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Stretching, Influencing, Managing and Surviving
A Rural Health Initiative Learning Experiment

Prepared for

REACH HEALTHCARE FOUNDATION

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INTRODUCTION

The overarching goal for the Rural Health Initiative (RHI) is to create a new way of investing in rural counties that promotes lasting change, ultimately impacting health indicators by increasing access to healthcare and reducing inequities for the unserved and underserved. REACH brought a collection of resources to this initiative. One of those resources includes a comprehensive evaluation component. The evaluation includes: a retrospective look at the first year[1] – a planning period; a developmental evaluation of each of the three counties' progress in year two (January-December 2013); and a developmental evaluation of the overall initiative.

This report documents what propelled REACH to consider the idea initially; how the idea developed into a concept; and the approach chosen to bring the concept to reality. The report also provides a few examples from the literature on successful initiatives as well as information and data about the three rural counties: Allen County, KS, Cass County, MO, and Lafayette County, MO. Additionally, it reveals how RHI was actualized by rural counties and REACH program officers as they embarked upon an *experiment* to build a *foundation for innovation* in each county. What is an *experiment*? We usually think of an experiment as a *test to try something new* or *to prove something works.* In the scientific laboratory, it is much easier to control the variables which might affect the results of an experiment. In the real world, working with people, there are few – if any – methods to control the assorted influences. Thus, in RHI Year One, we have lessons learned that builds our knowledge of how to work in rural communities and raises new questions to answer.

The report title, *"Stretching, Influencing, Managing and Surviving"* reflects the *movement and tensions,* the *give and take* between the county-level teams and REACH program officers; and, the *learning* that everyone involved gained during the planning period (April-December 2012). RHI invested time, talent and treasure and created a space for *learning, creating and innovating.* The county-level core teams also invested time, talent, and treasure along with a *will to drive change* in their rural communities. All of these investments are necessary and critical.

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[1] Actually a period of approximately six-to-seven months – April-November 2012 as the final proposal was submitted to the Reach Board of Directors in November 2012.

BACKGROUND

REACH has been investing in three urban and three rural counties for nine years. The approach has been a traditional philanthropy model offering both competitive and non-competitive grant awards to organizations. Over this period of time, REACH learned first-hand that success and opportunities in the rural and urban markets varied. Simultaneously, others were also learning that **rural areas were particularly difficult for *different* reasons.** In the health care arena, these differences are magnified because of geography, demographics, lack of resources, and access.

Over the past two decades, **research has revealed *unique barriers*** that rural communities face compared to urban communities: **significantly fewer health care providers**; **greater distances to clinics, hospitals, and specialty providers**; **greater percentage of uninsured residents**; **higher poverty rates**; **lower education levels**; and, **an older aging population** (Schur and Franco, 1999; Eberhardt et al., 2001; Gramm et al., 2003; Ziller et al., 2003; Grantmakers in Health, 2009).

The three rural counties served by REACH mirror the national data in discouraging ways: **the ratio of residents to primary care providers is near or above 3,000:1 and there are limited mental health and oral health providers** (MARC, 2011). Both Allen and Lafayette are HRSA designated *Primary Care Health Professional Shortage Areas.* Health outcomes for the residents show that they have higher rates of preventable hospital stays; lower rates of diabetic screening and mammography screening; more often die from chronic and/or preventable conditions such as colon cancer, coronary heart disease, lung cancer, vehicle injury and stroke; and, life expectancy is lower in two of the three counties. Further **compounding the problem is the fact that these disparities are increasing** (MARC, 2011).

To get a better sense of the challenges facing the three counties, following are data health care access and quality key indicators[2]:

Access to Care

Allen, Cass, and Lafayette counties all face significant challenges regarding health care access. All three counties exceed the national benchmark for percentage of population that is uninsured:

[2] REACH RHI Key Facts, with data from http://www.countyhealthrankings.org.

- National benchmark: 11% uninsured
- Allen County: 14% uninsured
- Cass County: 13% uninsured
- Lafayette County: 15% uninsured

Access to health care not only requires financial coverage, but also access to health providers. Having a sufficient supply of primary care physicians is essential to people obtaining the preventive and primary care services that they need. The ratio of individuals to primary care physicians can be used as an indicator of access to care:

- National benchmark: 631 to 1
- Allen County: 2,217 to 1 (3 ½ times the national benchmark)
- Cass County: 3,009 to 1 (nearly 5 times the national benchmark)
- Lafayette County: 2,735 to 1 (more than 4 times the national benchmark)

Quality of Care

Premature death can be measured in years of potential life lost (YPLL) before the age of 75. This measure of premature death can be used as an indicator of the quality of health care within a community or population. All three counties exceed the national benchmark for premature death:

- National benchmark: 5,466 years of potential life lost (YPLL) per 100,000 persons
- Allen County: 10,514 YPLL
- Cass County: 7,131 YPLL
- Lafayette County: 8,494 YPLL

Self-reported health status is a widely used measure of people's health-related quality of life and has been shown to be a reliable measure of current health status.

- National benchmark: 10% of adults reporting poor or fair health
- Allen County: 18% of adults reporting poor or fair health
- Cass County: 15% of adults reporting poor or fair health
- Lafayette County: 13% of adults reporting poor or fair health

If they are well-managed, ambulatory-care conditions can be handled in outpatient settings. These cases are referred to as preventable hospitalizations.

- National benchmark: 49 preventable hospitalizations per 1,000
- Allen County: 104 preventable hospitalizations
- Cass County: 77 preventable hospitalizations
- Lafayette County: 94 preventable hospitalizations

As REACH reviewed their investments and the health indicators in their rural counties, it was clear that the investments were not making the strategic difference desired. The rural communities continued to experience high levels of inequality of care, access, and health outcomes. Thus, **a new and different investment strategy was needed if change was to occur** in the counties and REACH was to fulfill its mission. The need for *something different* led REACH to begin a journey of investigation beyond the focused health care data into a broader literature review about what works in rural communities, in general; and, effective change strategies, in particular.

For purposes of this report, the literature review that REACH completed is merely highlighted. There are two broad categories: systems/community change and health care innovation. Highlights from the systems change literature reveal primary tenets[3]:

- Start by understanding the system you are trying to change.
- Involve both funders and nonprofits as equals from the outset.
- Design for a network, not an organization – and invest in collective infrastructure.
- Cultivate leadership at many levels.
- Create multiple opportunities to connect and communicate.
- Remain adaptive and emergent – and committed to a long term vision.

Lessons learned from the community change literature reveal useful guidelines[4]:

- Be clear as possible about goals, definition of success, and theory of change.
- With clear goals, invest in intentional strategies for achieving them.
- Have a clear theory of scale and make sure resources are proportional to the scale desired.

[3] Grant, H.M. (2010). *Transformer: How to build a network to change a system.* Monitor Institute.
[4] Kubisch, Anne C. (2010). Lessons to improve the design and implementation of community change efforts, *Voices from the Field III: Lessons and Challenges From Two Decades of Community Change Efforts.* The Aspen Institute: Roundtable on Community Change.

- Focus on effective implementation, capacity building, and alignment of objectives with capacities.
- Treat comprehensiveness as a principle – not a goal.

Highlights from the health care innovation literature also provide valuable guidelines[5]:

- Work regionally.
- Collect and use local data.
- Encourage collaboration.
- Be flexible.
- Focus on delivery system reform.
- Focus on workforce issues to expand access.
- Recruitment.
- Improve the pipeline into rural areas.
- Think creatively about technology.
- Build connections.
- Think beyond health care access.

Recommendations from *Modernizing Rural Health Care: Coverage, Quality and Innovation* (July, 2011) by UnitedHealth are particularly insightful about increasing access to health care in rural communities:

- Provide supports and incentives to expand the availability of rural primary care physicians.
- Encourage greater teamwork in rural primary care, including making full use of the skills of advanced nurse practitioners and other health professionals.
- Increase clinical collaboration across rural regions and with urban providers.
- Support greater integration and coordination of rural health care with health information technology.
- Use mobile infrastructure to bring care to rural areas.
- Adopt new approaches to improving consumer health and wellness, including new alliances with third-sector/non-traditional partners.

[5] *Rural Health Care: Innovations in Policy and Practice* (March, 2009). Grantmakers in Health.

The Institute of Medicine at the National Academies in its publication, *Quality through Collaboration: The Future of Rural Health* (2005) suggested a five-part strategy to advance a quality change effort in rural communities:

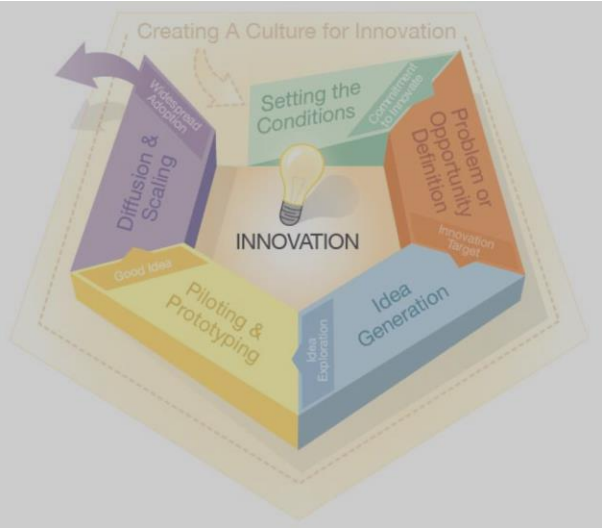
1. Adopt an integrated, prioritized approach to addressing personal and population health needs at the community level.
2. Establish a stronger quality improvement support structure to assist rural health systems and professionals.
3. Enhance human resource capacity of rural communities – health care professionals.
4. Monitor and assure that rural health care systems are financially stable.
5. Invest in building an information and communications technology infrastructure.

The extensive literature review enabled REACH to better understand the complexity of systems and community change and the entrenched barriers facing their rural communities. It convinced REACH that *business as usual* was not sufficient and that *innovation* was required.

How to go about *creating innovation* was the next question that had to be answered.

APPROACH

The approach needed was *innovation.* The framework used to think about creating innovation is from *Intentional Innovation: How Getting More Systematic about Innovation Could Improve Philanthropy and Increase Social Impact.*[6]



[6] G. Kasper & S. Clohesy, August 2008. W K Kellogg Foundation.

Using this framework, the knowledge gained from the literature review, in-depth data and information on the three counties, and a willingness to take risks, REACH formed the Rural Health Initiative (RHI), sought and received approval from its Board, and allocated a budget for a planning year.

REACH identified the following Guiding Principles for the RHI, which reveal it to be **truly innovative** for REACH as a funder, and require that the rural communities be innovative as well:

Leadership and Community Support

- A bold vision to dramatically increase access to health care (physical, mental and oral health), improve health outcomes for all citizens (*"a rising tide lifts all boats"*), and reduce health disparities.
- Broad community-wide support – need to share vision and seek feedback and support. Be prepared to face opposition – especially if policy changes are proposed – identify early on who likely opponents will be.
- Effective (engaged, committed) local leadership from multiple sectors.
- Rural innovation should be developed with the community – not for the community.

Collaboration and Risk Taking

- High level of teamwork, respect and collaboration – a primary early goal is to have a strong multi-sector network of partners.
- A willingness to take risks – to try new approaches and innovations – *"no tinkering around the edges."*
- Seek out and establish new and unexpected partnerships and affiliations.
- Multiple sectors engaged and seeking opportunities to innovate and partner.

Focus on a Sustainable System of Care

- Coordination of all elements of the delivery system – a fully articulated system of partnerships and referrals with executed agreements.
- Consumer and population focus: *"Is it good for the consumer?"* should be key question we always ask. Each organization, agency, and individual that participates in the health care system has a role to play in providing better care to individual consumers, targeting supports to different groups to improve population health, and lowering the costs of health care.

- A commitment to a system or network of care that ensures full participation of consumers and providers – *"No one goes unserved and no provider opts out of participation in the system."* When confronted with a barrier/excuse/resistance, we should always ask, *"What would it take to remove this as a barrier?"*

Coordination and Accountability

- Alignment with existing supportive efforts.
- Building on the strengths of local communities.
- Local ownership of implementation with reducing technical support over time.
- Evaluation of our work – engagement at the earliest possible time.

Having a framework of innovation, thinking innovatively, and even deciding on an innovative approach are not sufficient for success, however. REACH, and the counties, **would need to learn, teach and practice three important constructs in order to be successful**: *collective impact*, *network weaving*, and *capacity building*. It is critical to understand these constructs. It is also **critical to understand the depth and difficulty each requires f**rom the implementers and the funders. To be successfully implemented, this triumvirate **requires deep learning on multiple levels, enormous time commitments, and the ability to work on something with little or no results for long periods of time.** This is *hard work.* It is used with *adaptive problems* and requires *adaptive solutions.* It is, in no way, *business as usual.*

A brief highlight of each construct follows:

Collective Impact

According to Kania and Kramer (2011) collective impact was born out of frustration with attempting systems change for social problems. A few exceptions created an opportunity to look differently at how major social problems were being addressed. Success appeared to occur when there was cross-sector coordination focused on a specific large-scale social problem. Interventions developed by a single organization or one sector were not discovering solutions. *"No single organization is responsible for any major social problem, nor can any single organization cure it."* Intractable social problems such as rural health care access and equity are complex, adaptive problems and solutions may be found using a collective impact approach.

Kania and Kramer outline five conditions of collective impact success that work together: **a common agenda, shared measurement systems, mutually reinforcing activities,**

continuous communication, and backbone support organizations. *"Creating a successful collective impact initiative requires a significant financial investment: the time participating organizations must dedicate to the work, the development and monitoring of shared measurement systems, and the staff of the backbone organization needed to lead and support the initiative's ongoing work."*

In 2013, Kania and Kramer discuss the various obstacles to using collective impact and point out that *"...the greatest obstacle to success is that practitioners embark on the collective impact process expecting the wrong kind of solutions."* What dominate the social sectors are *programs* designed to address a specific problem. Collective impact is *"...an entirely different model of social progress."*

There are no silver bullets, no individual programs and no single organization that will be capable of solving the rural health needs in the three RHI counties.

Network Weaving

Networks – as Holley (2012) describes them – are also approaches to bring about system change. They are the people and organizations linked together working on a social problem and are often embedded within a collective impact approach. There are many different types, sizes and styles of networks and at the core, they include four parts: action, intention, relationship and support.

Network Weaving is foundational to RHI. It is a tool and method for the counties to engage and listen to community members, to build a larger base of people and organizations interested in the same rural health care issues, to create a sense of urgency in finding solutions, to share the work and funds, and to innovate and transform the landscape of their community. Distance, fewer resources and fewer people are recognized challenges rural areas confront. The Network Weaver Handbook is a *how-to* guide in understanding, creating, and improving networks with dual aims of innovation and transformation.

Capacity Building

The concept of Capacity Building as used in RHI is based on Aspen Institute's definition, *"community capacity is the combined influence of a community's commitment, resources, and skills that can be deployed to build on community strengths and address community problems and opportunities."* Aspen Institute identifies eight components of community capacity:

- Expanding, diverse, inclusive citizen participation
- Expanding leadership base
- Strengthened individual skills
- Widely shared understanding and vision
- Strategic community agenda
- Consistent, tangible progress toward goals
- More effective community organizations and institutions
- Better resource utilization by the community

Communities can build their capacity by developing *"…commitment, resources and skills."* When combined with collective impact and network weaving, building capacity produces a **triumvirate of approaches that strengthen possibilities for innovation and success.**

A few examples of successful social innovations illustrate the potential for RHI:

Kania and Kramer (2011)[7] outline a few collective impact successes:

Strive (in Cincinnati, Ohio and northern Kentucky) has increased student success in three large public school districts. In four years they were able to show improvement in dozens of key areas. Additionally, 34 of the 53 success indicators that are tracked show positive trends. The success is directly related to the approach they took. *"It is because a core group of community leaders decided to abandon their individual agendas in favor of a collective approach to improving student achievement. More than 300 leaders of local organizations agreed to participate, including the heads of influential private and corporate foundations, city government officials, school district representatives, the presidents of eight universities and community colleges, and the executive directors of hundreds of education-related nonprofit and advocacy groups."*

The Elizabeth River Project, in southeastern Virginia, began in 1993 when one woman decided that the river, which had been a dumping ground for industrial waste for years, needed to be cleaned up. They brought together representatives from multiple sectors – local and state governments, federal agencies, businesses, education, community groups and non-profits to develop a plan. *"Fifteen years later, more than 1,000 acres of watershed land have been conserved or restored, pollution has been reduced by more than 215 million pounds, concentrations of the most severe carcinogen have been cut sixfold, and water quality has significantly improved."*

[7] John Kania & Mark Kramer, *Collective Impact,* Stanford Social Innovation Review, (Winter, 2011).

> *Shape up Somerville*, led by Dr. Economos at Tufts University's Gerald J. and Dorothy R. Friedman School of Nutrition Science and Policy, tackled the rising childhood obesity crisis. Citizens along with government officials, educators, businesses, and nonprofits defined wellness and weight gain prevention practices. Schools provided healthier foods, taught children about nutrition, and promoted physical activity. Certifications were given to local restaurants for serving low-fat, high nutritional food. A farmers' market was started and city employees were given discounted gym memberships. Infrastructure was added and changed to encourage children to walk to school. *"The result was a statistically significant decrease in body mass index among the community's young children between 2002 and 2005."*

Grant (2010)[8] details the success of networks changing systems with a case study:

> RE-AMP Energy Network began in 2003 and is located in the upper Midwest. RE-AMP is a network of 125 nonprofits and funders across eight states. It has one goal: "*reducing regional global warming emissions 80 percent (from 2005 levels) by 2050"* Among their successes, RE-AMP has helped legislators in six states pass energy efficiency policies; promoted a highly rigorous cap-and-trade program; and stopped development of 28 new coal plants in the region. RE-AMP has increased its funding, developed shared resources for its members, built capacity of activists, and built stronger relationships between nonprofit organizations and funders. *"RE-AMP's process was well informed by decades of thinking related to systems dynamics and group facilitation. But what is new is the way in which RE-AMP combined these 'best practices' with 'next practices' to create a robust, resilient, and high-impact network."*

While RHI *is* an innovation, it is also a *change process.* Because rural communities have fewer resources to bring about change or to sustain an innovation, **creating the community's capacity to change is paramount**.

YEAR ONE PLANNING PHASE: LAUNCHING RHI

In March, 2012, REACH contacted three of their current grantees: THRIVE in Allen County, Kansas; Cass County Dental Clinic in Cass County, Missouri; and Health Care Collaborative of Rural Missouri (HCC) in Lafayette County. These three counties represent one-half of the service area and all of the *"rural areas"* for REACH. The grantees were asked to select a small planning team from their community to attend the National Rural Health Association (NRHA) Summit in Denver, CO and begin a collective, collaborative discussion on a rural health initiative. REACH provided funding for the teams to attend the Summit. The following table provides the names of the individuals who attended:

[8] Heather McLeod Grant, *Transformer: How to build a network to change a system – A Case Study of the RE-AMP Energy Network.* Monitor Institute (Fall, 2010).

Original Planning Teams

Allen County	Georgia Masterson Krista Postai David Toland Brian Wolfe
Cass County	Joe Christian Deborah Kirk Fred Pellerito Katie Schroeder Megan Turner
Lafayette County	Joe Christian Melanie Corporon Pam Johnson Toniann Richard Stephanie Taylor
REACH	Dawn Downes Carla Gibson Bill Moore

During their time in Denver, REACH presented an in-depth County Health Profile with the latest health data and information specific to each county as well as results of the comprehensive literature review spanning more than 20 years of research on systems change; insights from rural experts; challenges and barriers that rural communities face; and, strategies that have proven successful in systems change. Specifically, county-level core teams engaged in dialogue around three primary constructs: *Collective Impact*, *Network Weaving*, and *Capacity Building*. **When successfully implemented, these constructs empower rural communities to meet and overcome many challenges in creating *community change.***

At Denver, REACH challenged the teams to be *innovative*, *think big*, and *focus on moving the health indicators* when they returned to their communities and began the planning phase. To do this, RHI asked the **three counties to target their efforts in the remainder of Year One to the following**:

1. Create a sense of urgency, knowledge, and awareness around inequities of health care access and outcomes within each county.
2. Identify and mobilize human resources to create a county-wide leadership team and multi-sector community-based stakeholder group to lead and inform.
3. Create a vision and plan to address the problems identified.

During that time, REACH program officers purposefully tried not to bring their *power of influence* to bear on the county-level core teams' thinking. They were to allow the teams to struggle with the approaches and ideas of RHI and see what emerged. They attended meetings, held conference calls and responded to questions but tried to *stay out of the way* to enable the teams to truly think innovatively, strategically and thoughtfully.

In April 2012, REACH provided a half-day overview and training session on *Network Weaving*. One individual from each team attended the training and received a copy of the handbook, *"Network Weaving Handbook: A Guide to Transformational Networks."* The training session was followed by monthly conference calls which were open to all team members.

One of the first tasks facing the teams after the Network Weaving session was to expand their stakeholders by creating an *"expanded stakeholder advisory group."* Specific foci were diversity, *"new faces at the table,"* and consumer/client representation.

The planning year rounded out with a community of practice meeting in September, followed by concept proposals developed and submitted to REACH by all three counties for year two RHI work.

OVERARCHING FINDINGS

Training

The response to the half-day Network Weaving training was well-received; however, it did not translate well when done in conference calls. It caught some by surprise. *"Thought* [Network Weaving] *would catch on better. … I thought* [Network Weaving] *work would catch on. They took well with* [it at the training]*."* Assessments about where the individual counties were in their own network development and networking skills may have provided guidelines for developing a targeted plan of action to use in the electronic portion of the training. More structure and perhaps visuals, i.e., webinars, may have also made the discussions more compelling. Network Weaving as a *change strategy* may not have been fully understood. The word, "networking" may have unintentionally undermined the strategy as people assumed it was *"just networking"* in the traditional sense of business or social networking.

Initial Planning

In terms of multi-sector stakeholder groups, the Lafayette County team was the only team to create an expanded stakeholder group during the planning phase. It had sector and geographic diversity. The goal to bring more racial/ethnic diversity and representation from the population served (clients) was not achieved. One team member commented, *"We thought we had everybody at the table. We did not have major holes, but with RHI there are partners that could be* [connected to the clinics] *specifically but might not be interested in the network committees.*" The Lafayette core team, unfortunately, lost its connection with the expanded stakeholder group as the year progressed and was working to regain their interest and support at the end of 2012. However, Lafayette County had two people emerge as RHI leaders[9] early in the planning and the early strides made in Lafayette County provided huge momentum to the team in a critical time following the RHI launch. It propelled them forward into the creation/innovation segment of the planning phase.

In Allen County, two from the original planning team remained, two stepped aside, and two new people joined the core team in year one[10]. The Allen County core team did not meet formally until August – roughly four months after launch – and, therefore, created no momentum going into the fall when concepts and proposals would be due to REACH.

In Cass County, the core team integrated into *Connect*Cass[11]. While this move created a larger number of people discussing RHI in Cass County, it was not a productive relationship and cannot be considered an expanded stakeholder advisory group. Ultimately, insurmountable difficulties[12] arose which, by the end of the year, caused the initial group to break apart with only five remaining.

In the initial planning, there was enormous pressure *to get it right* on the part of the county-level core teams. As with most endeavors involving multiple people, there are different assumptions, expectations, interpretations, and communication styles. Even though the counties were specifically chosen because of their successful relationships with REACH, problems of clarity and understanding were experienced by members in all three counties. One county-level core team member said, *"Communication with REACH has been a real challenge. … It was not*

[9] These two were not part of HCC – the "backbone organization" for RHI in Lafayette County.
[10] See Allen County overview for more details.
[11] *Connect*Cass is a 501c3 organization that was re-formed from a previous non-profit. See Cass County overview for details.
[12] See Cass County overview for more details.

what we understood. We think that we are clear, and it isn't necessarily clear [to others]." It was definitely a struggle for people on both sides of the table. For example, one program officer said, *"I did assume there would be fits and starts. … I came in assuming it would be a good chance; more innovative and risky and more creative. We'd build upon each other's ideas to communicate. This is different because there's more of a collective initiative."* From Allen County, when asked what REACH could have done differently, a core team member stated, *"... define the parameters and if we ask them about where we are going, they could give us some direction."*

Part of the **clarity issue is connected to how they had worked with REACH on previous grants and initiatives.** The RHI is *different.* It is not *grant and go* programming. It is definitely not *business as usual.* The program officers provided an outline of what was expected over the year; guidelines on ways to do the work; information and data to consider in ideation; and many references to research articles. This was done during the initial launch and county-level core teams received electronic copies of all documents.

So what happened? Some team members read, learned and embraced the *new approach.* Others really wanted direct answers; not the struggles of finding their own way. A common theme from the interviews was *"Just tell us what to do."* They neither understood the *why of this new approach* nor wanted to spend the time in process focusing on the targeted year one steps. These teams had expertise and were used to *"doing"* and many were not keen on *"talking."*

Creating Ideas, Innovating

Two of the teams – Allen and Lafayette – were able to begin thinking, creating and innovating. While Allen County had not formed an expanded stakeholder group, they identified needs and programs to meet those needs in ways they had not tried in the past. Originally, Allen County was originally focused on an FQHC application. When that did not fall into place as expected, the team decided to offer a program focused on people in poverty (Circles Campaign) and conduct a county-wide strategic plan. The interest in the Circles Campaign appears to have been strongly influenced by one member of the core team who is a certified trainer in another similar program. The emphasis and desire around doing a strategic plan does not appear to have had a strong voice but perhaps emerged because the Allen County team was up against the

concept/proposal deadlines. One member noted, *"We just threw something together. We knew we had to have a proposal in."*

Lafayette County team created the *Live Well Health and Wellness Community*. *Live Well* is conceived as a system of access points throughout Lafayette County (physically and virtually) where residents can obtain information, education, services and connections for health care as well as other social services. *Live Well* could be seen as *multiple, mini one-stop-shops,* each providing at a minimum, information on *who, what, where,* and *when* for the social and health services available. At maximum, it was a fully-integrated health facility. During the *Ideation/Innovation* phase, HCC entered into agreements to manage two rural health clinics.

The Cass County team was not capable of fully embracing this portion of the planning phase. That is not to say that they did not spend time and effort on brainstorming and thinking about what they wanted to do as a project, program, initiative or, as many referred to it later, *the "It"*. However, they continued to struggle and remained at the initial phase throughout the year. Comments from members (original and those brought in later) reflect their frustration and disappointment,

- *"I wanted to see the outcome and we never did see what we were trying to see. We anticipated the "it" and we never did get there."*
- *"It continues to surprise me. 'We don't work well together. We don't have any successes. … Even when you have resources on the table. That surprised me."*

Concept, Proposal

All three county teams submitted concept papers to REACH after attending the Community of Practice (CoP) gathering in September and presenting what they had done up to that point on RHI. The concept papers from Allen and Lafayette teams mirrored what was mentioned previously (Circles, Strategic Plan, Live Well). Several members of the Cass County core team saw the presentation at the CoP as a *success. "We worked together on a powerpoint for the REACH meeting* [CoP] *and it felt like a big success because we all worked on it.*" And, it was a success for them given the struggles they had been going through for months.

After consultation and revisions, Allen and Lafayette Counties submitted proposals for year two; Cass submitted a proposal which was revised in consultation with program officers for extended planning.

RHI IN THE COUNTIES

Each county-level core team began this learning experiment with, as stated previously, a great deal of *WILL.* They also began from differing levels of capabilities, interest, and knowledge. They brought their past that strongly influenced assumptions, attitudes, expectations, wants, and needs. All of them got stuck at different points in time, and over different matters. Two of the three were able to work things out to move beyond the planning stage.

Each county has a story to tell about the RHI experience thus far. Following are brief essays on each county that hopefully provide more clarity around what they did and did not do; some of the challenges they faced; and, some of the discoveries they made.

Hearing is not listening - RHI Allen County

Thrive Allen County, a grantee of the REACH Healthcare Foundation was contacted in March 2012 and invited to bring a small team of individuals to the NRHA Summit and launch of RHI. Four individuals made up the original planning team. Thrive has been a REACH grantee for nine years and because of this strong relationship was seen as the obvious partner to engage in conversation about RHI.

The RHI discussions held during the NRHA Summit in Denver, Colorado, were viewed as both helpful and not helpful by Allen County participants. On the one hand, some found it refreshing that they were being asked for their opinions and were able to dialogue. As one participant stated, *"The delightful part of this was that REACH didn't have all the magic answers and they really wanted us to help direct the direction we wanted to go. That's been helpful.*" On the other hand, some thought that the time could have been better spent if they had had prior knowledge and worked on a plan instead of dialogue. *"We heard for years about something rural and, then, all of a sudden we were asked to go to Denver. We had no prior knowledge. … if we are going to come up with a plan, why didn't REACH engage with the people* [before]*?"*

Communication issues surrounded RHI Allen County from the very beginning. Confusion about the role of Thrive as the backbone organization in RHI emerged immediately. Messages about Collective Impact, Capacity Building and Network Weaving were perceived to exclude Thrive and were viewed as a lack of acknowledgement by REACH of the expertise existing in Thrive. The intent, according to REACH, was to expand the stakeholder base and allow ideas to emerge rather than have the ideas come from the Thrive organization alone. Since

Thrive had been operating as the primary health related community organization for a number of years in Allen County, the natural course of action placed Thrive in the leading role and others deferring to that leadership. These actions are not necessarily negative, but rather normal.

To further complicate matters, at the time of the RHI launch, the viability of applying for an FQHC was being investigated. Dollars from participating in the RHI were seen as potential funding for the FQHC. **This is what Thrive wanted to pursue but it was not the intent of RHI**. Additionally, Thrive understood that the annual operating grant was being replaced by RHI, and, therefore, Thrive did not apply for an Operating Grant, leaving them with a significant funding gap.

Over the course of the next few months, Thrive and REACH were able to work through much of the tension around clarity, miscommunications and perceptions. Unfortunately, damage had been done and, while RHI Allen County was able to pull it together, submit a concept paper and later a full proposal, the resulting lack of trust remained and clouded the RHI in Allen County.

The original RHI planning team changed after Denver with two leaving the team and two additional individuals joining. **The RHI planning team did not meet again until August 2012**, losing more than three months of time and significant motivation. In fact, it was only when notified of the Community of Practice gathering of the three County RHI core teams to be held in September and the request that each team make a formal presentation on RHI in their County, did the Allen County Team revisit RHI collectively. As a result of that critical time lost in the beginning, the concept paper and proposal were not as thoroughly researched as they could have been had the team been working from April forward. The Allen County team proposed two initiatives: Circles, a national program focused on those in poverty, and developing a county-wide strategic plan.

In October/November 2012, a professional facilitator hired by REACH to work with each County, began working with the Allen County team. As with the other two counties, discussions focused on the chosen initiatives as well as Collective Impact and Capacity Building to meet the ultimate goals of RHI.

Collective Impact, Capacity Building and Network Weaving were major components at the initial meeting and launch of RHI. Documents from the RHI launch in Denver indicate a significant portion of time and energy spent in dialogue and presentations about what the

research currently reveals as best practices in rural communities around health care and systems change. In the case of Allen County, the core team members were experts in their fields; all work in remote rural areas; and, were viewed in their communities as health care leaders. Thus, the nuances and variations between what they have been doing all along – *business as usual* – and the best practices resulting from these particular constructs or approaches (Collective Impact, Capacity Building, Network Weaving) may not have been fully appreciated. **Without the re-occurring conversations immediately following the launch and throughout the summer and fall, Collective Impact, Capacity Building, and Network Weaving were never seriously explored or embraced.**

Up-Down, Back & Forth - RHI Cass County

In the first quarter 2012, REACH contacted Cass County Dental Clinic (the first and only safety-net dental clinic serving Medicaid and low-income and uninsured children and adolescents in Cass County) and a grantee of the REACH Healthcare Foundation. The Cass County Dental Clinic was selected as the potential RHI grantee/collaborator by REACH because of their successful grantee-grantor relationship. A diverse team of five was invited to attend a preliminary informational session on the Rural Health Initiative (RHI) under consideration. This informational session was held in Denver, Colorado during the NRHA Summit.

At the time of the initial discussion on RHI, a Cass County-based organization was being re-organized from its original mission. *Connect*CASS, originally known as *The Community Health Assessment Team, or* CHART was officially formed in 1997. CHART was led by a volunteer Board of Directors and Members from multiple sectors within the County. CHART's work up until that time focused on abstinence education, suicide prevention, preventing child abuse and neglect, and developing a county-wide resource directory. At the time of the RHI dicussions, *Connect*CASS did not have an executive director. However, three of the individuals attending the Denver meeting were involved with *Connect*CASS in Board or Advisory capacities.

After the RHI launch in Denver, this planning team returned to Cass County to begin conversations about what RHI would look like in their County. Around the same time, an executive director was hired for *Connect*CASS. The RHI county-level team engaged with *Connect*CASS to develop an idea that would meet the overall objectives of the RHI.

Unfortunately, the RHI conversation became embroiled in situations with *Connect*CASS that not only limited the ability of the planning team to move forward on RHI, but became a source of conflict for *Connect*CASS. Simultaneously, the recently hired executive director left the position, leaving *Connect*CASS once again without formal leadership. As one team member from Cass County said, *"…at the beginning a very new executive director had a lot of issues with ConnectCASS. Things got ugly."*

The REACH Healthcare Foundation provided extensive resources and help to *Connect*CASS Board of Directors during 2012 to build Board capacity and reconcile perceived challenges and differences that emerged between the goals of *Connect*CASS and RHI. Additionally, REACH provided professional facilitation assistance in September to try to keep the team together and on track in the hope of developing and submitting an RHI proposal in October 2012.

Notes from the September 2012 meeting state the critical issues for the team:

- *"Review and affirm message and script*
- *Address developing a plan for network mapping*
- *Address developing a plan for the intentional recruitment of extended stakeholders*
- *Determine process, information and activities to begin considering relative to increasing access and improving health outcomes e.g. reviewing other models, identifying presenters and content experts, reviewing data, creating an information bank of resources, etc."*

Even though the Cass County team was able to develop and submit a concept paper in fall 2012, it was obvious to the REACH Program Officers that Cass was not in a position to move to Year 2 Implementation Phase. One Core Team member stated in an interview:

> *"*[My] *Assumption was that we were to develop a program, an idea for a pilot program between then* [April] *and the end of the year. When we submitted our concept paper we were asked not to submit* [a full proposal]. *I think this was correct. We were not ready. I was very naïve about the County and Connect*CASS*."*

Irreconcilable differences between some of the *Connect*CASS leaders' perceptions surrounding RHI developed as time went on. Documents from meetings and discussions during this time indicate strong resistance to the idea or concept of a group outside of *Connect*CASS moving forward with a project or initiative. In other words, several saw the RHI as *"competing with Connect*CASS" and as such, *Connect*CASS should receive the funding and be allowed to operate in their *usual way of business*. They did not understand or, perhaps accept, that the very

foundation of the RHI was to **create something new and innovative** outside the confines of existing leadership and organizations.

Notes from the facilitator in November reveal the obstructive and destructive behaviors and actions taking place in Cass County at that point in time:

> *"In train dynamic parlance the "resistance to momentum" slows the velocity of delivering services and product…in this instance progress in building community capacity. Putting more pressure on the front end does create movement but the "resistance" still only allows a small amount through the pipeline.*
>
> *Goal: identify resistance and develop strategies to reduce or eliminate thus allowing progress to flow…velocity to increase.*
>
> *The effort in Cass is to figure out avenues, strategies and methods for the community to benefit from funding that facilitates greater access to health care. The core team is not functioning in a manner that allows this to logically happen and is the major source or resistance to progress.*
>
> *Options – Change the configuration of the committee.*
> *Bring others to the table.*
> *Redefining goals.*
> *Something as simple as a vote and then setting up group norms.*
>
> *I believe the majority of people around the table are interested in figuring out how to invest these dollars. We are giving too much "power" and attention to the issue of "duplication of effort with Connect Cass* [sic]*." Rather than just saying "I can't see the difference," the job is to create a vision for how the dollars can be invested.*

In December 2012, members of the team who had been working on the RHI were each asked to make a commitment to RHI and to continue working on implementation. In January 2013, five individuals stepped forward and made a commitment to continue the RHI work and become the RHI Cass County Core Team[13].

While the Cass County Planning Team started out *"UP"* about the RHI possibilities for their community to identify and *do something different and innovative,* it soon went *"DOWN."* When RHI was brought to *Connect*CASS − an organization in the throes of reorganizing itself and with a new Executive Director − the reality was that the organization, for multiple and varied reasons, was not able to embrace what they could not control. Thus, RHI was seen as a competing force being explicitly funded by REACH and by doing so, undermining the mission and vision of *Connect*CASS.

Much effort and many resources were expended to bridge the differences and perceptions of the *Connect*CASS leadership; and, for a time there was a *"BACK and FORTH"* movement

[13] Since that time, one has resigned and efforts to recruit additional people have garnered one organization with two people alternating.

occurring. This *back and forth* action, in the end, only served to delay decisions about which people were *"IN"* and which were *"OUT."* On an *UP* note, the door was left open (as it always should be in these situations) to *Connect*CASS and to the individuals who decided not to continue participating in RHI planning.

Using Collective Impact and Building Capacity, re-introduced in fall 2012 as cornerstones of *how* to get emerging ideas from a larger base of constituents was neither easily understood nor embraced. Going *forth* even when these constructs were better understood and embraced, at least tentatively, was difficult and challenging.

The resulting RHI Core Team in Cass County consisted of a small group of stakeholders (usually four who regularly attended meetings) who all had full-time, professional jobs (aka not just 40-hours a week), two of the four do not live in Cass County, and three are relatively *new* to the geographic area. All are involved in other "outside of work" activities, such as church, volunteering, Boards, etc. Therefore, there was extremely limited capacity to spend sufficient time in developing as a team; to create messaging around what they were trying to do; to engage others and get more people to join the team; to do the administrative work (meeting preparations, notes, emails, etc.); and, even to attend bi-monthly meetings. To their credit, the RHI Core Team continues despite the many *ups and downs* and *back and forth* actions that have defined their journey.

Being comfortable in the uncomfortable **– RHI Lafayette County**

In early 2012, REACH contacted Health Care Collaborative of Rural Missouri (HCC) located in Lafayette County, Missouri, and invited a small team to attend the NRHA Summit and conversations about RHI. The Lafayette planning team included five individuals from a variety of backgrounds and organizations. HCC was a current REACH grantee and was invited based on that positive relationship.

The HCC has been in existence for approximately 10 years as a rural health care network. Three health care leaders in Lafayette County used a *collective impact process* to create HCC, albeit the process was not labeled "collective impact" at the time. As such, HCC is *grounded* in using stakeholder input, diversity, multiple perspectives, and strategic alignment in their programs and organizationally. This is an extremely important point. Because of this background, issues arising around role ambiguity, RHI intent, and expectations from both REACH and HCC's Board of Directors were immediately addressed and workable solutions

agreed upon. It was the beginning of *getting comfortable with being uncomfortable* for the Lafayette County team.

The planning team met in April after the RHI launch and developed a list of potential stakeholders to invite to a meeting in May. Documents from the May and June 2012 meetings indicate multiple sectors – health care, community, faith-based, social services, and business – were represented. The first expanded stakeholder meeting focused on brainstorming ideas to increase health care access and equity for Lafayette County citizens. The second and third on forming an RHI identity, developing a brand, and creating a marketing *look.* Two leaders were chosen by the expanded stakeholder group in July to head the RHI Lafayette County team. The core team subsequently expanded to include three additional people.

When the Community of Practice (CoP) was announced and each county core team was asked to present their RHI efforts, the Lafayette County team was well prepared. They had used an approach similar to collective impact in which access to health care is dramatically increased for the uninsured and underinsured citizens of Lafayette County. The *Live Well Health and Wellness Community* concept emerged. It included referral *access points* throughout the community where citizens could obtain education, information and services; connecting with the migrant farm worker population to determine their health care needs; and strengthening and diversifying the stakeholder base. The team had created a logo, a tagline, mapped out their strategies, and began working with the professional facilitator, Melissa Ness, provided by REACH by September 2012.

In an interview in 2013, a member of the Lafayette team stated, *"The first assumption was this was going to be another program of REACH. But as we got into it they showed us it was more of a long-term approach to addressing health care in Lafayette County. Now I would also say that, in my opinion looking back, it is the first time that a funding organization came to us and said 'be totally creative.' They came back and reigned us in which is to be expected under any circumstances, but they did tell us to be creative. It was the first time a funder took a leap at trying to really understand the differences in health care for rural and urban and they attempted to understand it."*

When the Lafayette County team submitted their *"Live Well Health and Wellness Community"* concept paper, the budget was approximately $350,000 for implementation. The team was notified by REACH that the budget needed to be significantly reduced. While the

resulting proposal still outlined the *Live Well* concept and the RHI team was committed to its implementation, funding was primarily focused on providing dental care for children on Medicaid or uninsured.

What resulted was a *disconnect* for the Lafayette team. They had performed; done what was asked; and brought together a community of diverse stakeholders to *create.* The group created *Live Well* - an idea which was innovative, bold and new. While providing dental care to children on Medicaid or uninsured was on the *Live Well* list of important services the community needed, it was a *traditional, usual approach.* The *disconnect* resulted in other consequences too. The team began to second-guess its processes and innovative thinking. They began to question what was *"really meant"* and to "*read between the lines"* in verbal and written communications from REACH. There was some hesitancy that did not exist before. This was also when they lost touch with their expanded stakeholder group. The Lafayette team again was learning to *be comfortable in the uncomfortable*.

Lafayette County had a lot of strengths going into RHI – a backbone organization familiar with the approaches of Collective Impact and Capacity Building; addressing issues and seeking solutions; a diverse, committed group of core team members and expanded stakeholders willing to put in time and energy; and, additional resources (funds, consultants) that helped them through the planning phase of RHI. This team made amazing progress over eight months. HCC *stepped back* from the leadership role but did not abandon the team; clarifying and assisting when necessary.

RHI at REACH

It was not just the county-level teams that had their share of *ups and downs*, *hearing but not listening*, or opportunities to *get comfortable with being uncomfortable*. RHI requires that program officers act and do in very different ways than in the past. A few sample comments from program officers reveal their own expectations and that, they too, were learning:

> *"I thought it would be much easier. Assumptions were that it would be quick and painless and we could go. I know it was a three-year project and sustainability was in there, but I thought it would be easier."*
>
> *"I think we thought it wouldn't be as drama-filled as it was."*
>
> "*We needed more help. We all have good intentions; but we get swallowed up in our lives and it is hard to take this much time …."*

While the program officers are experienced in REACH work and engaged with multiple grantees and programs, **the conceptual framework for RHI** (Collective Impact, Network Weaving, and Capacity Building) **demands that the funders set aside technical solutions, getting individual programs to fix problems, and refrain from assuming all the answers are even known.** In fact, REACH has a reputation for exacting specificity from their grantees. Therefore, in one way it was the **perfect** organization to launch this learning experiment – for themselves and the rural communities they serve.

As one program officer stated,

> *"This is a new way of engaging our rural communities. It is the most useful way in terms of understanding these communities that we could have found. For eight years we have invested in these rural communities and never understood the complexity of working there. Instead, we have been very traditional, hands-off investment. It was not changing anything in these communities. Because we don't have a lot of money, we have to be better at using it. ... This is a deeper level of engagement in the program people. We have learned more in 18 months than in eight years. We felt stressed because of the level of engagement and as a team we had no experience in that."*

LESSONS LEARNED

It would be easy to give the counties a *grade* on how they performed or what they accomplished. Perhaps easier still to compare and judge their performances against each other. But those approaches would be unfair and discount the conceptual framework upon which RHI rests. It is **hard work**, **takes long hours**, and **puts people in situations that challenge them intellectually and emotionally**. One team member stated, *"One of the challenges for this initiative is that there are a lot of expectations and a lot of pressure to succeed. Whether we put it on ourselves or not, it is a big deal."*

As can be seen from this report (and other documents throughout the planning phase) the three counties are very different. Some have more resources than others. Some have strong support from a backbone organization. The people that comprise the teams are different in their backgrounds, experiences, time availability, leadership and management qualities, and levels of comfort with ambiguity and trying new approaches.

What can be learned from RHI Year One includes the following:

- **Strong backbone organizations are critical**. Their ability and willingness to become *immersed* in a learning experiment such as RHI is also critical. They must relinquish control and trust the process. They must be willing to understand that others see things differently, and be able to listen to all without judgment. Strong

backbone organizations have connections and those connections have other connections. They must fully engage and work the connections for the benefit of all citizens.

- **A comprehensive assessment of where the teams (organizations and individuals) are in relationship to the approaches to be used is necessary, and should be done at the beginning**. For RHI it was collective impact, network weaving and capacity building. It would have benefitted everyone to have had a solid sense of what each county had done in these areas, what they were capable of doing, what they wanted to do, and what they did not know.
- **Technical assistance should be ready and offered in the beginning,** immediately following assessments.
- **Timing of the process steps and resources are important.** As evidenced by the lack of use for Network Weaving, this valuable resource may have been offered at the incorrect time. Also, the lack of professional facilitation from the beginning may indicate that timing for this resource was later than it should have been.
- **Evaluation should be set in place before the plan/initiative is launched**. There is always the problem with people not recalling events and it is best to capture the data and information as something is happening and tie it into a reflective piece.
- **Multiple learning modalities need to be used** to help all team members understand at a *deep level* how experiments such as RHI work, what is required (time, creativity, etc.), how to apply their new knowledge, and what similar experiments have discovered. An understanding and appreciation of learning modalities and how to effectively communicate to reach all is needed. It is not enough to *tell* and expect results.
- **Clarity of expectations** using definitive language, e.g., *progress means X, expanded stakeholder group means Y.*
- **Effective communication** requires repetition (people need to hear something 5-7 times to remember it) and explanations that provide unambiguous examples that people can relate to in their specific situation.
- **Regular follow-up**, preferably at least once a month, to keep people motivated, engaged, and to head-off any significant issues. Preferably, this would be done by the Program Officers so that they remain "in the loop" throughout.
- **Provide distinct points along the journey for people** to back-up, reassess, go a different direction, or stop completely in a manner that recognizes and applauds the efforts thus far, and is not seen or depicted as failure.
- **Be cognizant of the power inequity** that exists between a funder and a grantee and build relationships to lessen its impact. Be able to say it, talk about it, and tell how you feel about it. Seek to have honest, frank conversations.
- **Align resources to the experiment's goals**. People pay attention to where the dollars are to be spent and can easily lose the big picture view.
- **This work requires long-term vision.** Understand and support the fact that this is a long journey and requires much more time and resources than a traditional program grant process for the Foundation and for the grantees. This cannot be stressed enough.

METHODOLOGY

This retrospective look at RHI Year One began in earnest in late January 2013. At that time, the Technical Assistance Team (TA Team) was formally engaged, contracts signed, and the county-level team proposals had been reviewed and approved for Year Two. However, I was aware of RHI before then. As an evaluation consultant for HCC (Lafayette County), I was asked to participate in the RHI expanded stakeholder group meetings and, later, to be on their core team. As such, I attended the Community of Practice meeting as part of the Lafayette core team in September 2012. Thus, I had at least one perspective of what was being attempted with the RHI.

Beginning in fall 2012 and continuing throughout the first half of 2013, I read articles and attended webinars on collective impact, building capacity, network weaving, technical and adaptive problems and solutions as well as community and systems change. While some of these concepts were familiar, refreshed knowledge was necessary. In the case of network weaving and collective impact, major study was required. Discussions during the TA Team calls and meetings as well as one-on-one conversations also enhanced my depth and breadth of understanding of what REACH was trying to achieve and what pushed the need for innovation and systems change in the rural communities. In other words, I needed to be as knowledgeable as possible about the foundational constructs and concepts being used in RHI in order to properly and accurately *tell the RHI story.*

During the first quarter of 2013, I began meeting with the county-level core teams on a monthly basis, along with other TA Team members. At first, my role was to listen, begin to build relationships, and to understand where each team was going, and what struggles they were having. I also conducted a review of documents made available from the facilitator, teams, and REACH, the approved proposals and budgets, and met with TA Team members when I had questions.

In February, I began constructing a set of questions for face-to-face, individual interviews with members of each of the county-level core teams to elicit reflections on RHI Year One. The questions were vetted by the TA Team. I conducted thirteen interviews over the course of two months. The interviews were audio recorded, partially transcribed, and analyzed for themes. Looking specifically for similarities, differences, and clues as to *why* certain things happened

here and not there as well as major obstacles or counter-productive items to provide a picture of the efforts expended for and in each county.

As the weeks and months progressed, I continued to meet monthly with the county-level teams. My role became more active as they defined and refined their initiative/program/idea, I helped clarify expectations and sought to help them understand outcomes, metrics, benchmarks, and measures for Year Two. Simultaneously, I was thinking about Year One and trying to keep the boundaries between the two years clear.

Also during this time, the RHI Theory of Change was being developed by the TA Team and the county-level teams were being asked for reactions to it. It was during these discussions that the enormity of what was known and not known became clear to me. At that point, I began writing this report, taking it beyond *what was said* to *what happened and possibly why it happened.* The time to think, study, and reflect upon what I was learning as the evaluator and part of the TA Team as well as what I heard from others was critical to understanding how very difficult this work is for everyone involved. Creating the capacity to change is multi-level and synergistic. It requires a depth of understanding that only a couple of people had in Year One.

This report is only the *first chapter* of the story. What has transpired thus far in Year Two tells more of the story for each county, REACH and the TA Team.