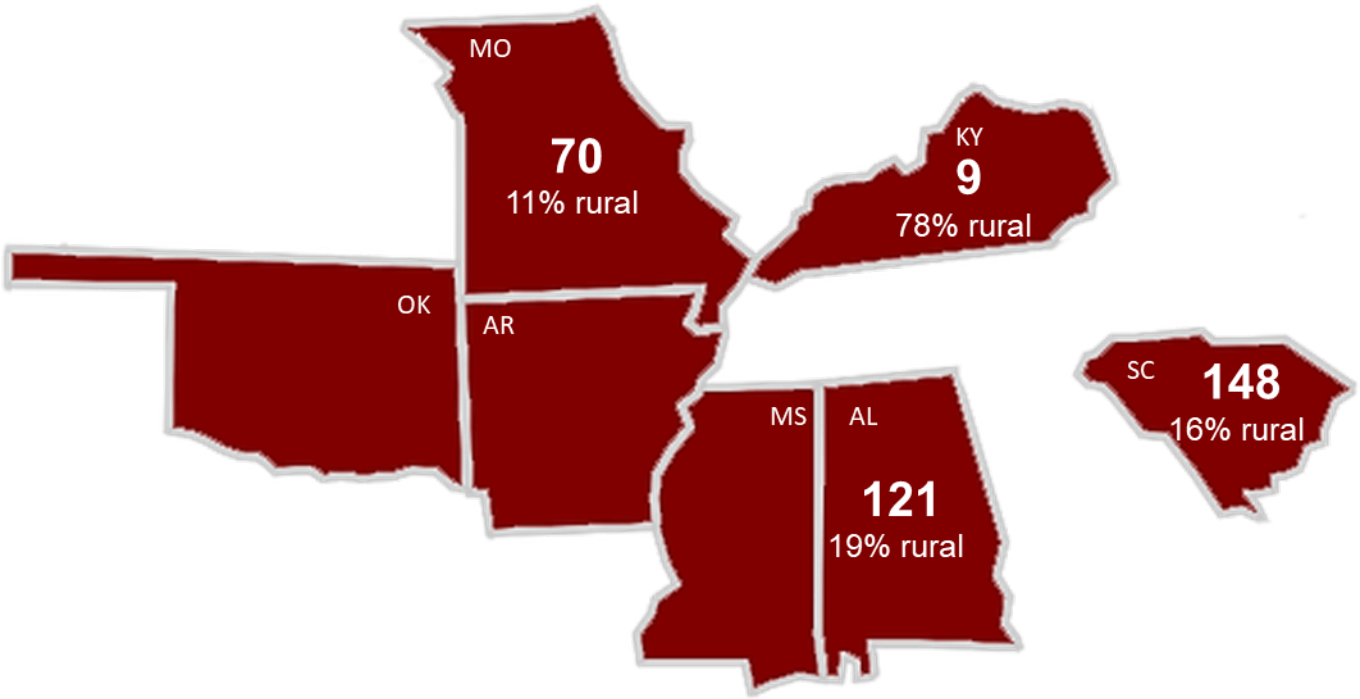
Nationwide: 858 trainees
26% rural background



FY 2019 data

BHW's Presence: Nurse Anesthetist Traineeships

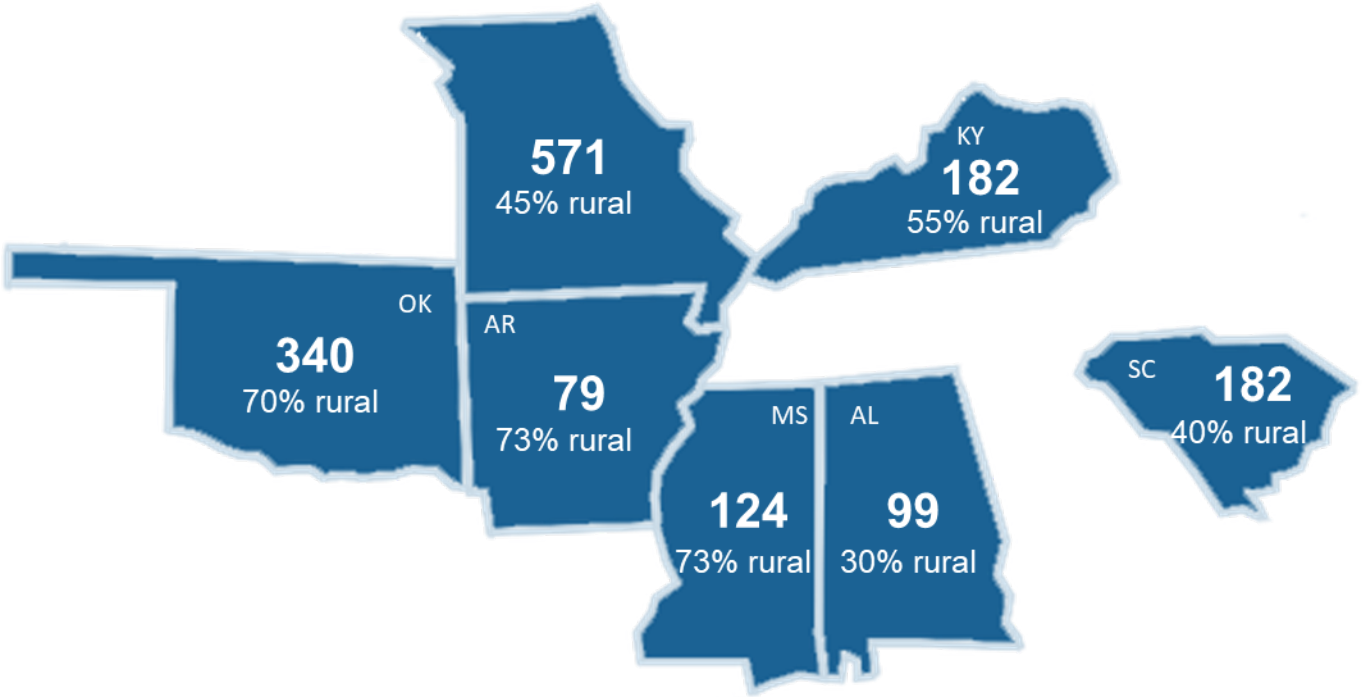
Nationwide: 2,647 trainees
18% rural backgrounds



FY 2019 data

BHW's Presence: National Health Service Corps

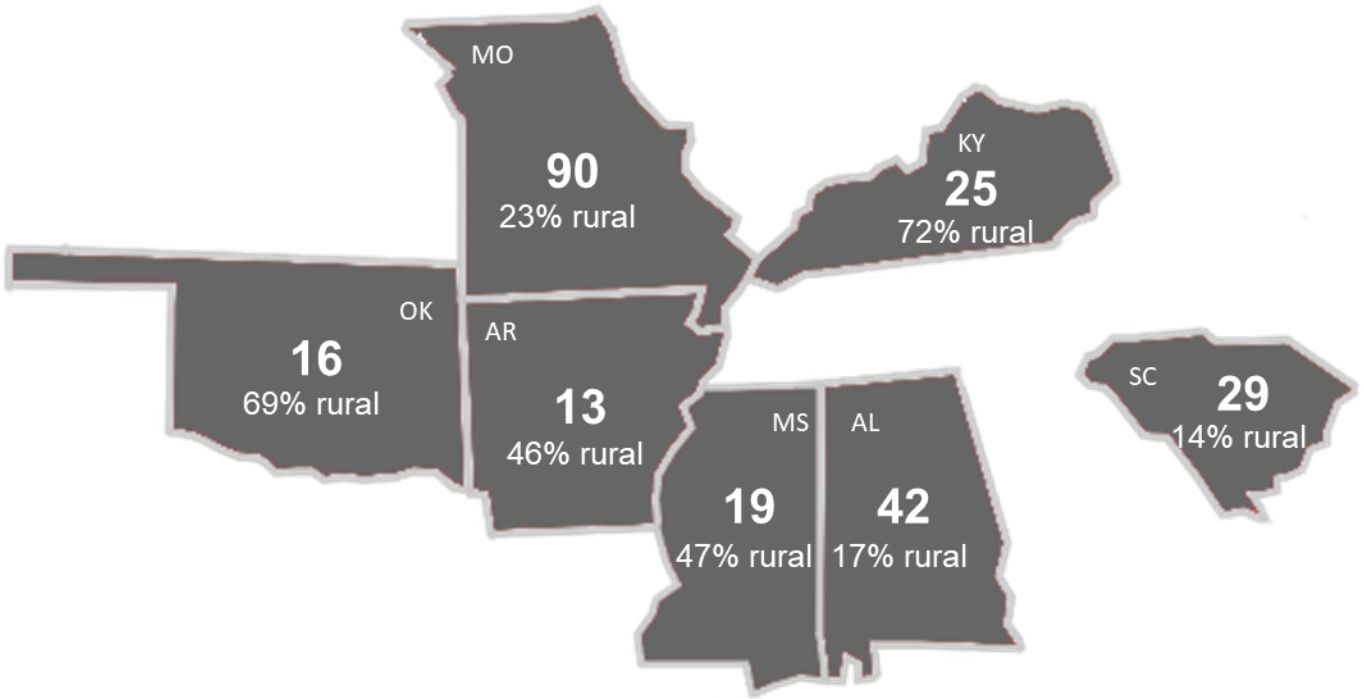
Nationwide: 13,053 participants
34% in rural setting



FY 2019 data

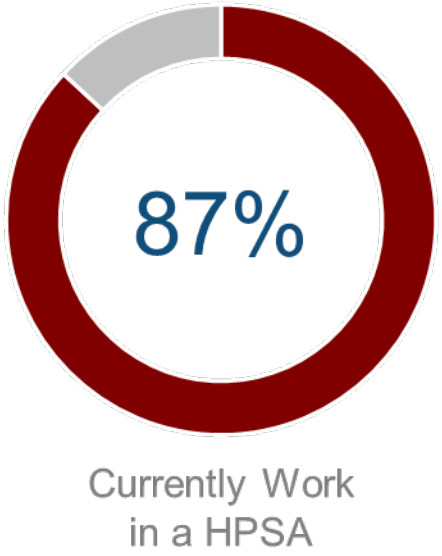
BHW's Presence: Nurse Corps

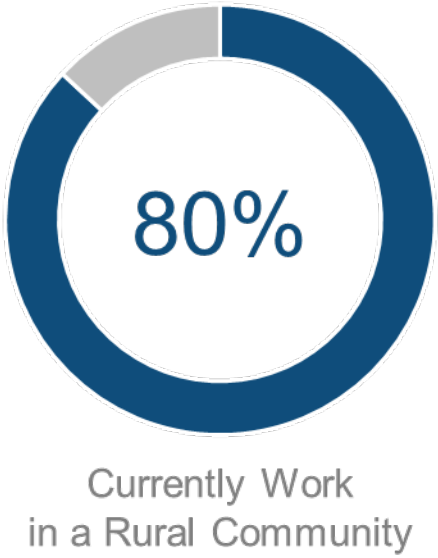
Nationwide: 1,928 participants
22% in rural setting



FY 2019 data

BHW Clinician Retention (2012-2018)





Based on 6,547 clinicians who completed their NHSC or Nurse Corps service in a rural community.

Telehealth Training

Transitioning to Telehealth Training

HRSA Health Workforce

BHW Resources

Linking Providers to Communities

Health Workforce Connector

Where health care professionals connect with sites

- Over 26,000 sites
- Nearly 5,000 opportunities
- Customized profiles
- Powerful filters

Virtual Job Fairs

Bringing together recruiters and job seekers

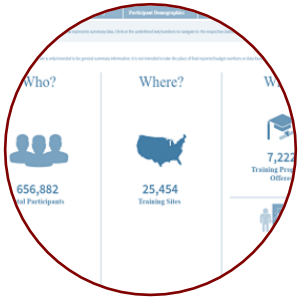
- Live!
- Free
- Online
- Fully interactive

For NHSC and Nurse Corps healthcare facilities

https://connector.hrsa.gov/connector/

Health Workforce Data

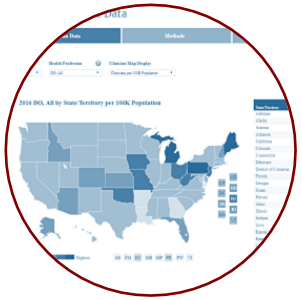
Alumni Clinician Dashboard



Health Professions Training Programs

Unified Clinician Dashboards

data.HRSA.gov



Area Health Resources Files

Shortage Areas

The Future Health Workforce

BHW will continue to strengthen the health workforce and support clinicians working in rural and underserved areas by strategically investing in our workforce development programs.

- **Education**
  Building a diverse and well-trained workforce committed to improving the health of the underserved
- **Training**
  Incorporating education and training as an essential component of quality improvement and workforce retention
- **Service**
  Connecting a quality health workforce to our underserved and rural communities

HRSA Health Workforce

Questions

Contact Us

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Expanded role of the community-based pharmacist in the community

Nasima M. Camp, MPH
presenting for Kathy Byrd MD, MPH
and the Patient-centered HIV Care Model Team

Background

- Antiretroviral therapy (ART) has led to decreased HIV-associated morbidity and mortality
- Providers face challenges providing HIV care
  - Long-term management, ART side effects, drug interactions
- The demand for HIV care providers is greater than ever
- HIV workforce may be declining rather than growing
- The National HIV/AIDS Strategy (NHAS) recommends increasing the number and diversity of available providers and expanding models of team-based care

Expanding the HIV care workforce

- Increase provision of HIV care by general practitioners, physician assistants, and nurse practitioners
- Co-management of HIV care with HIV specialists for clinicians with low HIV patient volume
- Increase collaborations with existing practitioners (e.g., between clinicians and community-based pharmacists)

Why community pharmacists?

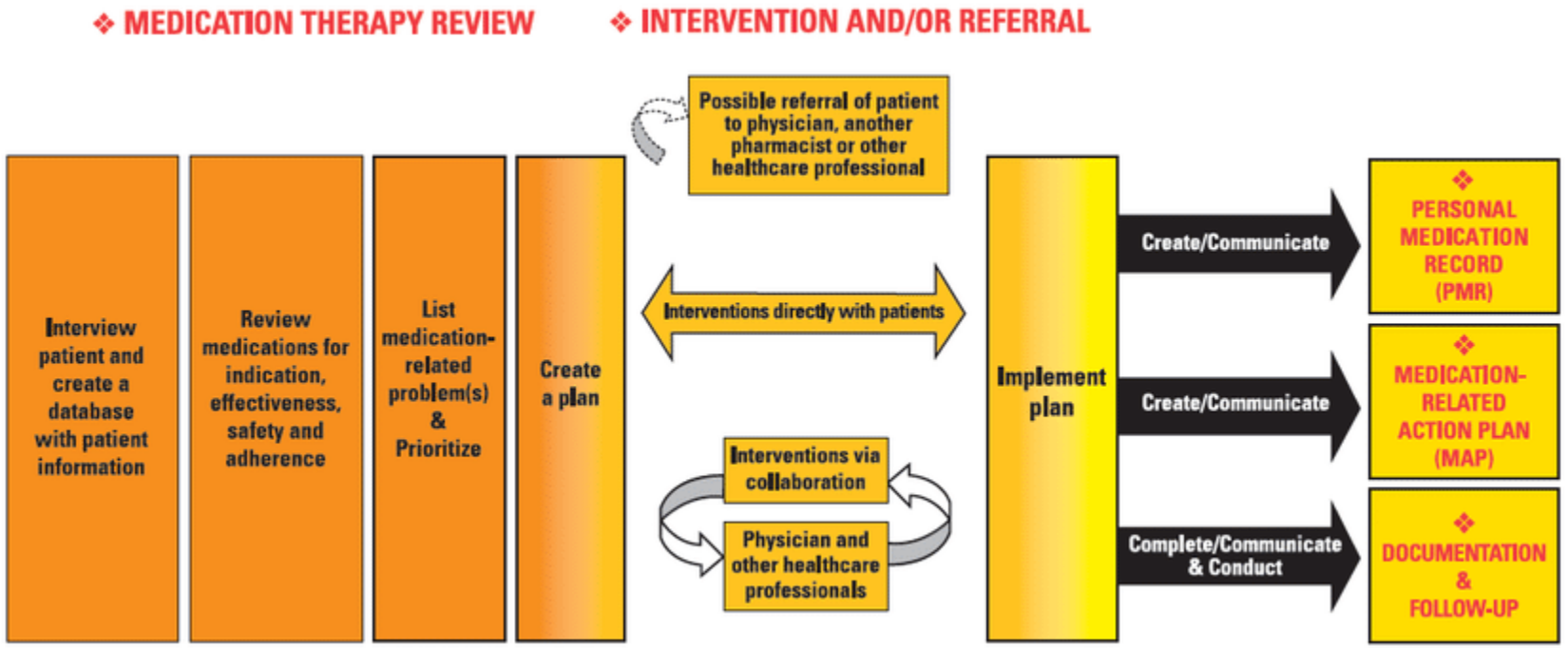
- In a unique position to provide HIV treatment and prevention services
- Are among the most accessible of healthcare settings
- Can offer a wide range of services including PrEP, HIV screening, syringe sales, and adherence counseling
- Pharmacist-led services, such as Medication Therapy Management (MTM) have been shown to improve patient outcomes

What is Medication Therapy Management (MTM)?

A distinct service or group of services that optimize therapeutic outcomes for individual patients. MTM services are independent of, but can occur in conjunction with, the provision of a medication product

–American Pharmacists Association

Medication Therapy Management (MTM)



Patient-centered HIV Care Model (PCHCM)

Patient-centered HIV Care Model (PCHCM)

- Between August 2013 and September 2016, CDC, Walgreen Co., and University of North Texas Health Science Center System College of Pharmacy collaborated to develop and implement the Patient-centered HIV Care Model
  - Goal: To increase communication and collaboration between community-based pharmacists and primary medical providers for patient-centered care.
  - Objectives: To improve retention in care, adherence to therapy, and HIV viral suppression

Project sites and staff training

- Ten project sites comprised of a medical clinic partnered with ≥1 community-based HIV-specialized retail pharmacy
- Project pharmacists *previously* trained in:
  - HIV treatment and prevention and HIV counseling
  - HIV Medication Therapy Management (MTM)
- Total of 765 persons enrolled
- Each participant received at least 12 months of services

Foundation of the Patient-centered HIV Care Model

- Built upon the MTM model and included enhanced services
- Required sharing of patient clinical information between *clinicians* and *pharmacists*
- Required increased communication and collaboration between clinic medical providers and pharmacists

Patient-centered HIV Care Model

CLINICS

SHARE INFORMATION

- ✓ Complete medication list
- ✓ Medical problem list
- ✓ Lab test results
- ✓ Social history
- ✓ Immunization history

Patient-centered HIV Care Model

CLINICS

PHARMACY

SHARE INFORMATION

- ✓ Complete medication list
- ✓ Medical problem list
- ✓ Lab test results
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Patient-centered HIV Care Model

CLINICS

PHARMACY

SHARE INFORMATION

- ✓ Complete medication list
- ✓ Medical problem list
- ✓ Lab test results
- ✓ Social history
- ✓ Immunization history

CONDUCT MTM

Patient-centered HIV Care Model

CLINICS

SHARE INFORMATION

- ✓ Complete medication list
- ✓ Medical problem list
- ✓ Lab test results
- ✓ Social history
- ✓ Immunization history

PHARMACY

CONDUCT MTM

- ✓ Monitor refills
- ✓ Monitor lab results
- ✓ Adherence support
- ✓ Ancillary services

Patient-centered HIV Care Model

CLINICS

SHARE INFORMATION

- ✓ Complete medication list
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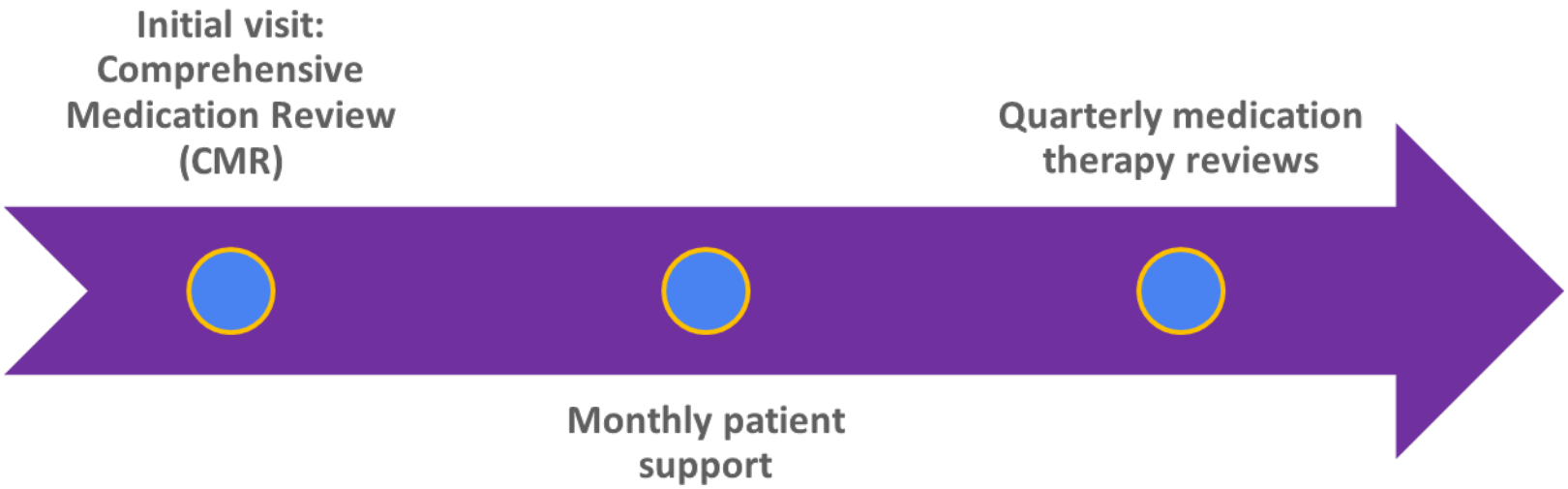
- ✓ Immunization history

PHARMACY

CONDUCT MTM

- ✓ Monitor refills
- ✓ Monitor lab results
- ✓ Adherence support
- ✓ Ancillary services

Typical encounter schedule



Methods

Methods

- The proportion of persons retained in care and virally suppressed was calculated, pre- and post-model implementation
  - Retention in care: ≥1 medical visit in each 6-month period of a 12-month measurement period with a minimum of 60 days between medical visits
  - Viral suppression: HIV RNA < 200 copies/mL in last test in a 12-month measurement period
    - Pre-measurement period: 12 months prior to the first CMR
    - Post-measurement period: day after first CMR to 12 months forward
- The proportion of persons with viral loads ≥1,500 copies/mL was also determined, pre- to post-implementation

Methods continued

- Inclusion criteria:
  - Documentation or evidence of HIV diagnosis ≥12 months prior to the enrollment date (retention in care)
  - ≥1 viral load test result in each measurement period (viral suppression)
- The relative percentage change of the proportion of persons retained in care and virally suppressed was calculated, pre- to post-implementation
- The proportion retained in care was modeled using log binomial regression
- The proportion virally suppressed was compared using McNemar's test
- Cost and cost-effectiveness were determined using standard methods

Results – retention in care

Characteristics of enrolled participants

	Characteristic	Total enrolled (n = 765)
Median age (years)		48 (IQR: 38 – 55)
		n (%)
Race/ethnicity	Black, non-Hispanic	331 (43)
	White, non-Hispanic	185 (24)
	White, ethnicity unknown	69 (9)
	Hispanic	101 (13)
	Other/Unknown	79 (10)
Gender	Male	555 (73)
	Female	193 (25)
	Transgender	17 (2)
Medical insurance	Medicaid	257 (34)
	Medicare	155 (20)
	Multiple	55 (7)
	Ryan White/ADAP	113 (15)
	Private insurance	115 (15)
	Uninsured/Unknown	70 (9)

Proportion of persons retained in care, pre- and post-model implementation by characteristic

	Characteristic	Baseline (n = 680)	Follow-up (n = 625)		
		N (%)	N (%)	% Change*	†p-value
Total		413 (61)	428 (69)	13	0.002
Age in years	≥50	210 (63)	221 (70)	12	0.029
Race/ethnicity	Black, non-Hispanic	178 (60)	202 (73)	23	<0.001
Sex‡	Male	294 (60.4)	309 (68.8)	13.9	0.005
	Female	108 (60.0)	110 (67.9)	13.2	0.086
Medical insurance	Ryan White/ADAP§	53 (63.9)	61 (78.2)	22.4	0.023
	Private Insurance	49 (58.3)	53 (70.7)	21.3	0.069

*relative percentage change, †The p-values are the tests of significance comparing the relative retention rate (pre- versus post-implementation) within each level of each factor ‡Transgender persons were excluded from analysis due to small numbers, § ADAP = AIDS Drug Assistance Program

Byrd KK, et al. *Retention in HIV care among participants in the Patient-centered HIV Care Model—a collaboration between community-based pharmacists and primary medical providers*. AIDS Patient Care STDS. 2019; 33(2):58-66.

Results – viral suppression

Proportion of persons virally suppressed, pre- and post-model implementation by characteristic

	Characteristic	Baseline	Follow-up		
		N (%)	N (%)	% Change*	p-value
Total		486 (75)	558 (86)	15	<0.001
Age in Years	18-24	12 (48)	22 (88)	83	0.002
	25-34	58 (60)	73 (75)	26	0.009
	35-49	144 (69)	170 (81)	18	<0.001
	≥50	272 (86)	293 (92)	8	0.001
Race/ethnicity	Black, non-Hispanic	180 (63)	222 (78)	23	<0.001
	White, non-Hispanic	118 (81)	138 (95)	17	<0.001
	White, ethnicity unknown	60 (97)	57 (92)	-5.0	0.178
	Hispanic	72 (82)	83 (94)	15	<0.001
	Other/unknown	56 (82)	58 (85)	4	0.414

*Relative percentage change

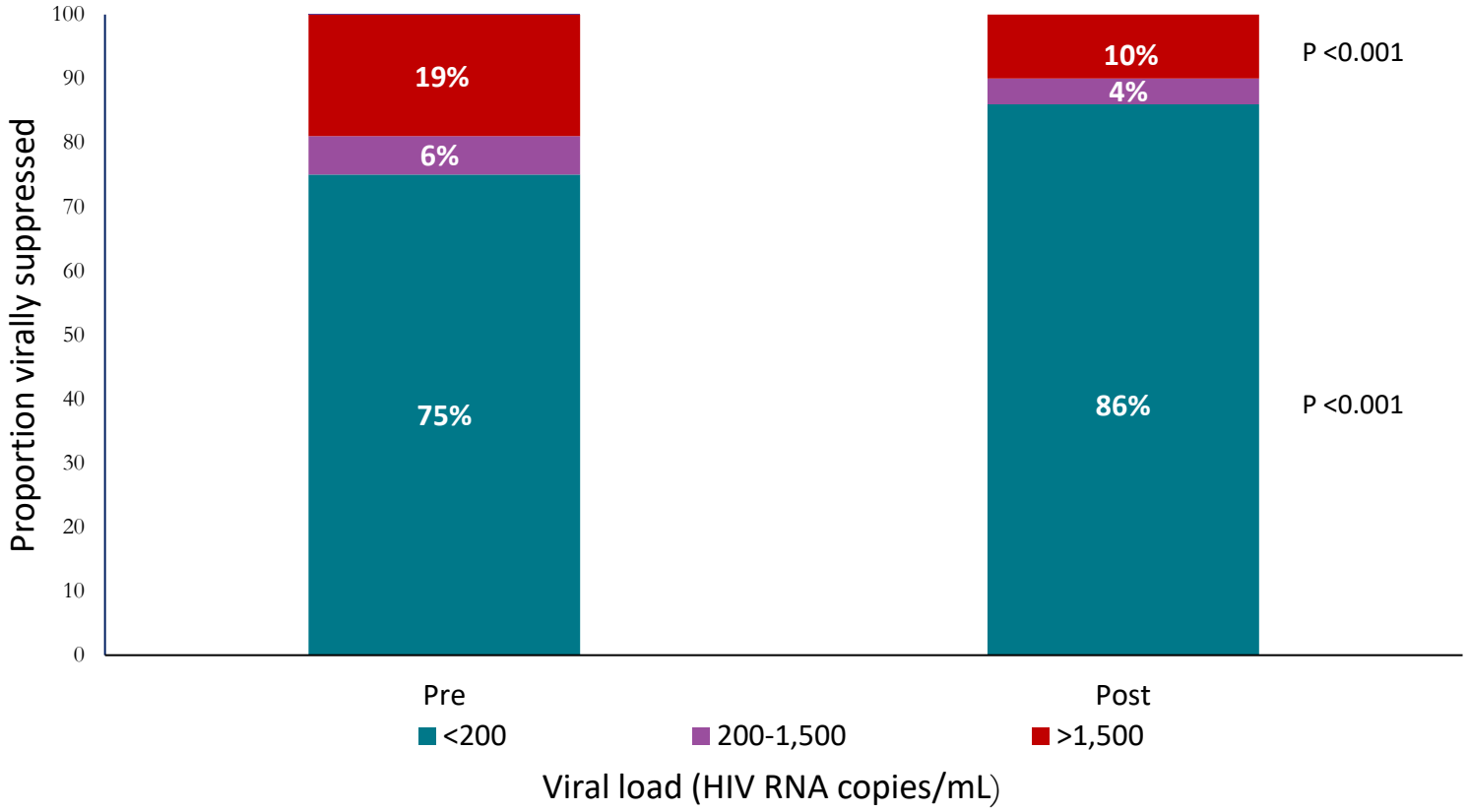
Proportion of persons virally suppressed, pre- and post-model implementation by characteristic

Characteristic		Baseline	Follow-up		
		N (%)	N (%)	% Change*	p-value
Sex†	Male	368 (78)	419 (89)	14	<0.001
	Female	111 (68)	127 (77)	14	0.006
Medical Insurance	Medicaid	156 (71)	178 (81)	14	0.002
	Medicare	111 (83)	120 (90)	8	0.029
	Multiple	47 (98)	46 (96)	-2	0.317
	Ryan White/ADAP‡	60 (65)	74 (80)	23	<0.001
	Private Insurance	68 (72)	89 (94)	31	<0.001
	Uninsured/unknown	44 (72)	51 (84)	16	0.020

*Relative percentage change †Transgender persons were excluded from the analysis due to small sample size ‡ADAP = AIDS Drug Assistance Program

Byrd, KK, et al. *Adherence and viral suppression among participants of the Patient-centered HIV Care Model project—a collaboration between community-based pharmacists and HIV clinical providers.* Clin Infect Dis. 2020 Feb 14;70(5):789-797. DOI: 10.1093/cid/ciz276

Proportion of persons virally suppressed, pre- and post-model implementation



Proportion of persons with HIV and mental health conditions* retained in care and virally suppressed pre- and post-model implementation by characteristic

	Retained in care				Virally suppressed			
	Baseline	Follow-up			Baseline	Follow-up		
	N (%)	N (%)	% Change†	p-value	N (%)	N (%)	% Change†	p-value
Total	252 (60)	265 (68)	13	0.009	306 (79)	329 (90)	13	<0.001
Non-psychotic Disorder ‡	220 (60)	227 (67)	11	0.043	274 (80)	294 (91)	13	<0.001
Psychotic Disorder §	32 (59)	38 (78)	31	0.056	32 (70)	35 (83)	20	0.070
Substance use‖	31 (50)	40 (68)	36	0.036	40 (66)	51 (86)	32	0.001

*Mental health conditions = a mental health diagnosis or ≥1 antidepressant, antianxiety or antipsychotic medication prescription, pre-implementation period. †Relative percentage change. ‡Includes persons with a non-psychotic disorder diagnosis or ≥1 antidepressant/antianxiety prescription, pre-implementation period. § Includes persons with a psychotic disorder diagnosis or ≥1 prescription for an antipsychotic medication, pre-implementation period. ‖Includes persons with a mental health condition and substance (alcohol or drug) use, abuse or dependence in the pre-implementation period. *Byrd et al. 2020. doi: 10.1007/s10461-020-02913-2*

Cost and cost-effectiveness

Cost and cost effectiveness

- Average cost per visit: $48
- Incremental cost per patient virally suppressed: $5,039
- Intervention is cost-savings
  - Could remain cost saving if at least 8 additional patients virally suppressed
  - Could be cost effective if as few as 4 additional patients were suppressed

Analysis limitations

- Project pharmacists were not reimbursed for model services, which may be required to scale the model
- The measurement period was short (12 months)
- Persons with no viral loads in either the pre- or post-implementation periods were excluded from the viral suppression analysis
- PCHCM was a demonstration project, not a research study; the pretest-posttest evaluation design is not as rigorous as a study with control groups
- The cost-effectiveness estimates are dependent on the modeling and parameter inputs used in the analysis

Summary

Augmenting the HIV workforce

- Increased collaboration allows for more pharmacist involvement in patient care
  - Sharing information allows a “second set of eyes” to review and identify gaps in therapy and allows pharmacists to work with clinicians to develop therapy-related action plans
  - Reduces the burden of care
  - Increases the diversity of healthcare professionals in HIV care
  - Can lead to better service to patient and better outcomes

Implementation

- Collaborations must be developed
- Clinicians may benefit from training on working with pharmacists
- Pharmacists with specialty training in HIV are most suitable
- Reimbursement for pharmacist services needs to be addressed

Conclusions

Conclusions

- Collaborations, between community pharmacists and HIV clinicians, can lead to improved patient outcomes
- Similar collaborations can be implemented to augment the HIV workforce but collaborations need to be fostered

Acknowledgments

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Disclaimer

The findings and conclusions in this presentation are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Thank you!

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Division of HIV/AIDS Prevention

HRSA
Health Resources & Services Administration

Addressing HIV Workforce Challenges in Rural Communities

2020 National Ryan White Conference

August 14, 2020

Rachel Moscato, MPH
Public Health Analyst
Federal Office of Rural Health Policy (FORHP)

Vision: Healthy Communities, Healthy People

Overview

- Overview of The Federal Office of Rural Health Policy (FORHP)
- Rural Workforce Landscape
- Rural Workforce Resources and Innovative Approaches
- Upcoming Funding Opportunities

The Federal Office of Rural Health Policy (FORHP)

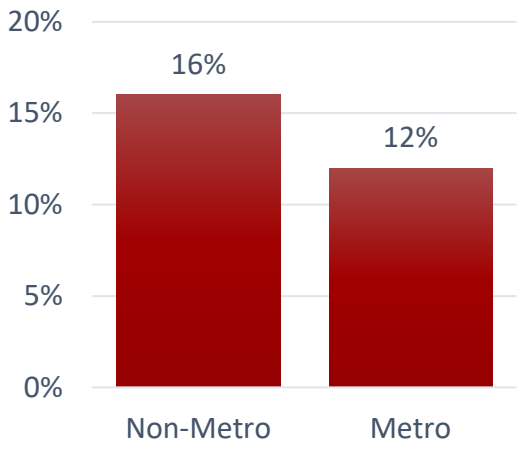
Mission:
FORHP collaborates with rural communities and partners to support programs and shape policy that will improve health in rural America.

FORHP Organizational Structure

The Rural Population

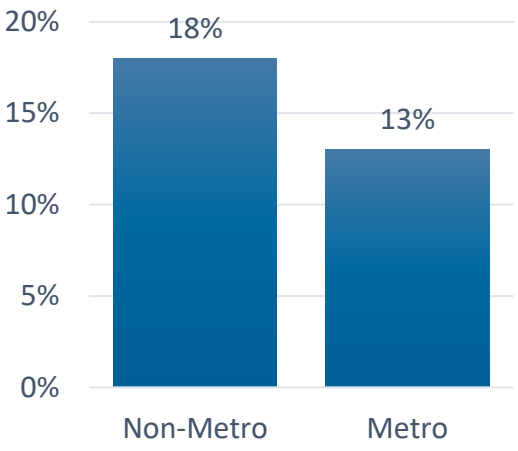
Older

Population Age 65 or Older



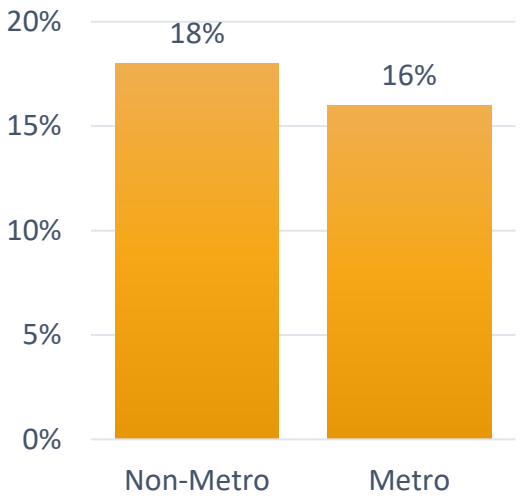
Sicker

Limitations of Activity Caused by Chronic Health Conditions



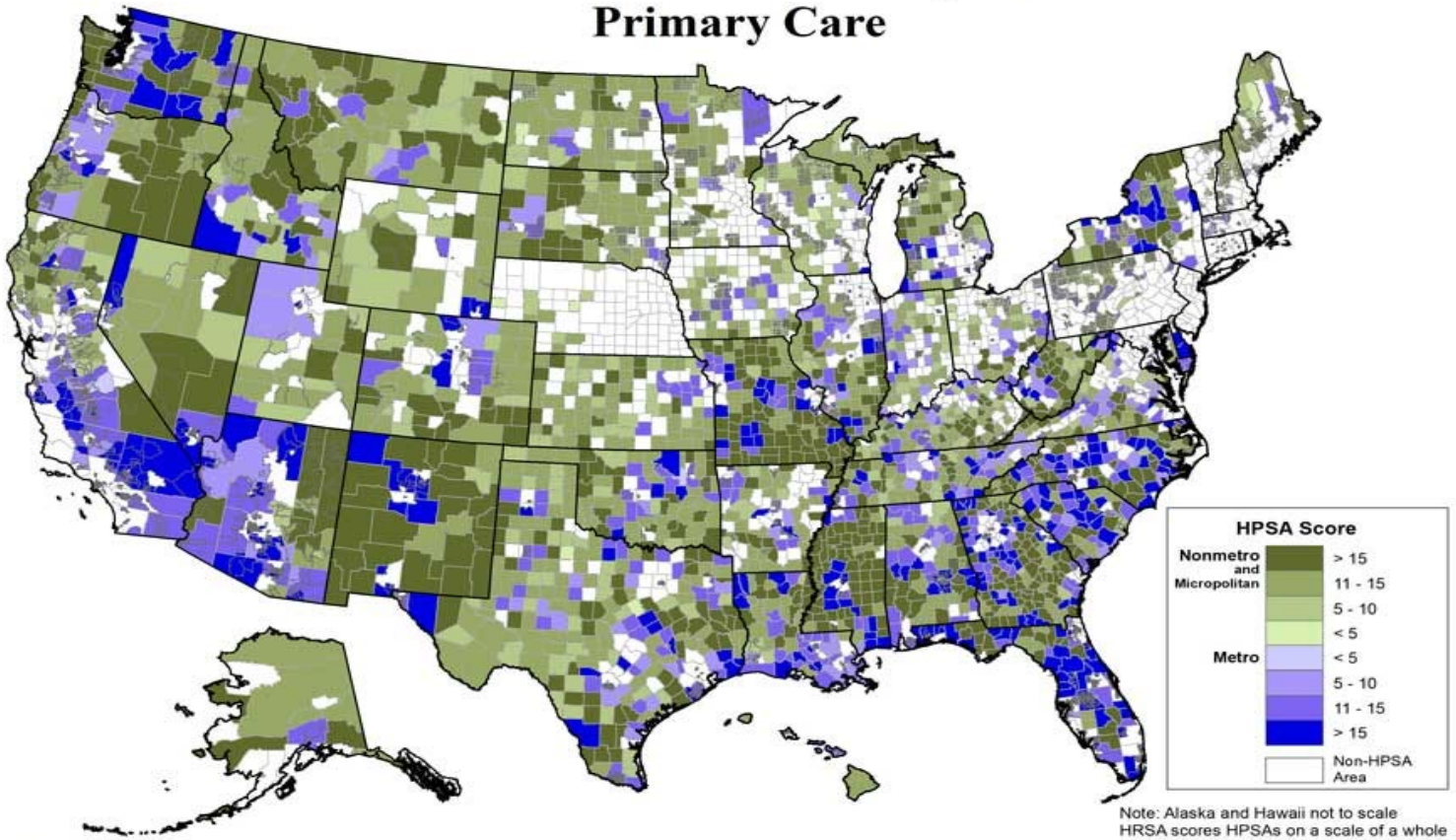
Poorer

Population Below Federal Poverty Line



Source: 2014 Update to the Rural-Urban Chartbook (NORC), data from 2010

Health Professional Shortage Areas
Primary Care

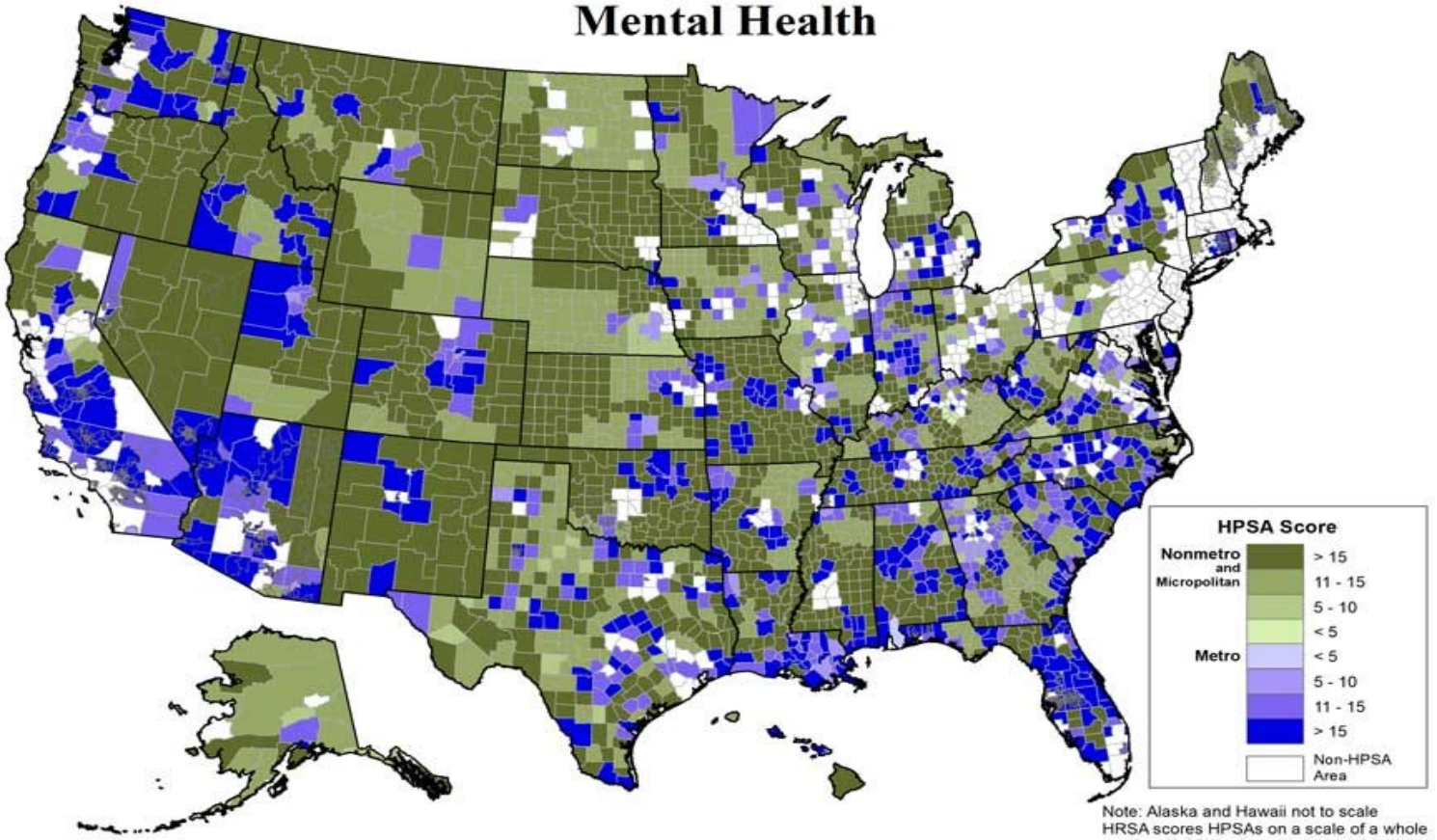


Note: Alaska and Hawaii not to scale
HRSA scores HPSAs on a scale of a whole number (0-25 for primary care), with higher scores indicating greater need

Source(s): data.HRSA.gov, U.S. Department of Health and Human Services, April 2020

RHIhub
Rural Health Information Hub

Health Professional Shortage Areas
Mental Health



Note: Alaska and Hawaii not to scale
HRSA scores HPSAs on a scale of a whole number (0-25 for mental health), with higher scores indicating greater need

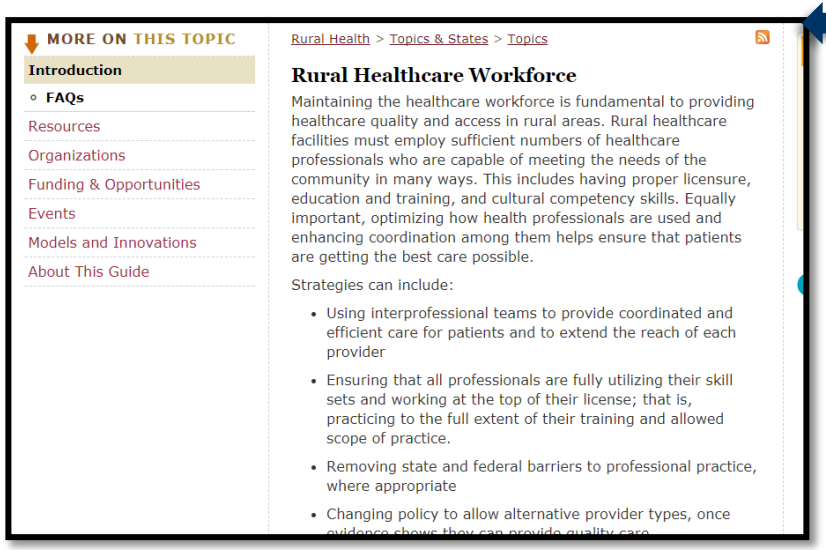
Source(s): data.HRSA.gov, U.S. Department of Health and Human Services, April 2020

RHIhub
Rural Health Information Hub

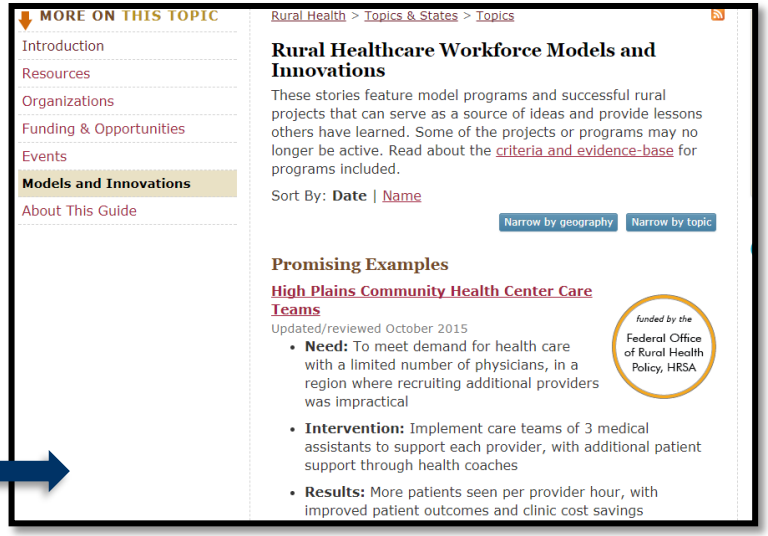
Rural Healthcare Workforce Resources and Innovative Approaches

Rural Health Information Hub (RHIhub)

Topic Guides



Models and Innovations



https://www.ruralhealthinfo.org/

Rural Healthcare Workforce Innovations

ASPIN's Certified Recovery Specialist Program

- Provides four levels of training for CHWs through e-learning
- In 2019, ASPIN trained 61 CHWs, cross-trained 37 behavioral health case managers as CHWs, and 26 individuals in the Indiana Navigator Pre-certification Education.

https://www.ruralhealthinfo.org/project-examples/746

Rural Healthcare Workforce Innovations (2)

FORWARD NM Pathways to Health Careers

- A comprehensive workforce pipeline program, including programming for middle and high school students, undergraduate and graduate students, primary care program students, and medical and dental residents.
- The program reaches over 2,000 school-aged students throughout the service areas and hosts 70+ rural rotation experiences annually.

https://www.ruralhealthinfo.org/project-examples/724

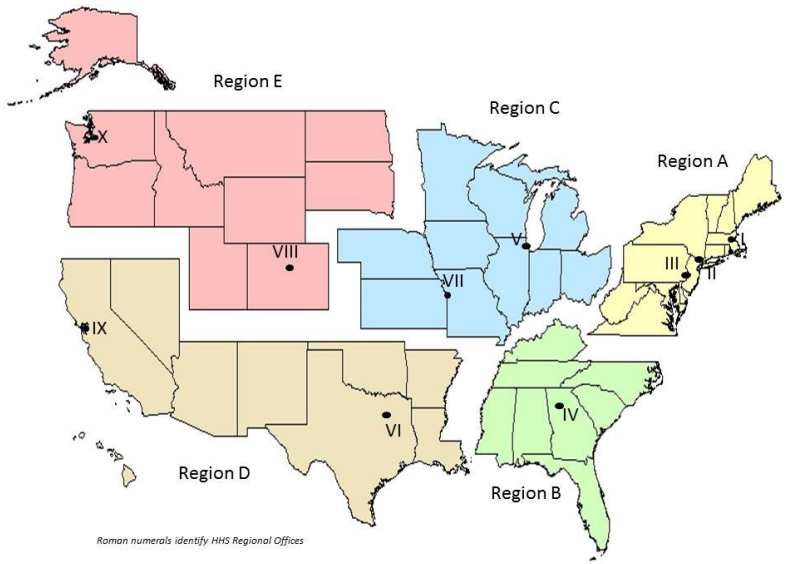
Rural Recruitment and Retention

- The National Rural Recruitment and Retention Network (3RNet)
  - State-Level Resource for job seekers and employers
- Tools for Enhancing Retention
  - New Training Module Series

    https://www.3rnet.org/

State Offices of Rural Health

- Share information, resources and innovative projects with other rural health stakeholders
- Coordinate with other state partners on rural health issues
- Link rural health stakeholders to Federal and state resources
- Rural recruitment and retention

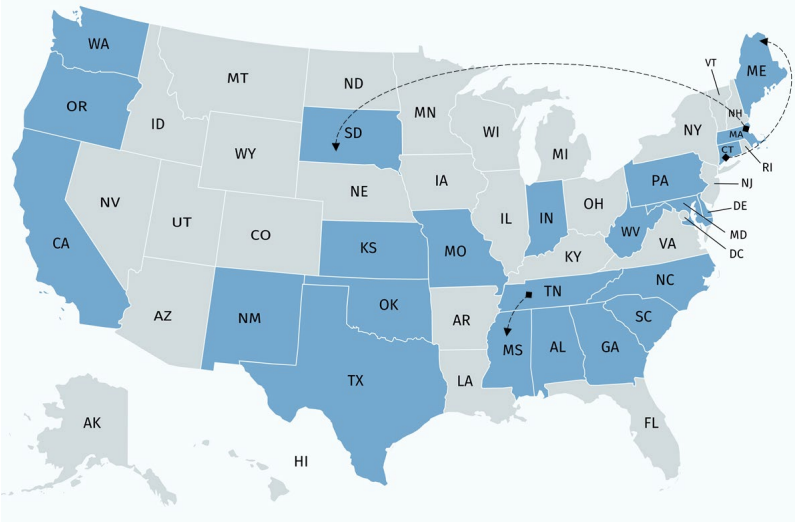


Connect with your SORH: https://nosorh.org/nosorh-members/

Rural Residency Planning & Development Program

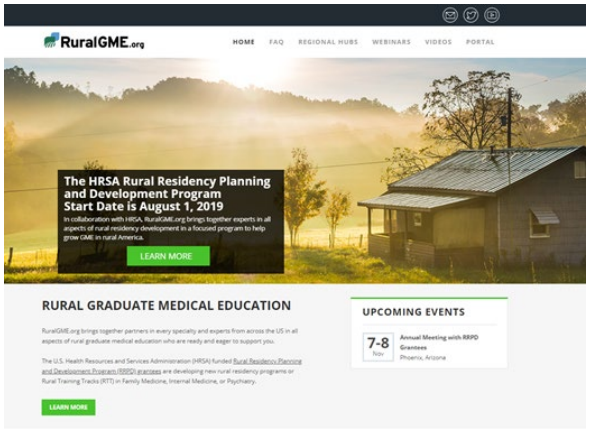
Expanding Rural Residency Training

RRPD Recipients and Rural Training Sites



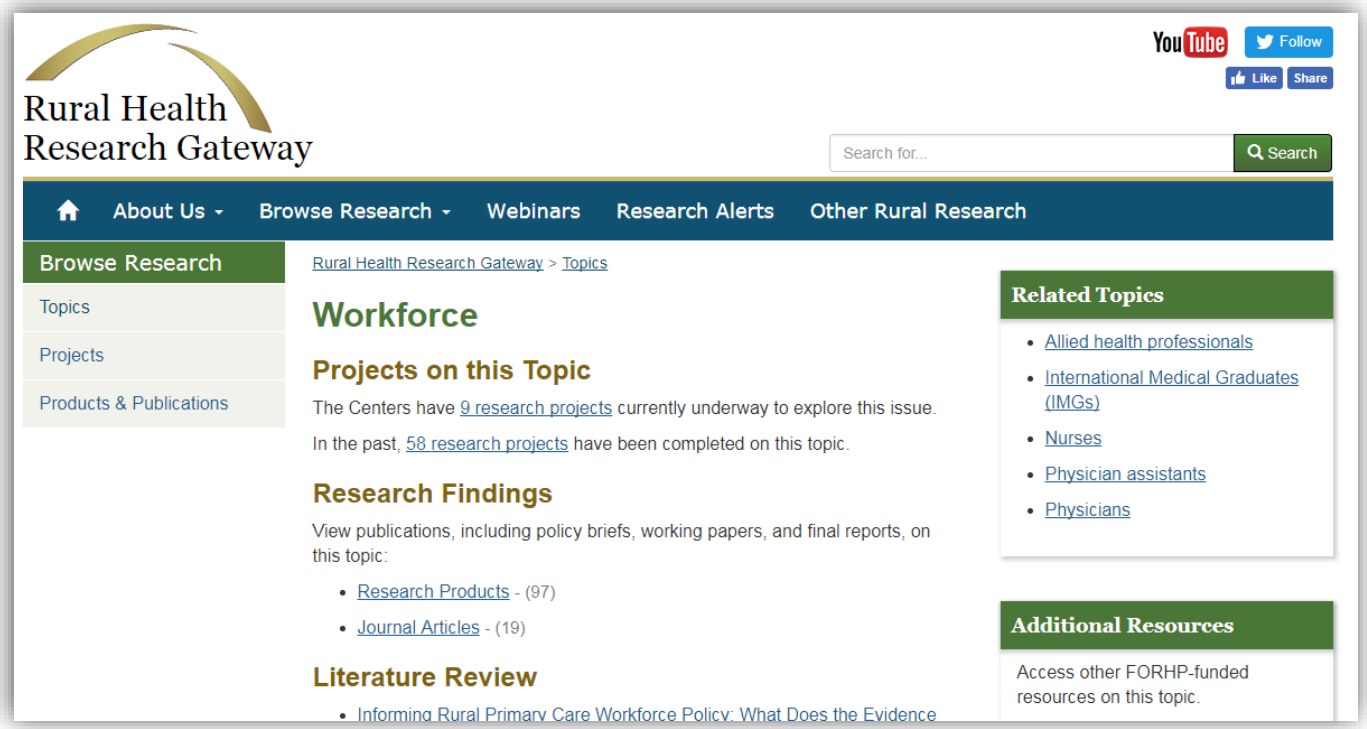
- In FY19 HRSA awarded $20M to 27 recipients across 21 states
- Multi-year grant to expand the number of rural residency programs in family medicine, internal medicine, and psychiatry
- Support planning and development costs accrued while achieving ACGME accreditation

RRPD Technical Assistance Center (TAC)



- Consortium led by the University of North Carolina (UNC) at Chapel Hill consist of experts in all aspects of rural residency development
- The RRPD-TAC provides technical assistance to help grow graduate medical education programs in rural America
- All RRPD program awardees are required to collaborate with the RRPD-TAC to develop new, sustainable and accredited residency programs

Rural Health Workforce Research



https://www.ruralhealthresearch.org

Upcoming Funding Opportunities

- **Rural Health Network Development Planning (Network Planning)**
  - Application available in Fall 2020
  - Purpose is to assist in the development of an integrated health care network, specifically with network participants who do not have a history of formal collaborative efforts. Network Planning goals are: (i) to achieve efficiencies; (ii) to expand access to, coordinate, and improve the quality of essential health care services; and (iii) to strengthen the rural health care system as a whole.

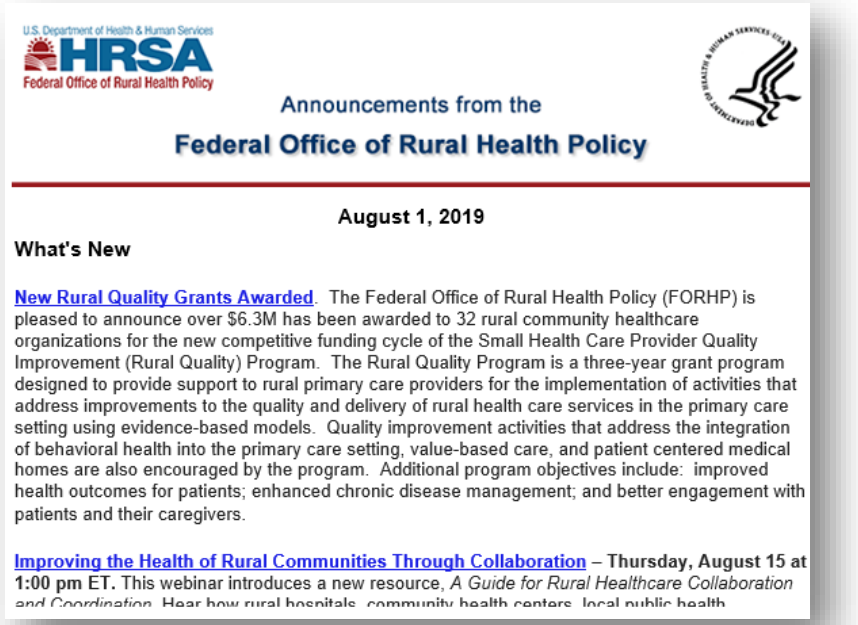
- **Rural Health Care Services Outreach Program (Outreach)**
  - Application available Winter 2020
  - Provides support to promote rural health care services outreach projects utilizing evidence-based or promising practice models in order to address community-specific health concerns.

- **Additional FORHP Funding Opportunities** available on our website.

FORHP Weekly Announcements

- Rural-focused Funding Opportunities
- Policy and Regulatory Developments Affecting Rural Providers and Communities
- Rural Research findings
- Policy updates from a Rural Perspective

To sign up: Email Michelle Daniels at mdaniels@hrsa.gov



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

Announcements from the
Federal Office of Rural Health Policy

August 1, 2019

What's New

New Rural Quality Grants Awarded. The Federal Office of Rural Health Policy (FORHP) is pleased to announce over $6.3M has been awarded to 32 rural community healthcare organizations for the new competitive funding cycle of the Small Health Care Provider Quality Improvement (Rural Quality) Program. The Rural Quality Program is a three-year grant program designed to provide support to rural primary care providers for the implementation of activities that address improvements to the quality and delivery of rural health care services in the primary care setting using evidence-based models. Quality improvement activities that address the integration of behavioral health into the primary care setting, value-based care, and patient centered medical homes are also encouraged by the program. Additional program objectives include: improved health outcomes for patients; enhanced chronic disease management; and better engagement with patients and their caregivers.

Improving the Health of Rural Communities Through Collaboration – **Thursday, August 15 at 1:00 pm ET.** This webinar introduces a new resource, *A Guide for Rural Healthcare Collaboration and Coordination*. Hear how rural hospitals, community health centers, local public health

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