# Collaborations between Local Public Health and Healthcare: A Case Study Series Highlighting Rural Success Stories

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## BACKGROUND

Local health departments (LHDs) and healthcare delivery organizations commonly collaborate on a variety of activities, including those related to community health assessments (CHAs), emergency preparedness and response, infectious disease, behavioral health, and population health goals.[1,2] These collaborations can range in terms of their purpose, structure, challenges, and impacts. Within rural areas, LHDs and local healthcare delivery organizations operate in different contexts than their urban counterparts. For example, rural organizations tend to face greater challenges related to reaching economies of scale, workforce shortages, healthcare needs, and access to healthcare resources than urban communities.[3-5] However, rural areas often have greater levels of community engagement, stronger community ties, and workforces with greater tenure in local organizations.[6-9] Each of these unique factors further contributes to the range of collaborations that exist across the country, and the greater reliance on collaborations in rural areas specifically.

The purpose of this report is to provide a series of case studies highlighting successful collaborations between rural-serving LHDs and local healthcare organizations across the country, with different purposes, structures, and lessons learned.

## METHODS

As part of a larger qualitative study, a convenience sample of rural-serving local public health and healthcare organization collaborations was identified. In order to be included, organizations had to be located in a rural area (defined by Rural Urban Continuum Codes) or serve or support a large rural population (defined by Census Bureau population estimates or by participant organizations).[10,11] Further, we prioritized variation in the purpose, partners, and locations to describe a range of collaboration examples. Case studies were developed through virtual, semi-structured group interviews conducted via Zoom with participants representing local public health, local healthcare, and other relevant partner organizations between April and May 2025. Interviews were recorded with consent and professionally transcribed. A deductive, rapid coding approach was deployed to describe the collaboration context, purpose, structure, development, sustainment, and impacts, as well as an overview of the program or scenario of focus, when relevant.[12,13] After initial case study drafts were prepared, they were shared with participants for review to ensure accurate information and for final approval of public release. This work was deemed non-human subjects research by the East Tennessee State University Institutional Review Board.

## CASE STUDY OVERVIEW

A total of 4 case studies were developed, each following a similar structure. Case study locations and topics are listed below, organized geographically from west to east.

**Case Study 1: Supporting families after childbirth in Jefferson County, Oregon.** This case study details an ongoing collaboration between a critical access hospital and a LHD in addressing the needs of new parents through health department staff visits in the hospital after delivery. Health department staff support new parents by facilitating connections to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and additional programming without added burden on parents.

**Case Study 2: A community paramedicine program in Marathon County, Wisconsin.** This case study describes the coordinated effort between a local health system, a county LHD, and a city fire department to develop and implement a community paramedicine program. The program focuses on preventing falls and addressing the needs of individuals who frequently use emergency medical services and the emergency department, ultimately lowering the pressure on those systems and better addressing the health-related needs of their patient population.

**Case Study 3: Hospital and health department data sharing in Hancock County, Ohio.** This case study highlights the experiences of a hospital and a LHD collaborating around data sharing, with a focus on two areas: 1) infectious disease prevention and control; and 2) development of a community health assessment (CHA) and a community health improvement plan (CHIP) alongside other community partners.

**Case Study 4: Emergency response for a train derailment in Beaver County, Pennsylvania.** This case study focuses on the response in Pennsylvania to a train derailment that occurred in East Palestine, Ohio on February 3, 2023, just miles from the Pennsylvania-Ohio border. A local Federally Qualified Health Center (FQHC) and the Pennsylvania Department of Health, including a local public health nurse, worked alongside other partners to stand up and manage a temporary health resource center for approximately 3 weeks.

CASE STUDY 1:

# Supporting Families After Childbirth

## BACKGROUND

Jefferson County is located in central Oregon, with Madras serving as the county seat. The county is classified as rural according to the Oregon Office of Rural Health definition (10 or more miles from a population center of 40,000 or more people).[16] Jefferson County Public Health provides programs and services aimed at protecting the health of all residents in Jefferson County. St. Charles Madras is a 25-bed critical access hospital that is part of the St. Charles Health System, the largest healthcare provider in the region. The hospital serves the residents of Jefferson County and the surrounding area by delivering various services, including the operation of a family birthing center that supports over 150 births annually.

Jefferson County Public Health and St. Charles Madras are collaborating to improve maternal and child health in Madras and the surrounding county. It is anchored in promoting family participation in two programs following childbirth: 1) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); and 2) Family Connects.

## PROGRAM OVERVIEW

According to the U.S. Department of Agriculture, WIC is a federally supported program that "provides free healthy foods, breastfeeding support, nutrition education and referrals to other services."[17,18] WIC serves income-eligible individuals with nutritional risk, including women who are pregnant, were recently pregnant, or are breastfeeding, infants, and children under 5 years of age.[19] In the state of Oregon, WIC is administered through the Oregon Health Authority, which provides programmatic guidance for local agencies

## COMMUNITY CHARACTERISTICS

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|---|---|
| **Primary Location:** | • Jefferson County, OR<br>• Madras, OR |
| **Organizations:** | • Jefferson County Public Health<br>• St. Charles Madras (critical access hospital) |
| **County Population[14]:** | 24,502 |
| **County Land Mass[14]:** | 1,781.7 square miles |
| **County Rural-Urban Continuum Code (2023)[15]:** | 3 (Metro: Counties in metro areas of fewer than 250,000 population) |
| **Percent County Rural (2020)[15]:** | 66.99% |

Jefferson County
Public Health
Prevent. Promote. Protect.

St. Charles
HEALTH SYSTEM

such as Jefferson County Public Health to support WIC implementation.

Similarly, Family Connects is a universal home visiting program administered through the Oregon Health Authority as part of a statewide initiative known as Family Connects Oregon.[20,21] In Jefferson County, the program is available to residents through Jefferson County Public Health. All families with newborns are eligible to participate. According to the Oregon Health Authority, this evidence-based model involves a nurse home visitor working with "families to identify what families need and want from local resources, and then provides an individualized, non-stigmatizing entry into a community system of care."[20]

## COLLABORATION PURPOSE & STRUCTURE

> ***"We just really want to support healthy moms and healthy babies — just making sure that our patient population has access to and knowledge of what resources are out there and available to them."***
>
> ***Hospital Program Leadership***

Jefferson County Public Health and St. Charles Madras seek to ensure that all birthing parents have awareness of and access to any needed services or other resources prior to leaving the hospital with a newborn. They are using an intentionally simple, yet successful collaborative structure to connect with families directly in their hospital room and promote participation in WIC and/or Family Connects as appropriate. This structure is underpinned by the co-location of Jefferson County Public Health and St. Charles Madras, increasing the ability of staff to move between the two facilities in "[r]ain, snow, [or] sunshine." It is further supported by coordination between the WIC and Family Connects staff within Jefferson County Public Health as the programs work together to support families.

> ***"Partnering with St. Charles Medical Center is an incredible opportunity to make sure that those new moms have everything that they need before they actually leave the hospital. We're fortunate enough to be in the same parking lot as St. Charles Medical Center. We do take advantage of that and being able to see the new parents before they leave the hospital."***
>
> ***Public Health Program Coordinator***

Hospital nurses approach each birthing parent with the opportunity to connect with Jefferson County Public Health staff for WIC and Family Connects. With patient permission, nurses email Jefferson County Public Health, notifying them of the births of any interested parents on Monday through Thursday mornings, as applicable. After coordinating internally and with hospital nurses, a WIC certifier and a Family Connects staff member walk to the hospital to visit families. If both staff members are not available, one staff member will represent both programs using a form and guidelines created for that purpose.

Each visit with birthing parents is generally limited to 5-10 minutes, with staff taking care to both meet parents where they are at and not overburden them. After introductions, staff gather information on family-related needs, such as car seats, formula, or breast pumps. Additionally, staff share information about the two programs and work to schedule any future

visits. These include a WIC appointment within the next week for eligible families, and a Family Connects home visit ideally around three weeks after birth for interested families. Each family also receives a new baby blanket donated by a non-profit organization. More recently, Jefferson County Public Health has sought to increase engagement with fathers to support infant bonding and paternal engagement. In addition to offering congratulations, staff inform fathers that they may receive a front-facing baby carrier or a backpack diaper bag designed for fathers when they attend their upcoming WIC appointment. Jefferson County Public Health secured grant funding to purchase the carriers, diaper bags, and other supplies for families.

## COLLABORATION DEVELOPMENT & SUSTAINMENT

Prior to the current collaboration, Jefferson County Public Health had a Perinatal Care Coordinator who visited hospitals and healthcare offices to support participation in WIC; however, this approach was "hit and miss." WIC staff believed that the opportunity for families to connect directly with program staff was the most effective approach for supporting participation, with a focus on ensuring staff presence in hospitals. At a rural health conference in 2022, Jefferson County Public Health leadership facilitated introductions that ultimately connected WIC staff with relevant nurses at St. Charles Madras. After discussing how the organizations could work together, including sharing information about births, the collaboration launched three years ago. Initially, hospital visits were limited to WIC staff. However, WIC staff provided information about Family Connects and followed up with program staff if families expressed interest. Hospital visits were formally expanded to include Family Connects staff roughly two years ago, with St. Charles Madras informing relevant providers of the expansion in preparation for it. Further, the collaboration between the organizations continues to expand as WIC and Family Connect staff seek to increase engagement with fathers.

> ***"The proximity [is a facilitator to the collaboration], but also the sense of community here. Because we're small but mighty... I like to say, 'It takes a village, even when you're grown.' I feel like Jefferson County Public Health and St. Charles Madras really embody that. If they weren't willing to work with us, or if [program leadership] didn't have the initiative to be like, 'There's this gap and this is what we're going to do to fill it,' it would not work at all. Even with this proximity, it's the fact that [all of the] nurses all have the drive, their personal mission to help all of the families here in Jefferson County in any way that they can."***
>
> ***Public Health Program Coordinator***

Jefferson County Public Health and St. Charles Madras highlighted several factors that have supported collaboration development and expansion. The co-location of the two organizations has strengthened their working relationship, including as it relates to maternal and child health. A strong sense of community, combined with a shared commitment to supporting families among organizational leadership and staff, further facilitates collaboration. Importantly, staff are willing to collaborate across organizations. They view their approaches as complementary, rather than becoming competitive or territorial over

patients and programs. At the same time, the collaboration between Jefferson County Public Health and St. Charles Madras has encountered several challenges. St. Charles Madras initially faced early legal concerns about sharing patient information with Jefferson County Public Health; however, St. Charles Madras implemented an updated workflow to address these concerns without sharing patient information. While most births are captured through current processes, gaps may remain in sharing births with Jefferson County Public Health, particularly those that occur on Fridays and Saturdays. Multiple strategies are being used to minimize gaps, including: 1) WIC or Family Connects staff calling hospital nurses to monitor Friday births; 2) hospital nurses distributing information and other items to families on behalf of Family Connects over the weekend; and 3) hospital nurses contacting WIC staff via phone when needed.

## COLLABORATION IMPACTS

Jefferson County Public Health and St. Charles Madras highlighted the reach and positive impacts of their collaboration for families with newborns. Since the beginning of the program, Jefferson County Public Health and St. Charles Madras continue to strive to connect with every family before they leave the hospital, supporting families across the region. Birthing parents are receptive to the overall approach, with few declining visits from Jefferson County Public Health staff. Jefferson County Public Health also indicated that parents are generally pleased with the visit and look forward to future visits with WIC and/or Family Connects.

Moreover, the collaboration benefits families in several ways, according to Jefferson County Public Health and St. Charles Madras. Families have greater awareness of and access to any needed services or other resources before leaving the hospital. It also helps build their relationship with WIC and Family Connects staff, increasing comfort during future visits. Family Connects also provides warm handoffs to other programs and resources, providing additional support for families.

> ***"There have been times on the weekend that we've had mothers give birth, and for whatever reason, they need some items. I'm happy to come in on a Saturday and drop those off and chat with them as well. Just to make sure that they know that they're taken care of, and Jefferson County is wrapping their arms around them because that's what we can do."***
>
> ***Public Health Program Coordinator***

In addition to strengthening families, Jefferson County Public Health and St. Charles Madras described positive impacts of the collaboration on their staff and programming. Hospital nurses are not only enthusiastic about visits from WIC and Family Connect staff, but also appreciate that they can contact those staff for support when needs arise. WIC and Family Connect staff similarly feel welcomed, with the enthusiasm of the nurses contributing to a sense of professional fulfillment. As for programming, the collaboration supports the growth of WIC, Family Connects, and other public health programs that can further support families.

CASE STUDY 2:

# A Community Paramedicine Program

## BACKGROUND

Marathon County is located in central Wisconsin, with the county seat in Wausau. While the county is classified as metropolitan, over 43% of the population is considered rural. The county has a variety of health and healthcare partners, including but not limited to Aspirus Health, the Marathon County Health Department, and the Wausau Fire Department which provides emergency medical services (EMS) to the city and surrounding area. In addition, Aspirus Wausau is among the busiest of the 18 Aspirus Health hospitals and draws patients from rural areas around North Central Wisconsin and beyond the county boundaries.

## PROGRAM OVERVIEW

In 2024, Aspirus Health, the Marathon County Health Department, and the Wausau Fire Department came together to establish a community paramedicine program. The program was motivated by several factors including:

- Preventing falls as a goal of the hospital and health department in their community health needs assessments and improvement plans
- Preventing unnecessary emergency department visits, which add to overwhelmed emergency department (ED) and EMS systems
- Addressing health-related needs and social determinants of health of individuals who frequently use EMS and ED services

The program is currently led by one community paramedic. They respond to medical-related EMS calls that do not require medical transport to the ED and provide

## COMMUNITY CHARACTERISTICS

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| **Primary Location:** | • Marathon County, WI<br>• Wausau, WI |
| **Organizations:** | • Aspirus Health<br>• Wausau Fire Department<br>• Marathon County Health Department |
| **County Population[22]:** | 138,013 |
| **County Land Mass[22]:** | 1,545.2 square miles |
| **County Rural-Urban Continuum Code (2023)[23]:** | 3 (Metro - counties in metro areas of fewer than 250,000 population) |
| **Percent County Rural (2020)[23]:** | 43.39% |

several key services to support the healthcare-related needs of community members. Services include:

- In-home assessments
- Medication reconciliation and compliance checks
- Home safety checks
- Health education
- Coordination with primary care providers, specialists, and home care providers

The program and associated services are designed to respond to both acute and chronic health-related needs and address upstream causes of EMS calls and ED encounters, thereby meeting the complex needs of high-risk patients and reducing pressure on EMS and the ED. In addition to responding to urgent needs, the program provides scheduled in-home visits to those enrolled.

## PROGRAM OVERVIEW

All organizations were involved in initially establishing the program and securing funding and continue to participate in monthly meetings. In addition, Aspirus Health brings medical expertise, contributes funding, enables the community paramedic to access their electronic medical record (EMR), and provides ongoing provider communication with the community paramedic as needed. The Marathon County Health Department developed the original white paper that supported the launch of the program, was an initial funder, and is an ongoing partner. The Wausau Fire Department employs the community paramedic. In addition to funding from partner organizations, the program is supported through a three-year commitment from the Aspirus Health Foundation, the Judd S. Alexander Foundation, and city of Wausau, as well as other grant funding.

## COLLABORATION DEVELOPMENT & SUSTAINMENT

In 2017, Wausau Fire and Aspirus Health piloted a community paramedicine program with the focus on preventing hospital readmissions after discharge following a diagnosis of pneumonia, congestive heart failure (CHF), or chronic obstructive pulmonary disease (COPD). This model relied on an EMS staff member being available and did not end up being a sustainable model.

In their 2023 community health needs assessments and health improvement plans, both Aspirus Health and the Marathon County Health Department identified fall prevention as a key priority area. In conversations between all three partners, they identified an opportunity to revamp the program in a more sustainable way that would meet their organizational needs and the needs of the community. Members of the collaboration also described program goals and purpose align with each organizations' mission, vision, needs assessment, or improvement. This alignment facilitated leadership and local support.

***"We just all came together to brainstorm, what could this look like and how could we partner in a meaningful way so that we could address some of the things that we were seeing in our community, not just one area but the systems so that they weren't overwhelmed? We could get patients what they need, in the time that they need it, at the level they need it. We knew we had some opportunity there."***

***Hospital Leadership***

The current program began in 2024 and is funded through 2027. The goal of the collaborators is to demonstrate the value of the program during this time and ultimately secure long-term, sustainable funding. In addition to serving the local Wausau and Marathon County communities, opportunities may exist to replicate the program model in other communities across the region, state, and nation.

## COLLABORATION IMPACTS

Since the program began in 2024, there have been notable impacts for patients and the organizations involved. In the first 6 months of data, there were:

- A 65% reduction in 911 calls, with 83 patient encounters diverted from 911 (decreasing from 129 calls to 46 calls), which equates to a savings of $82,600
- A 50% reduction in ED visits with 52 patient encounters diverted from the ED (decreasing from 103 visits to 51 visits), which equates to an estimated $130,000 in cost savings

The program is also able to address patient needs that can be challenging to address in the ED. For example, the community paramedic has been able to identify and address:

- A patient drinking diet soda instead of traditional soda in response to high blood sugar
- A patient continuing medications for months after they were supposed to be stopped
- Identification and rectification of home safety needs including installation of grab bars, installation of smoke detectors, and removal of trip hazards

***"[We've seen] very, very good catches in the field and that's just simply something that it's not possible to be able to catch in the clinic setting because you can't see what we can see in the home going through the cabinets and really taking the time. We have that luxury when we're able to go and sit with the patient and discuss things with them. Pretty significant, significant findings with those medication reconciliations. Those have opened a lot of eyes."***

***Community Paramedic***

## LESSONS LEARNED

**Record Access & Communication:** Access to medical records and direct communication between the paramedic, ED, and primary care providers in the Aspirus Health system was considered vital to the success of the program. Despite initial challenges, Aspirus Health was able to bring together all relevant departments within the health system to discuss the value and importance of the community paramedic having access to medical records.

**Hiring Considerations:** The Wausau Fire Department intentionally filled the community paramedic position with a candidate who also met the minimum requirements to serve as a fire department employee. This arrangement ensured the paramedic could maintain their position in case the program lost funding.

**Data Collection:** The Wausau Fire Department has been proactive in collecting data from the beginning to demonstrate the value of the program and to secure future funding. Future data collection will include patient health outcomes from Aspirus Health.

CASE STUDY 3:

# Hospital and Health Department Data Sharing

## BACKGROUND

Hancock County is located in northwestern Ohio. The county is classified as nonmetropolitan, with over 31% of the population characterized as rural. Blanchard Valley Hospital, Hancock Public Health, and the Center for Civic Engagement are partnering to advance individual and community health in Hancock County. These organizations, along with several others, are part of a larger health coalition called Be Healthy Now Hancock County (BHNHC), which collaborates to address the community's health needs. Further, the Center for Civic Engagement brings together BHNHC members to share data, build on existing strategies, identify barriers, and more. The formal partnership between Blanchard Valley Hospital, Hancock Public Health, and the Center for Civic Engagement began in 2016. While Hancock Public Health primarily serves the residents of Hancock County, Blanchard Valley Hospital, as part of the Blanchard Valley Health System, has a larger service area comprised of eight counties. However, a majority of the population served by Blanchard Valley Health System resides in Hancock County.

Blanchard Valley Hospital, Hancock Public Health, and the Center for Civic Engagement are collaborating to collect, share, and/or use data in several areas, including: 1) infectious disease prevention and control; and 2) Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP).

## COMMUNITY CHARACTERISTICS

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|---|---|
| **Primary Location:** | Hancock County, OH |
| **Organizations[24]:** | • Blanchard Valley Hospital<br>• Hancock Public Health<br>• Center for Civic Engagement<br>• Be Healthy Now Hancock County |
| **County Population[25]:** | 74,920 |
| **County Land Mass[25]:** | 531.3 square miles |
| **County Rural-Urban Continuum Code (2023)[26]:** | 4 (Nonmetro: Urban population of 20,000 or more, adjacent to a metro area) |
| **Percent County Rural (2020)[26]:** | 31.81% |

## COLLABORATION PURPOSE & STRUCTURE

Blanchard Valley Hospital and Hancock Public Health engage in bi-directional sharing of data and other information to support infectious disease prevention and control. Multiple mechanisms with differing levels of formality are used. The two organizations host monthly meetings aimed at promoting centralized communication around infectious diseases. Hancock Public Health is similarly invited to participate in quarterly meetings of an infection control committee organized by Blanchard Valley Health System. Beyond meetings, local public health and hospital staff with infectious disease-related roles communicate regularly and openly as needs arise. For example, when Blanchard Valley Hospital enters reportable conditions into a state-level database, hospital staff will simultaneously share this information with relevant local public health staff when urgent. Such interactions provide an opportunity for local public health staff to answer questions or obtain needed information for hospital providers.

Additionally, Blanchard Valley Hospital, Hancock Public Health, and BHNHC, in partnership with additional organizations, leverage a formalized process to complete the CHA/CHIP for Hancock County. Although the county was applying a collective impact approach to address social determinants of health, “silos” remained in their CHIPs. In response, BHNHC focused on integrating established coalitions that are supported by the Center for Civic Engagement. This integration allowed the CHIP to build on existing strategies that address the needs of the local community. Additionally, it provided opportunities to expand data collection, sharing, and utilization for the CHA/CHIP.

BHNHC hired a public health consultant to expand primary data collection for the 2024 CHA to include a community survey, key informant interviews, and focus groups. Each organization within BHNHC contributed to the design of the survey, with Hancock Public Health providing additional support for data collection. All organizations participating in the broader CHA/CHIP process were subsequently invited to review the CHA data, resulting in the collaborative identification of a set of CHIP priority areas, accompanying strategies, and the responsible organizations.

> ***“As we started this new iteration of the [CHA] and the [CHIP], we wanted to make sure that we incorporated the existing work in the community through those collaboratives, and then have the [CHIP] either embrace those to support those or enhance that work that’s already happening."***
>
> ***Center Leadership***

Similarly, BHNHC supported the design and implementation of a structured process for reporting progress by priority area, starting with the 2023-2025 CHIP. Building on a process from Blanchard Valley Hospital and with the support of Hancock Public Health, participating organizations enter progress updates for their priority areas from the past quarter and set goals for future quarters using a shared spreadsheet. To support monitoring progress, each organization within BHNHC also ensures that goals embedded in a CHIP are structured as SMART goals. Quarterly meetings offer a group setting to review progress, identify gaps or challenges, and make any needed adjustments to CHIP strategies. Further, Hancock Public Health created and maintains a complementary, public-facing dashboard to

share CHIP progress, challenges, and successes with the broader community.

> ***"I think something that we learned from [a] previous CHIP to the one we're working on now is that we really need to hone in and make sure that we have SMART goals at the table, because our previous CHIP, they were blanket statements. Nothing was measurable. . . . It made it a challenge to report progress when we didn't have anything measurable to report on."***
>
> ***Health Department Leadership***

## COLLABORATION DEVELOPMENT & SUSTAINMENT

While Blanchard Valley Hospital and Hancock Public Health had a longstanding working relationship, the COVID-19 pandemic, which began in 2020, further strengthened their collaboration. The resulting collaboration has since been sustained, evolving to support broader infectious disease prevention and control.

Similarly, the collaborative process for the CHA/CHIP in Hancock County was initiated in response to the passage of the Affordable Care Act in 2010. Blanchard Valley Hospital, Hancock Public Health, the Center for Civic Engagement, and the rest of BHNHC have since collaborated on multiple CHA/CHIP cycles, with the next CHIP anticipated to launch in 2026. Furthermore, BHNHC has sought to institutionalize the CHA/CHIP process, ensuring it can be sustained through organizational policy rather than relying on specific staff members.

Blanchard Valley Hospital, Hancock Public Health, and the Center for Civic Engagement identified additional factors that have influenced the development and sustainment of both collaborations. A shared patient population underpins collaboration, particularly for Blanchard Valley Hospital and Hancock Public Health. The value of strong leadership was also highlighted, with their respective organizational boards described as positive, collaborative, and supportive of community-based initiatives. Strong communication between Blanchard Valley Hospital and Hancock Public Health for infectious disease prevention and control, as well as among all participating organizations for the CHA/CHIP, was similarly identified as a facilitator. Though limited capacity among staff engaged in collaborative efforts remains a primary barrier.

> ***"[E]verybody in rural America is really busy, and everybody's got daytime jobs. These are things that are part of our job, but we've also got lots of other things to be doing. Just getting people together with enough time to sit and deliberate, come up with plans of what we want to do is a challenge."***
>
> ***Hospital Leadership***

## COLLABORATION IMPACTS

Blanchard Valley Hospital and Hancock Public Health outlined multiple benefits of bidirectional data sharing and other information for infectious disease prevention and control. Regular meetings focused on infectious disease were described as valuable, providing a dedicated space to discuss emerging trends, manage cases, share expertise, and identify opportunities for collaboration. Similarly, direct communication between local public health and hospital staff with infectious disease-related roles facilitates timely information sharing between

organizations. For example, local public health staff may share health alerts from the Centers for Disease Control and Prevention with hospital staff for internal dissemination, increasing the likelihood that hospital providers view the alerts. Without this direct line of communication, public health staff would be limited to using a fax machine to share information with those providers. More broadly, hospital staff appreciate the collaboration with local public health staff. This relationship, for example, provided a significant source of professional support for providers during the peak of the COVID-19 pandemic.

> ***"We also have our monthly infectious disease meeting that came about sometime last year just as we started seeing the need for more centralized communication between us partners . . . 'Can we discuss the management of this case?' or 'I have this case that may have exposed people in our hospital, and how can we work through that together?' . . . [or] 'Does public health have any insight on any emerging infectious diseases that might be coming into the area that we don't usually see, and what do we need to know about that?' . . . That collaboration, just touching base monthly, getting all of our heads together so that we can tie up that communication loop, has really been helpful."***
>
> ***Health Department Staff***

Blanchard Valley Hospital, Hancock Public Health, and the Center for Civic Engagement likewise identified positive impacts associated with the expansion of the collaborative CHA/CHIP process. Combining multiple data collection strategies for the CHA yielded "more and better data" on Hancock County relative to to prior cycles. The inclusion of focus groups and key informant interviews, for example, enhanced their ability to gather insights from various populations who experience health disparities and related challenges. Ultimately, the expanded CHA contributed to a more robust understanding of community health needs. Leveraging the CHA data to collaboratively identify CHIP priority areas and strategies similarly helped to minimize duplication and support existing strategies across participating organizations. Further, the expanded process for reporting on CHIP progress fostered a greater sense of accountability for implementing strategies, both among participating organizations and to the broader community.

Alongside process-related impacts, the three organizations highlighted broader implications of the CHA/CHIP for residents and organizations in Hancock County. For example, while the position could not be sustained, Hancock Public Health hired a community health worker to address social determinants of health based on a CHIP. Similarly, improvements in health outcomes tied to CHIP strategies were described, with diabetes prevention and management being a key area of success. For this initiative, Hancock Public Health launched a continuous glucose monitoring program for individuals with diabetes. The program grew from 100 to 500 people and had notable improvements among participants.

Among Blanchard Valley Hospital, Hancock Public Health, and BHNHC, data sharing efforts of each organization and the coalition as a whole work to promote the health and well-being of the community.

CASE STUDY 4:

# Emergency Response for a Train Derailment

## BACKGROUND

Beaver County is located in western Pennsylvania along the Pennsylvania-Ohio border. It is classified as a large metropolitan county; however, nearly 30% of the population is considered rural. Darlington Township is located in the northwestern portion of Beaver County, with a population of roughly 1,800. Primary Health Network, one of the largest Federally Qualified Health Centers (FQHC) in Pennsylvania, serves the residents of Beaver County and the surrounding area. It is comprised of multiple clinical sites across Pennsylvania and northeast Ohio, including several in Beaver County. Pennsylvania has a mixed public health governance structure, with local public health services in Beaver County led by the Pennsylvania Department of Health. Specifically, the state provides a community health nurse and operates a health center that delivers safety net services and select clinical services. The health center also routinely refers residents to local FQHCs such as Primary Health Network for additional services.

In February 2023, a train carrying hazardous materials derailed in East Palestine, Ohio, in close proximity to Beaver County and adjacent to Darlington Township. Multiple train cars were derailed, breached, and/or caught fire, leading to a vent and burn operation aimed at releasing stored chemicals. A combination of evacuation and shelter-in-place orders within a two-mile radius of the site were also issued.

In response to growing concern from Pennsylvania residents and elected officials, the Pennsylvania Department of Health and Primary Health Network, in partnership with other state and local agencies, collaborated to establish a temporary Health Resource Center

## COMMUNITY CHARACTERISTICS

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|---|---|
| **Primary Location:** | • Beaver County, PA<br>• Darlington Township, PA |
| **Organizations:** | • Pennsylvania Department of Health<br>• Primary Health Network (Federally Qualified Health Center [FQHC]) |
| **County Population[27]:** | 168,215 |
| **County Land Mass[27]:** | 434.7 square miles |
| **County Rural-Urban Continuum Code (2023)[28]:** | 1 (Large metro: In metro area with at least 1 million residents) |
| **Percent County Rural (2020)[28]:** | 28.92% |

The Primary Health Network
Embracing Excellence in Healthcare

Pennsylvania Department of Health

in Darlington Township. While many partners contributed to the response in both Pennsylvania and Ohio, this case study focuses on the interactions between local healthcare and public health in Pennsylvania.

## HEALTH RESOURCE CENTER OVERVIEW

The Health Resource Center provided public health services to Pennsylvania residents affected by the train derailment, including those in Beaver County, for approximately three weeks. The specific activities of the Health Resource Center focused on four key areas, each of which had a dedicated physical space and was supported by various state and/or local agencies:

- Assessment of Chemical Exposures (ACE) Survey: The Health Resource Center administered the ACE survey, a Centers for Disease Control and Prevention (CDC)-developed methodology for collecting data following environmental emergencies.
- Clinical Assessment: The Health Resource Center conducted a basic assessment of acute medical needs, answered health-related questions, and provided necessary referrals.
- Behavioral Health Services: The Health Resource Center provided behavioral health screening, assessment, and necessary referrals, with spiritual care available to supplement these services.
- General Resources: The Health Resource Center supplied informational materials from relevant agencies (e.g., Department of Agriculture), answered questions, and made referrals to other resources (e.g., air, water, and soil testing) as appropriate.

## COLLABORATION PURPOSE & STRUCTURE

After deciding to launch the Health Resource Center as an on-ground, collaborative response, the Pennsylvania Department of Health identified needed services and contacted relevant state and local agencies to support the effort, including Primary Health Network. Specific to healthcare services, the Pennsylvania Department of Health prioritized collaborating with a local healthcare partner, Primary Health Network, allowing the response to leverage their established local connections and resources. The Health Resource Center structure and operations were then formalized through an operations plan and an organizational structure that outlined relevant agency and individual roles. To support the ongoing and evolving needs of the community, each day began with a "huddle" involving all partners to identify team-related needs, support teams in carrying out their roles, and foster coordination across agencies.

The Pennsylvania Department of Health served as the lead agency, providing overall site coordination. This included the community health nurse for Beaver County managing the Health Resource Center's front desk and working to mitigate potential bottlenecks. As part of this role, the nurse greeted residents and conducted an initial assessment to help direct them to the appropriate services based on their needs. The Pennsylvania Department of Health did not receive additional funding dedicated to the response. The response relied on normal operating funds, with the exception of supplementing an existing contract for their State Medical Assistance Team to support the clinical assessment focus area.

Primary Health Network served as the local healthcare partner in collaboration with the

State Medical Assistance Team. They underpinned the clinical assessment focus area, including the deployment of a mobile unit to support service provision. As part of this role, Primary Health Network provided warm handoffs to affiliated primary care providers and other medical teams for patients seeking care. They also offered to serve as a medical home for those without established care. Primary Health Network delivered services to residents free of charge, with partial coverage of their total costs later received as part of a larger settlement connected to the event. Further, during the response, Primary Health Network shared process-oriented data with the Pennsylvania Department of Health highlighting the reach of their services, including the number of individuals served and types of acute conditions addressed.

## COLLABORATION DEVELOPMENT & IMPLEMENTATION

The Pennsylvania Department of Health and Primary Health Network identified a variety of factors that positively influenced their collaborative response to the train derailment. First, rurality was described as a driver of innovation in their response. Partners indicated that rurality facilitates collaboration, creativity, and innovative solutions in the face of limited resources, while minimizing inter-organizational competition given a limited number of local agencies. This setting resulted in the design of a Health Resource Center grounded in partnerships and local connection. Second, strong communication and coordination, both internally and externally, were identified as important facilitators. Lastly, previously established relationships among the Pennsylvania Department of Health (which employs the local community health nurse) and Primary Health Network, built on trust, were described as "pivotal in our success," contributing to an efficient and comprehensive response involving multiple partners.

> ***"[T]he relationship and the trust, the partnership, that we had, even prior to the event, allowed this to occur without hesitation. If I was going to be advising other communities in the area, my advice is to work on that good relationship. Don't wait until there's a crisis."***
>
> ***Primary Health Network Leadership***

Conversely, the Pennsylvania Department of Health and Primary Health Network identified several factors that negatively influenced their response. First, a lack of funding for disaster response was described as a challenge. Federal funding, for example, frequently focuses on on disaster preparedness, but timely funding for disaster responses is often more limited and delayed. Second, disaster response was characterized as "inherently reactive," and, in this case, the situation continued to evolve in real time. However, these challenges were mitigated by strong partnerships and staff with the ability to pivot quickly. Third, staffing capacity was discussed as a potential concern. The same group of staff are often assigned responsibilities for disaster response, over and above their regular responsibilities, which continued during the response. This additional burden may contribute to staff fatigue over time, especially for lengthy responses. Lastly, there was also recognition that physicians generally do not have extensive training on environmental exposures or illnesses. The Pennsylvania Department of Health thus collaborated with a poison control center, state toxicologists, and others to provide a series of virtual webinars targeted to regional healthcare providers, including those with Primary Health Network. The webinars were designed to prepare providers for what they may

experience as a result of the train derailment. Primary Health Network leadership conducted additional background research and contacted a poison control center for real-time consultation to further support their services.

> ***"[I]t is well known that physicians are not generally well versed in dealing with environmental exposures and illnesses, and so we saw a need there. Certainly, we were getting calls and concerns, and so we did put together a webinar with the poison control center and our toxicologists and some other folks, and presented that webinar three different times. We were really aiming for clinicians in that region who would be seeing those patients specifically, but it was very well attended and we had over, I think, about 500 participants over the three times that we conducted that webinar. I totally agree that that was definitely a good time well spent and a good resource to our clinical community."***
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> ***Pennsylvania Department of Health Leadership***

## COLLABORATION IMPACTS

The Pennsylvania Department of Health and Primary Health Network described the Health Resource Center as a success, suggesting that it may serve as a model for future emergency responses. In short, they designed and implemented a comprehensive response to meet residents' needs. Over a period of approximately three weeks, the Health Resource Center served a total of 563 individuals from Beaver County and the surrounding area. As a result of this experience, the Pennsylvania Department of Health is modifying state-level response plans to enhance preparedness for future emergencies.

> ***"[O]ur emergency preparedness efforts have envisioned a wide range of times where we would have to go out and provide a service to the community, but never anything quite like this. Never a more holistic healthcare, behavioral health, information, data collection [effort]. . . . And so, we have adapted our response plans to be more nimble. . . . We need to be more purpose-agnostic and allow our sites to do all of these, and often in collaboration with each other. . . . That has shifted where we are going with some of our response plans at the Commonwealth level to make us better prepared for future events like this."***
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> ***Emergency Preparedness and Response Leadership, Pennsylvania Department of Health***

Concerning the clinical assessment focus area, Primary Health Network indicated that most residents seeking services did not have significant clinical manifestations. Nevertheless the Health Resource Center provided a dedicated space for residents to ask needed questions and share their experiences. Moreover, the engagement of Primary Health Network as a local healthcare partner fostered continuity of care among residents who sought services. Many patients are estimated to have continued to receive primary care or behavioral health services through Primary Health Network. As an FQHC, Primary Health Network can also provide enabling services and collaborate with other local agencies to address any nonmedical drivers of health. Lastly, Primary Health Network established a patient registry using their electronic health record, allowing them to follow up with patients who were served by the Health Resource Center as needed.

## NOTES


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