REACH Foundation's Rural Health Initiative: Year Three Report (CY2014)

Creating Systemic Change in Rural Communities

Adena Klem, Ph.D.
Founder, Klem Consulting

June Holley
Founder, Network Weaver Ltd

6/1/2015

Table of Contents

I. INTRODUCTION 1
II. BACKGROUND 5
III. RURAL HEALTH INITIATIVE DESIGN 6
IV. EVALUATION DESIGN 7
V. THEORY OF CHANGE DEVELOPMENT 8
VI. OVERVIEW OF RHI ACTIVITIES 14
VII. EVALUATION FINDINGS FOR IMPLEMENTATION YEAR 2 29
VIII. LESSONS LEARNED 43
IX. CONCLUSION 54
X. REFERENCES 56
Appendix 1: 2011 Demographics of Counties 57
Appendix 2: Sample Network Maps 58
Appendix 3: Early Outcome Checklist and Explanation 76
Appendix 4: Network Culture Assessment 81

This evaluation report was funded by the REACH Healthcare Foundation.

Recommended Citation: Klem, A.M. and Holley, J. (2015). *REACH Healthcare Foundation's Rural Health Initiative: Creating Systemic Change in Rural Communities*. Olathe, KS: REACH Healthcare Foundation.

I. INTRODUCTION

What Does It Take To Create Meaningful Change In Health Care Access In Rural Communities?

There are nearly 50 million people living in rural America. Historically, rural communities have experienced issues related to access to care, recruitment and retention of health care providers and seen hospitals and other health care providers located in more isolated communities struggle with economic viability. Although 20 percent of Americans live in rural communities, less than 10 percent of the country's physicians practice in those areas. Poverty and lack of insurance also impede consistent and comprehensive access to medical care in rural communities. Nearly one-quarter of all adults in rural communities are uninsured, and nearly 60 percent of the rural uninsured come from families with a low income, defined as 200 percent of the federal poverty level or less. Furthermore, lack of money, time, or both often prevent residents from traveling to the urban medical centers that offer the services they need (Commonwealth Fund, 2009; Rural Health Research and Policy Center, 2009).

Some innovative strategies for supporting health in rural communities have been explored including but not limited to:

- telemedicine, case-based learning, and disease management techniques to guide rural community providers in applying best practices;
- various uses of videoconferencing (e.g., mentor and train nurse practitioners to perform video procedures while a doctor watches in live time); and
- use of extension services to bring evidence-based care to rural practices and/or to support health education and prevention programs (The Commonwealth Fund, 2009).

Taking a different, yet still innovative, approach to creating change has been to explore opportunities to build capacity of community members to advocate and act in the rural policy arena such as the Kellogg Foundation's "Rural People, Rural Policy Initiative." This multi-year Initiative uses a systems approach to community change by energizing and equipping networks of organizations to shape policy that improves the lives of rural people and the vitality of rural communities (The Kellogg Foundation, 2008). Rather than focusing on alleviating symptoms, such as economic decline or a thin infrastructure, the systems change approach seeks to address the underlying factors that cause the symptoms or keep the symptoms from being addressed.

Taking a systems change approach means looking at all the factors impacting access to health care – including policies, routines, relationships, resources, power structures, and values – and thinking of them as an interacting whole. When local communities take a systems change approach they identify where the leverage points are to create change and then mobilize the community across organizational, geographic, and role boundaries to address those leverage points in innovative ways.

However, a systems change approach is much more effective when it is combined with a network building approach. Network building has three different aspects, shown in Figure 1 below:

1. A values and skills shift

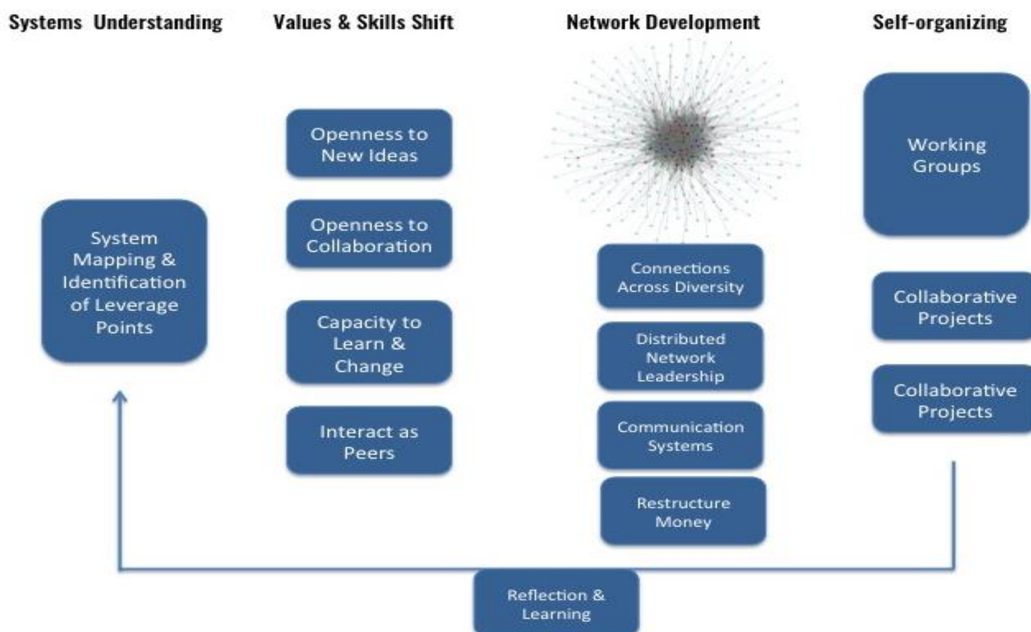
   For networks to be effective, people need to work together in new ways. This requires new values and behaviors, such as openness, peerness, appreciation of diversity, increased capacity to learn and change, and being comfortable with uncertainty and open to collaboration. It also requires the development of new skills such as those needed to work collaboratively, reflect on experience, and build relationships of trust.

2. Network development
   - Connecting people across differences and divides
   - Developing distributed and widespread leadership so that change happens in many different venues
   - Setting up communications systems so that people throughout the community
   - Restructuring money to support innovation and collaboration

3. Self-organizing

   Self-organizing is the capacity of many people to take initiative and collaborate on innovative projects to make change. Often networks create working groups to focus on leverage points in the system. A series of experimental, innovative, collaborative projects emerge from the working groups to begin to shift the system.

Figure 1. Elements needed for Effective Systems Change



Systems change is particularly challenging in rural communities where poverty is generational and fewer assets are available to lead the charge for change. There are also fewer evidence-based improvement strategies that have been documented in rural communities. Despite these drawbacks, a systems approach has the potential to create the long-term meaningful changes necessary to influence health outcomes that have been stagnant for decades.

This report presents one such Initiative that is focused on clearly documenting an approach tailored for and implemented in rural communities. The Rural Health Initiative (RHI) was developed by the REACH Healthcare Foundation in March 2012 and is now entering its third year of implementation in 2015, following an initial planning period. At the outset, REACH Foundation staff and key local rural partners committed to work together to identify innovative strategies for creating meaningful improvements in the health outcomes of their rural communities. Though these stakeholders recognized that they were trying something new, they did not yet know what it would take to implement Network-Based Systems Change in their rural communities, nor was it even defined that way in the beginning. As implementation progressed and new skill sets developed among members of the rural counties, Initiative needs – and associated technical assistance provided by the Foundation – shifted in response to these new learnings. This report attempts to capture this developmental evolution in learning. The report opens with a presentation of the basic components of RHI, chronicles annual activities, and presents the theory of change driving the planning and evaluation of the Initiative. Next, early lessons learned and recommendations for next steps are shared. Box 1 on page 4 presents some of these early learnings from the first two years of RHI Implementation – learnings that will be returned to throughout the report.

BOX 1
EARLY LEARNINGS FROM THE RURAL HEALTH INITIATIVE

1. **Network-Based Systems level change requires a focus on changing a culture** – which means changing well-ingrained behaviors of community members – and not just the organizations that make up the system. A key aspect of culture that needs to shift is the style of leadership, which needs to transition from a hierarchical to a peer leadership model. Peer leadership helps connect people, supports self-organizing and learning, encourages openness to innovation and collaboration, and builds everyone's capacity to learn and improve.

2. **An anchor institution – such as a Foundation– can provide the external influence necessary to begin the change process**. An outside entity can help a community create urgency, express clear expectations, and provide needed resources. At the same time, foundations also need to be flexible in how they do business or risk undermining the initiative.

3. To mobilize sufficient energy to generate systems change requires the **development of a network with a core of well-connected people and a periphery of less well-developed ties to experts, resources and other communities to bring in new ideas**. This network needs to generate multiple collaborative actions involving people from different parts of the network (e.g., crossing systems perspectives such as health and education). To support systems and culture change and network development also requires a different kind of technical support: introduction to new ideas and concepts and ongoing coaching to support new approaches and peer learning are key. However a Technical Assistance Team needs to be aligned around the new concepts and strategies so that a consistent message is shared.

4. Changing behavior requires **regular and clear communication with a shared language** that is meaningful to all participants. Language can both clarify and obfuscate – a shared language can help to compare innovations across communities but can also make the innovation less accessible to community members.

5. Networks in the throes of innovation need the **space in which to make mistakes, learn what they need to learn, and have time to grow the trust necessary** for meaningful improvement to occur. However, too much time on process can stop forward momentum in its tracks. It is imperative to find the right balance between time to build capacity while simultaneously implementing a change strategy that makes a visible difference.

II. BACKGROUND

The REACH Foundation established the Rural Health Initiative (RHI) in March 2012 in order to identify innovative strategies that dramatically improve access to health care services and reduce health inequities in three rural counties that are part of the Foundation's service area: Cass and Lafayette Counties in Missouri and Allen County in Kansas. The goal of the Initiative was to develop a systematic and coordinated approach to community change that would increase the odds of successfully breaking through the persistent barriers to healthcare access for the rural poor and medically unserved and underserved in these counties.

Prior to the launch of RHI, the 2011 County Health Rankings for REACH's three rural counties indicated several unique barriers to access. For instance, the ratio of population to primary care physicians in the three counties was near or above 3000:1 (Mid-America Regional Council (MARC), 2011) which was significantly higher than the national rate of 631:1. Accessing a mental health or oral health provider was even more limited and relied to some extent on tele-health as well as school-based services for children. The one county with a community mental health center – Allen County, KS – tended to focus on crisis intervention rather than prevention due to a small staff.

Additional barriers to health care in the three counties included high rates of poverty and fewer residents with health care coverage. In 2010, MARC estimated that approximately 15-16% of the population in these three counties was uninsured and that more than one-third of the population was persons living at or below the 200% poverty line. Furthermore, poverty rates had increased by more than 40% in one of the three counties and moderately increased in a second county. The federal agency Health Resources and Services Administration (HRSA) has designated Allen, KS and Lafayette, MO as Primary Care Health Professional Shortage Areas with a medically underserved population. Having a usual primary care provider is associated with higher likelihood of appropriate care, and a usual source of care is associated with better health outcomes. In 2010, 86% of Americans had a usual health source of care but those with low incomes were less likely to than those with higher incomes and the uninsured were twice as likely as the insured to lack a usual care source (Clancy, Munier, and Brady, 2012).

These disparities in health care access and coverage have led to significant inequalities in health outcomes of residents in these rural communities. Compared to national rates, the three rural counties had higher rates of preventable hospital stays, and lower rates of diabetic and mammography screening. When compared to national rates, persons living in REACH's rural counties died more frequently from chronic and/or preventable conditions such as colon cancer, coronary heart disease, lung cancer, vehicle injury and stroke. Life expectancy was lower than the national average in two of three rural counties. County health rankings indicated that each of the rural counties exceeded the national benchmark in premature death; in fact, Allen County, KS exceeded the national benchmark by more than 200% (MARC, 2011). See Appendix 1 for an overview of each county's demographics in 2011.

Despite almost a decade of investment in these counties, REACH could see no meaningful improvements in health access and outcomes. After taking a hard look at these findings, REACH concluded that there was a need for a different approach to investing in rural health. The idea for the Rural Health Initiative emerged from these discussions.

To develop such an approach, the Foundation reached out to partner with known organizations within the three rural counties. Together with these community partners, REACH aimed to create innovative and meaningful community strategies for improving the three county health systems with the ultimate goal of improving health outcomes and reducing disparities in those outcomes for residents of those communities, particularly those living in poverty.

III. RURAL HEALTH INITIATIVE DESIGN

To create the original design of the Rural Health Initiative (RHI), REACH started by investigating best practices for supporting rural health, systems change, community impact, and rural grant making and then melded those best practices together to create a process framework to orient early thinking. The hope was that through a set of guiding principles and suggested best practices for creating community change, the leadership teams in each community would take the opportunity to create innovative solutions.

These guiding principles of RHI included:

1. Sharing and promoting a bold vision of dramatically improving access to health care.
2. Engaging strong leaders from a range of sectors to come together to ask hard questions about new approaches.
3. Rejecting the status quo so that the Initiative did more than tinker around the edges but crafted a systemic approach to community-wide change.
4. Being entrepreneurial in spirit and approach; avoiding business as usual; seeking ways to innovate and be flexible with regard to solutions, strategies, and investments.
5. Promoting and fostering cooperation and collaboration.

The best practices were culled from a thorough review of the literature on systems/community change and health care innovation and included:

- Collective impact: cross-sector coordination focused on a specific large-scale social problem that requires five conditions for success - a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and a backbone support organization.

- Network weaving or a network approach: a strategy to create the capacity for continual innovation and action, accomplished by building a network of people interested in a common area (for RHI, it was about increasing access to health), developing the culture,

skills and systems to encourage many people to initiate collaborative action, and spending time on tracking, deep reflection and learning to allow communities to transform the landscape of their community.

- Capacity building: 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. Communities can build their capacity by developing commitment to the vision along with the necessary resources and skills for success.

An advisory team consisting of national and local experts in these guiding principles and practices was created with the intent of providing advice and helping to guide the Initiative over time.

Additional detail about the early components of RHI can be found in the Year 2 evaluation report available from the REACH Foundation.

IV. EVALUATION DESIGN

Evaluating community change initiatives as complex as RHI requires an approach that helps stakeholders clarify how the components of the initiative will ultimately lead to the desired goals. At the same time, because RHI is designed to enhance innovation and evolve quickly in response to new learnings, it requires an evaluation strategy more flexible than traditional evaluations. In response to these demands, the RHI evaluation design shifted in 2014 to combine two complementary approaches: theory of change and developmental evaluation.

A. Theory of Change

A theory of change is particularly effective as a tool for developing solutions to complex social problems. It provides stakeholders with a specific and measurable description of their community change initiative that forms the basis for strategic planning, on-going decision-making and evaluation. A basic Theory of Change explains how a group of early and intermediate accomplishments sets the stage for producing long-range results. The theory of change process then helps stakeholders articulate the assumptions that explain both the connections between early, intermediate and long term outcomes and the expectations about how and why proposed interventions will bring them about.

A graphical representation of the long-term outcomes and their preconditions is created to represent the pathway of change. The pathway of change shows how the intervention activities are tied to each outcome so it is clear what needs to occur to ensure that the long-term outcomes are ultimately obtained. In this way, a Theory of Change helps initiative stakeholders create an honest picture of the steps required to reach their long-term goal(s). The process also provides an opportunity for stakeholders to assess what they can influence,

what impact they can have, and whether it is realistic to expect to reach their goal with the time and resources they have available.

As will be discussed in greater detail below, the stakeholders of the Rural Health Initiative worked with the RHI evaluator to create an overarching theory of change for the Initiative. As with any good theory of change, this theory continues to evolve as the RHI stakeholders learn more about what it takes to create meaningful change and those changes are integrated into the evaluation.

B. Developmental Approach to Evaluation

Because RHI is operating in a dynamic and novel environment with complex interactions, a traditional program evaluation design cannot capture the shifts in thinking – and, in turn, shifts in implementation strategies – that can occur with new learning. Developmental evaluations are used in these circumstance because they recognize that innovation occurs in complex and uncertain environments and an important role of the evaluation is to facilitate real-time, or as close to real-time as possible, feedback to stakeholders thus facilitating a continuous feedback loop (Patton, 2010). Measures and tracking mechanisms are developed quickly as new outcomes emerge; and data is shared in a user-friendly format. In this way, the evaluation ensures that stakeholders learn enough to get to impact. The long-term goal of the Initiative is still to improve health outcomes and reduce inequities in these outcomes but the main intent of the evaluation is to ensure that data is collected and shared in a way that supports strategic learning, thus increasing the likelihood that the Initiative will implement innovative strategies that are more likely to lead to meaningful community change.

When RHI was kicked off in 2012 the implementation plan was based on best practices and literature. As RHI implementation began and stakeholders could see how the process was unfolding in the communities, the RHI implementation framework evolved to better meet the needs of the rural communities. The goal of the evaluation is to capture this learning cycle. Essentially, the evaluation uses theory of change to guide data collection and help stakeholders clarify the WHAT of the Initiative. Then this data is shared in a continuous feedback loop to make mid-course corrections in implementation interventions as needed.

V. THEORY OF CHANGE DEVELOPMENT

As mentioned above, stakeholders' understanding of what needs to happen to create change – and particularly to innovate – in rural communities has evolved dramatically over the course of the Initiative which can be seen in the changing versions of the RHI theory of change. Prior to beginning the Initiative, Foundation staff spent a great deal of time examining best practices in community change, community organizing, collective impact, and rural change efforts. The proposed RHI structures included key elements from the Collective Impact philosophy, Social Networks, Community Change, and Capacity Building literature. During the first year of implementation, an initial draft of the RHI Theory of Change was developed to try to capture

these components being implemented. This draft describes how improvements in health outcomes will occur as a result of a focus on collective impact, capacity building, and community engagement in conjunction with the implementation of a specific health intervention (see Figure 2 on page 10).

At the end of Implementation Year One, an evaluation consultant specializing in theory of change was brought in to revisit the theory of change and revise it to represent the latest learnings and experiences of RHI participants. With input from the TA team and Foundation Staff, the evaluation consultant developed the current RHI Theory of Change (see Figure 3 on page 11).

Revising the RHI theory of change involved meetings with the TA Team and Foundation Staff to surface underlying assumptions about what supports were necessary to lead to meaningful change in rural health systems. These conversations helped bring a greater clarity around what RHI is and is not and what needs to happen for implementation to occur. Working backward from what RHI strives to accomplish, the long-term goals of RHI are to improve health outcomes and reduce disparities in those outcomes within the RHI rural communities. For those long-term goals to improve, the intermediate outcomes – or the health systems outcomes – must improve which means increasing access to health services, improving quality of care, and better coordination among services as well as better utilization of services by consumers. For these intermediate outcomes to improve, the health care system itself needs to be streamlined and more effective including, but not limited to: medical homes, clear navigation resources, outreach and education, common referral systems and warm handoffs among service providers, common data systems, tele-health and other place-based strategies, and so on. And for the health system to be more effective, the community must build the capacity and conditions for this kind of meaningful change to occur by:

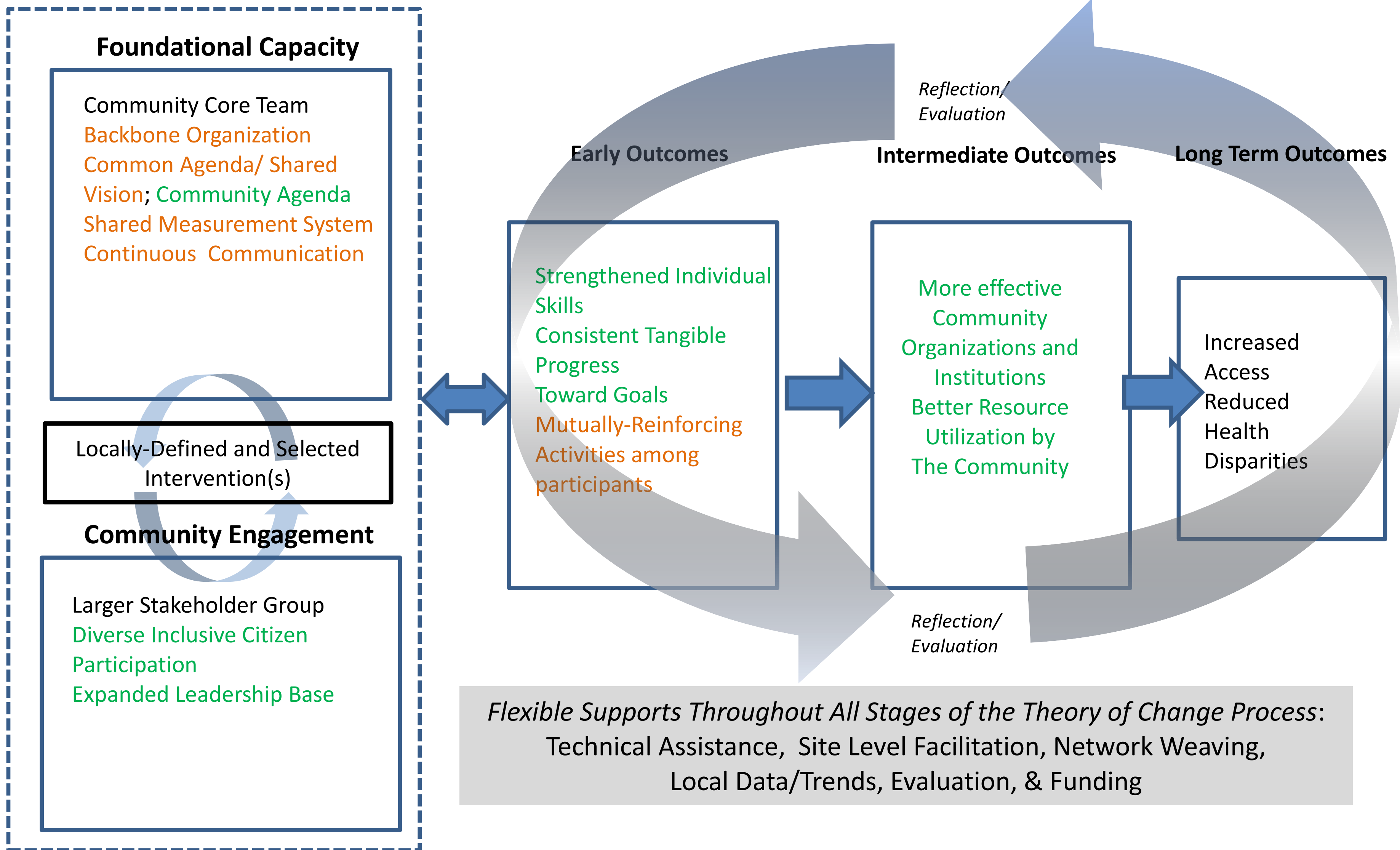
Theory of Change Process

There is now an increased understanding of what we are trying to achieve. We have narrowed and focused and looked at how the strategies lead to the outcomes. That clarity has helped sites understand [RHI] better and feel like it is more manageable. [It's] not so overwhelming; now it feels like the [sites] can do it.

REACH Program Officer

- creating structures such as a core leadership team and workgroups where the work of change can occur;
- establishing processes for developing new skills, growing new leaders; establishing more effective measurement and communication strategies; and
- expanding stakeholders for more diverse and inclusive community engagement.

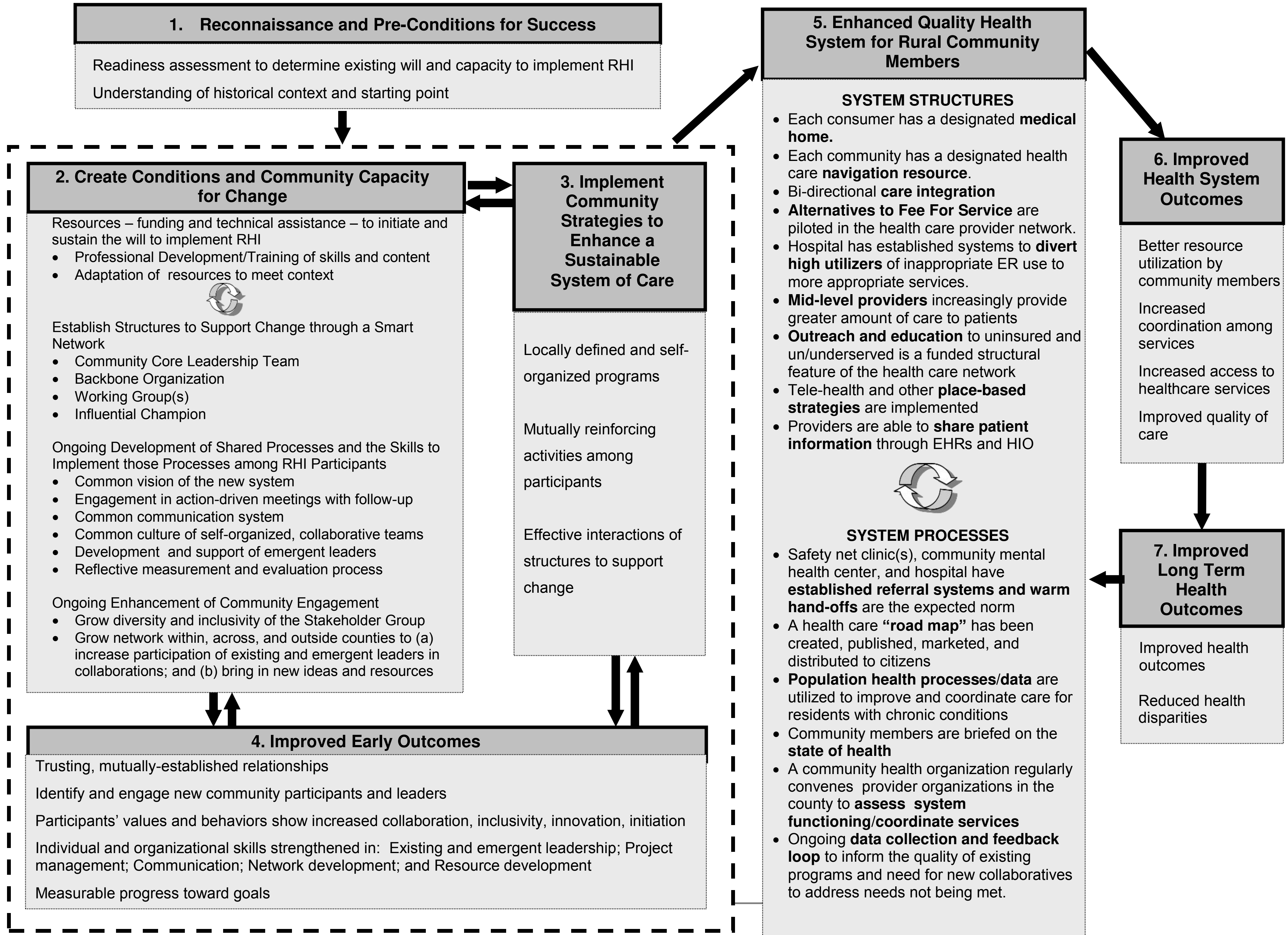
Figure 2. Rural Health Initiative – Draft Theory of Change Version Feb. 15, 2013



Flexible Supports Throughout All Stages of the Theory of Change Process:
Technical Assistance, Site Level Facilitation, Network Weaving,
Local Data/Trends, Evaluation, & Funding

Orange font = Collective Impact conditions that support change (Kania and Kramer, 2011)
Green font = Capacity Building outcomes that can be used to monitor change (Aspen Institute, 1996)

Figure 3. Rural Health Initiative – Draft Theory of Change Version August 14, 2014



Finally, the community can use a health-related intervention as the platform upon which to build these conditions, structures, and processes. An intervention also provides some early wins for the Initiative that serves to increase enthusiasm for and engagement in the Initiative.

As this Theory of Change evolved, the TA Team members acknowledged a lack of understanding and clarity around some of the concepts – particularly concepts related to the network approach. Another interesting challenge was defining what should be included in an ideal rural health care system. This component of the revised theory of change went through several iterations in response to new learnings in the field as well as experiences of county participants. Finally, there was also a recognition that certain resources, structures and processes seemed to be more necessary than others for sites to experience success in implementing their interventions. In fact, the Foundation's decision to focus 2014 technical assistance on network development and leadership development came out of this Theory of Change work. According to the REACH program officers for RHI:

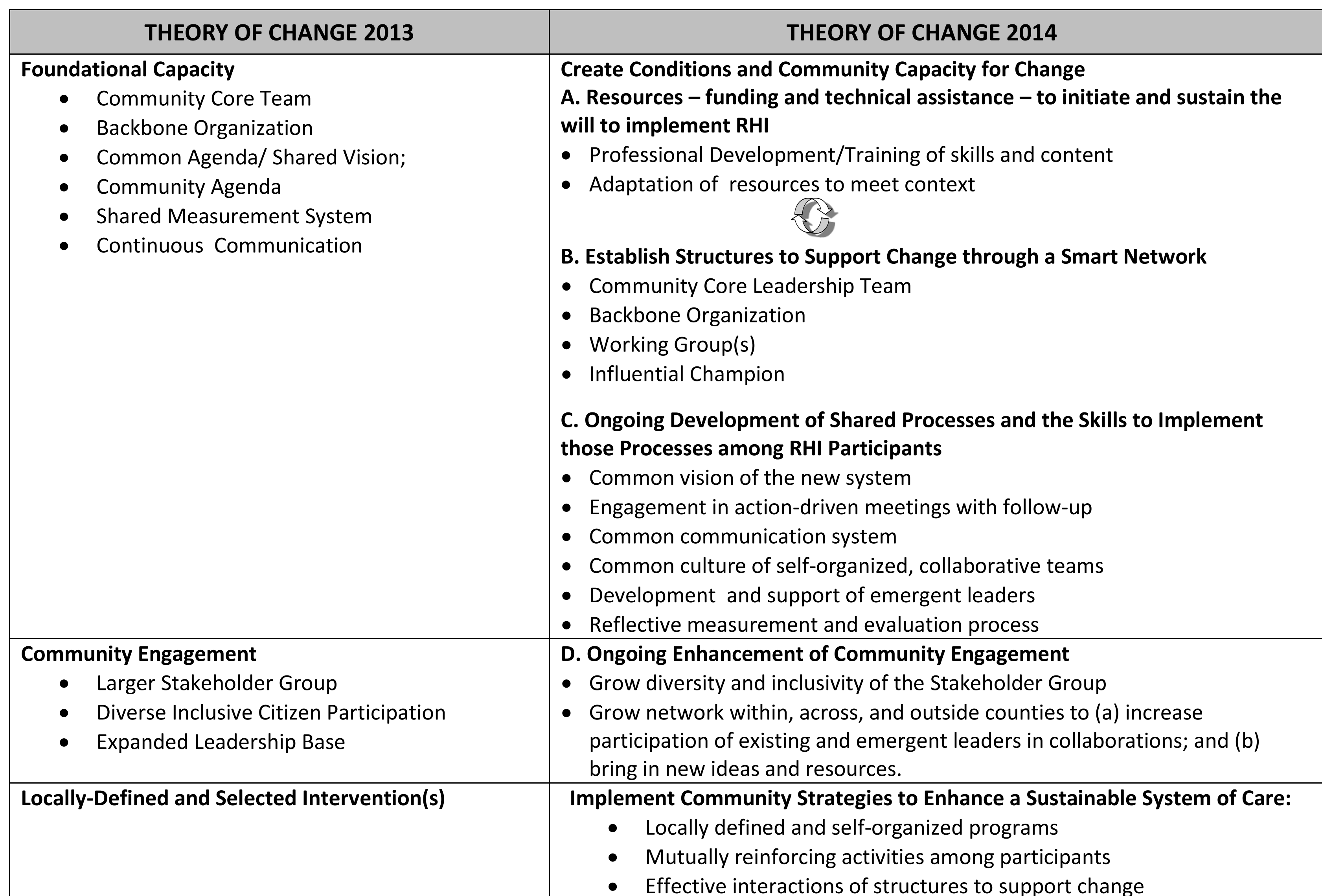
> *"There is now an increased understanding of what we are trying to achieve. We have narrowed and focused and looked at how the strategies lead to the outcomes. That clarity has helped sites understand [RHI] better and feel like it is more manageable. [It's] not so overwhelming; now it feels like the [sites] can do it."*
>
> *REACH Program Officer*

> *"[Theory of Change] provides a page off of which to work. It is a road map. It provides distinction and clarity….[we] increase access through network and leadership development."*
>
> *REACH Program Officer*

See Table 1 on page 13 for a comparison of how REACH Staff and the TA Team brought greater clarity to the main components of what RHI is and what supports are needed to implement RHI. This second iteration of the Theory of Change represented not only a fine-tuning of the RHI vision but an opportunity to clarify and further define its components. At the outset of the Initiative, the actual content of RHI was intentionally amorphous with the goal of putting some structures into place and then letting the communities innovate. This caused some frustration among the county participants with regard to what the Foundation's expectations really were. A common refrain from the sites was "just tell us what to do and we'll do it." However, RHI was a groundbreaking Initiative and the Foundation staff were learning alongside the county participants so they were not willing to be that prescriptive.

Once the Foundation and TA Team developed their version of the RHI Theory of Change at the initiative level, the evaluation consultant began to work with the counties to develop their own versions of the RHI theory of change at the local level. This work involved helping them to think through how the REACH version of the RHI theory of change needed to be adapted to more fully represent the unique county complexities. These county-level theories of change are still under development.

Table 1. Comparison of Supports Necessary to Create Change



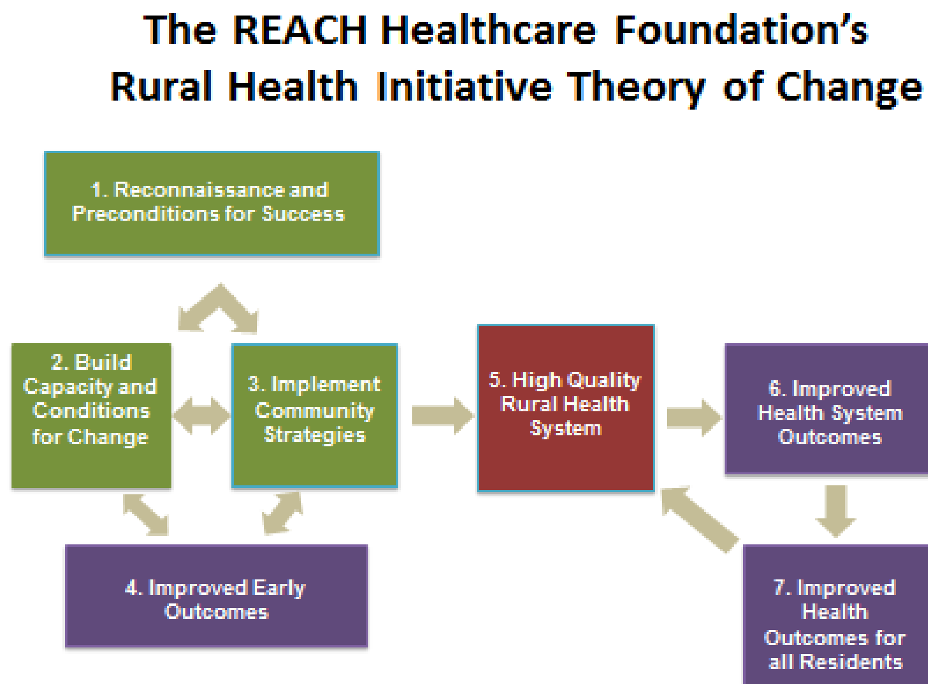
THEORY OF CHANGE 2013	THEORY OF CHANGE 2014
Foundational Capacity • Community Core Team • Backbone Organization • Common Agenda/ Shared Vision; • Community Agenda • Shared Measurement System • Continuous Communication	**Create Conditions and Community Capacity for Change** **A. Resources – funding and technical assistance – to initiate and sustain the will to implement RHI** • Professional Development/Training of skills and content • Adaptation of resources to meet context **B. Establish Structures to Support Change through a Smart Network** • Community Core Leadership Team • Backbone Organization • Working Group(s) • Influential Champion **C. Ongoing Development of Shared Processes and the Skills to Implement those Processes among RHI Participants** • Common vision of the new system • Engagement in action-driven meetings with follow-up • Common communication system • Common culture of self-organized, collaborative teams • Development and support of emergent leaders • Reflective measurement and evaluation process
Community Engagement • Larger Stakeholder Group • Diverse Inclusive Citizen Participation • Expanded Leadership Base	**D. Ongoing Enhancement of Community Engagement** • Grow diversity and inclusivity of the Stakeholder Group • Grow network within, across, and outside counties to (a) increase participation of existing and emergent leaders in collaborations; and (b) bring in new ideas and resources.
Locally-Defined and Selected Intervention(s)	**Implement Community Strategies to Enhance a Sustainable System of Care:** • Locally defined and self-organized programs • Mutually reinforcing activities among participants • Effective interactions of structures to support change

VI. OVERVIEW OF RHI ACTIVITIES

The RHI activities presented in this section of the report represent Boxes 2 and 3 from the latest iteration of the Theory of Change (see Figure 3, page 11):

- **Theory of Change Box 2** focuses on the activities of the Foundation and County Stakeholders designed to build capacity and conditions for change. This included the resources provided by the Foundation (both grant monies and technical assistance provided), structures put into place in the counties, community engagement strategies implemented, as well as skills and processes developed by county stakeholder to support implementation of RHI.
- **Theory of Change Box 3** focuses on the specific community strategies that each county implemented as part of RHI.

Figure 3 is shown in a simplified version below:



Activities are presented first for the planning year (CY2012) followed by Implementation Years 1 and 2 (CY 2013 and 2014, respectively). Within each year, specific activities and resources (including grant monies and technical assistance) are described.

A. The Planning Period: April – December 2012

RHI Timeline

Planning Period
April - December 2012

Year 1 Implementation
January – December 2013

Year 2 Implementation
January – December 2014

In 2012 the REACH Board invested $70,000 in a 9-month planning phase ($4,000 planning grants to each county, $30,000 to bring all of the key participants to a kick off meeting, and $28,000 to begin building the capacity of the three core leadership teams and Foundation staff). Three partner organizations from the targeted rural counties were identified for the Initiative – Health Care Collaborative of Rural Missouri (HCC) in Lafayette, Thrive Allen County, and Connect Cass – due to the strength of prior relationships with REACH.

These grantees were invited to bring their best "thinkers" to join Foundation staff for a meeting at the 2012 National Rural Health Association conference in Denver, CO. This session kicked off the planning year of the Initiative. The planning year was designed to provide time for the Foundation and county partners to conceptualize and collaborate with national, regional and local experts to develop a meaningful and thoughtful design for investment in healthcare system realignment, connectivity, and innovation in the rural counties. Each county organization received their planning grant and was asked to submit a full 2013 proposal to REACH at the end of the planning year.

For the counties, the steps in the planning year included:

- Creating a core leadership team to attend the Denver launch and then lead implementation of the Initiative in their counties: The intent of the core leadership team was to include people from key community groups throughout each county to keep the RHI work focused on the goals of the Initiative.
- Engaging a broad cross-section of stakeholders to advise the core leadership team in each county.
- Identifying, building, and strengthening networks of organizations within counties to begin forming relationships, partnerships and collaborations in order to create a coordinated system of care.
- Developing multi-sector relationships within and across counties; establishing learning communities so leaders from different perspectives and disciplines could benefit from lessons learned and create a common framework for understanding how rural communities tackle these hard issues.
- Identifying high impact, locally possible strategies to bring about dramatic change in access and outcomes along with an action plan for implementation of the strategies.
- Participating in a Community of Practice meeting at the REACH Foundation in September 2012 with participants from all three counties asked to present progress to date.
- Submission of final proposals at the end of 2012 for the 2013 Calendar year.

Table 2 presents the range of strategic activities provided to both the county teams and Foundation staff during the planning period.

Table 2. Major Activities of RHI Planning Period: April – December 2012

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov
RHI Kick Off in Denver, CO	X							
Core Leadership Teams Form		X	X					
Communications (FAQs, Talking Pts, News Releases)			X	X	X			
Recruiting for Expanded County Stakeholder Groups			X	X	X	X	X	X
Outreach and Engagement with Community				X	X	X		
Network Weaving Introduction & Monthly Coaching		X	X	X	X	X	X	X
Ongoing Planning – Core Leadership Teams		X	X	X	X	X	X	X
Discussion and Advisement with Foundation	X	X	X	X	X	X	X	X
Intensive Facilitation from Connections Unlimited					X	X	X	X
RHI Network Meeting/Presentation of Team Concepts						X		
Detailed Discussions and Refinement of Concepts						X	X	
Concept Papers and Budgets Submitted							X	
Original RHI Evaluator Selected								X
Implementation Year 1 Coordinated Planning							X	X

Technical Assistance During Planning Period (Theory of Change, Box 2). Technical assistance was not provided during the planning year – with the exception of a half-day training on network weaving – as it was not considered necessary at the outset of the Initiative. For the half-day training, an Ohio-based network development consultant trained core leadership team representatives on the principles of network weaving and helped them to use network mapping to begin documenting a network for each county. Monthly coaching sessions were also conducted for interested core team and stakeholder members though these were sparsely attended and the original interest in network mapping dissipated over the year.

In the fall of 2012, REACH hired an RHI facilitator to work with each County core team. Discussions focused on their chosen interventions as well as strategies for implementing Collective Impact and Capacity Building to meet the ultimate goals of RHI. The RHI Facilitator implemented a structured process for community capacity building in each county, strengthened the focus and quality of planning occurring in all three counties, and supported the development of the RHI proposals for 2013. At this time, an evaluator was hired to begin a retrospective look at the planning period.

B. First Year of Implementation: January – December 2013

The original intent for the implementation years of RHI was to target funding and technical assistance on implementation of high potential impact strategies that could build upon early efforts to create a climate and norm of innovation, collaboration, and community partnership and ownership. With guidance from Foundation staff and the RHI facilitator, both Allen County

and Lafayette County submitted proposals and were funded for the first year of implementation. Cass County requested and was awarded a 2013 grant for extended planning. Thus the trajectory of change in Cass County compared to Lafayette and Allen Counties clearly diverged from this point on.

The REACH Foundation approved $450,000 for the Rural Health Initiative for 2013. To support their interventions, Lafayette County received $150,000 and Allen County received $101,653; Cass County received $75,000 for continued planning. Additional funds in the amount of $123,347 were provided to further support RHI, bring in technical assistance and other resources for the counties, and evaluate the Initiative.

County Interventions (Theory of Change, Box 3). The counties spent the first year of implementation as follows:

- Lafayette County: During 2013, the Lafayette County team, with the Health Care Collaborative of Rural Missouri (HCC) serving as the primary RHI grant recipient for Lafayette County, created the Live Well Health and Wellness Community Initiative. 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. Live Well brings together individual and organizational leaders from a broad and diverse spectrum to promote positive changes to the health outcomes of Lafayette County residents.

  HCC has been building a dynamic and committed foundation for ten years. RHI provided an opportunity to take this work to the next step by incorporating direct and indirect health care services; education and training of health care professionals and support service staff; identification and networking of health care and social services; and the establishment of two new FQHC clinics which provide locations for New Access Points in Waverly and Concordia, Missouri. A specific, immediate focus was to meet the critical need for oral health services, especially to the uninsured, under-insured and poor in Lafayette County. According to the Executive Director of HCC,

  > *[REACH] has given us the flexibility to morph and change. When RHI came along, we had a place to start and had a project starting in the clinics. [For other counties] it was just a concept. Our plan was: Year 1 – plan; Year 2 – open clinic; Year 3 – build people. The clinic was always on the table. We knew we needed a social services aspect but didn't have money. The plan was always there but [RHI] gave us the money to develop the people.*

As the RHI resources helped to get the Live Well clinics off the ground, the RHI core team also began planning for a Community Connector program to be piloted in CY2014. The Community Connectors are community-based workers who help link community members to resources within the community. Connectors not only identify available resources but also help to make appointments and follow up to ensure the supports were effective.

- Allen County: Allen County decided to offer a program focused on people in poverty (Circles Out of Poverty project) and conduct a county-wide strategic plan. The Circles project was designed to assist families emerging from generational poverty by increasing their social connectedness with their more affluent cohorts. By forming these new relationships, persons emerging from poverty could gain an understanding and a skill set to help them navigate the demands and benefits of a middle class society, including those relating to healthcare access.

  Allen County – under the guidance of Thrive Allen County – also conducted a Safety Net Strategic Planning process to engage all significant safety net providers in extended structured planning with the goal of a formal agreement to integrate services, avoid duplication, share resources, exchange information and fill in gaps of services relating to access by the poor and medically underserved. The safety net providers included the Allen County Regional Hospital, Family Physician's RHC, SEK Multi-County Health Department, Southeast Kansas Mental Health Center and Community Health Center of Southeast Kansas (FQHC).

- Cass County: Cass County's RHI Core Leadership team requested additional time and resources to plan and engage in community capacity building prior to launching a pilot planned for 2014. Thus, the core leadership team proposed to use 2013 to: 1) continue to build the capacity of the core leadership team; 2) expand to the larger county-wide community through thoughtful network development, focus groups and listening sessions; 3) compile and review data, and receive input from key partners and stakeholders; 4) identify the needs and opportunities within the community; and 5) ensure that the community was ready and prepared to implement a collective impact project designed to achieve their vision for the county and the RHI. Throughout 2013, Cass County participants continued to experience various internal struggles around leadership and who to engage in the Initiative which affected the RHI momentum.

  At the end of 2013, Cass County's RHI Core Leadership Team decided – with the full support of REACH – to not submit a 2014 grant, but use remaining 2013 budget dollars to support network building and a dental clinic expansion in Harrisonville. REACH was hopeful that Connect Cass would be able to provide leadership since they had recently hired a new Executive Director. REACH expected the core team to be expanded and network building activities (i.e., mapping) would occur, along with funds directed to the dental clinic in Harrisonville in 2014.

Technical Assistance During First Year of Implementation (Theory of Change, Box 2). In 2013, technical assistance was increased to support the counties as they moved toward implementation of RHI interventions. The Technical Assistance (TA) Team now consisted of expertise in the areas of facilitation, rural health access, network weaving, and community change:

- RHI Facilitation –The RHI Facilitator from the RHI Planning Year continued to provide advice and consultation services for the three core leadership teams around advocacy and public policy issues, designed and helped facilitate community capacity building efforts, along with some leadership development sessions. Essentially, the RHI Facilitator served as a convener, a catalyst to conversation and dialogue, a coach, a problem solver, mediator, and a connector to resources and information. She designed work processes and accountability mechanisms to track activity and monitor progress of each group's activities and plans.

  With the support of the RHI Facilitator, the core teams spent a great deal of Year One Implementation on building relationships and developing basic organizational processes. Though frustrating to the Foundation at the time, hindsight allowed the REACH staff to recognize that the counties needed this time to figure out their own internal dynamics of how to work together so they could figure out what needed to change. According to the REACH Foundation's Vice President of Program, Policy and Evaluation, "…once REACH staff stepped out of the process… we could look back retrospectively and say that taking a year to work on dynamics – who they were, what they were about, why they were coming together, who was in charge – was necessary. And our frustration was that nothing related to RHI was happening. But now we get that that process was essential for them to learn a new way to work together with very unconventional ideas of leadership and accountability that had to be worked through." This work was particularly helpful in Allen and Lafayette Counties. By the end of 2013, the TA Team and REACH Foundation felt that these counties no longer needed this type of facilitation and let the counties know they would need to hire facilitation through their own funding if they still felt they needed this support.

  "Once REACH staff stepped out of the process… we could look back retrospectively and say that taking a year to work on dynamics – who they were, what they were about, why they were coming together, who was in charge – was necessary. …now we get that that process was essential for [the counties] to learn a new way to work together with very unconventional ideas of leadership and accountability that had to be worked through."

  Dr. William Moore, Vice President of Program, Policy, and Evaluation, REACH Healthcare Foundation

KEY TAKEAWAY

It would have been useful to have had the facilitator explicitly teach local teams (and others) advanced facilitation skills so that the communities had an increased capacity to hold effective meetings. More community members with advanced facilitation skills would have helped to broaden those who can take leadership positions and better prepare them to effectively lead the Working Groups that later emerged.

- Coordination and Engagement – The RHI Coordinator (Executive Director of the Center for Community Support and Research at Wichita State University) was responsible for scheduling, deploying, and supporting technical assistance services across the different counties and TA providers. The RHI Coordinator developed and facilitated two Advisory Team meetings, three Community of Practice meetings for the counties, and TA Team meetings/phone calls (three in person). He also provided connections to leadership skill development.

- Rural Community Programs and Policy – The RHI Rural Content Expert was responsible for bridging initiative-level work with core team activities. She frequently joined the RHI Facilitator on site during core-team meetings at all three counties and brought a wealth of content knowledge about rural programs and policy to the core teams. She also supported the Foundation by serving as a member of the RHI Advisory Team.

- Network Development – The RHI Network Consultant was responsible for providing information to the TA Team and local programs about the network approach and how it could be applied to this project. She presented on this topic at TA Team and Community of Practice sessions and participated in the TA Team calls.

- In November 2013, an expert in the Theory of Change approach to planning and evaluation was brought in to revisit the current RHI Theory of Change and to help bring clarity to the strategies necessary to improve health outcomes in these rural counties. She was asked to assume the evaluation of RHI for the 2014 year to capture changes in outcomes associated with the new RHI Theory of Change.

During Year One Implementation (CY2013), much of the technical assistance continued to focus on implementing the tenets of Collective Impact and the Network Approach, both of which included an emphasis on collaboration, self-initiation, and innovation (see Table 3 on page 22-23 for a comparison of these two concepts. The core leadership teams of Allen and Lafayette focused on the familiar process of implementing their RHI projects while they struggled with how to define and implement the basic tenets of collective impact and capacity building elements (e.g., core leadership team, backbone organization, common vision/agenda, ongoing communication, common measurement system, community engagement). During this time,

the RHI Facilitator provided support to implement the Collective Impact structures. And while the RHI Network Consultant participated in the TA Team meetings and talked occasionally with the counties, the Network Approach component of RHI moved to the back burner as the counties and TA Team grappled with understanding how all of the concepts fit together.

As implementation of the RHI progressed, it became clear that the way these two philosophies were being implemented in the RHI counties caused them to be at odds with each other rather than working in conjunction. The Network Approach utilizes the structure of working groups to provide opportunities for emergent leaders to step forward, initiate projects, and take on new roles in the community. In contrast, Collective Impact utilizes a more traditional approach to leadership and project development with a core leadership team to create the work and a backbone organization to support the work. As a result, the counties fell into more traditional (and comfortable) patterns of behavior – particularly around leadership. The counties continued to use a traditional hierarchical approach to leadership which did not focus on developing emergent leaders in the same way the Network Approach would. The RHI Foundation Staff and TA Team recognized this conflict as they worked to revise the REACH Foundation RHI Theory of Change (see below for details) and adapted the technical assistance offered during the 2014-15 year to better support network and leadership development:

> *"At the beginning, we couldn't figure out how the concepts fit together and supported each other. As a whole group, we were trying to figure that out. We were also trying to get the structure figured out. It's not clear that the learning that needed to occur – the change in REACH's emphasis away from collective impact and toward leadership/network development – would have happened without the process we went through….trying and seeing things weren't working."*
>
> TA Team Member

KEY TAKEAWAY

It was the process of grappling together with the Theory of Change that helped the TA Team and REACH staff begin to combine the three conceptual strands of collective impact, network development, and capacity building. Many assumptions were unearthed and discussing these assumptions helped develop more clarity about the strategies needed for change.

One of the issues of a collaborative TA Team is how to meld the efforts of the team so that they complement and support each other. The Theory of Change work shows that considerable progress can be made when time is spent explicitly working on this.

Table 3. Comparing the Collective Impact and Network Approaches

Common Element	Collective Impact	Network	Similarities & Differences
How do people make sense of the problem or possibilities?	COMMON AGENDA. Shared understanding of problem. Identify leverage points. Set boundaries to system or issue.	CREATIVE SYSTEM ANALYSIS. Different perspectives on problem. Identify leverage points to drive experimentation.	Both stress value of working collectively and identification of leverage points. Network emphasizes learning from each other's differences to get a more complex perspective on problem.
How does network work together?	BACKBONE ORGANIZATION. Emphasis on coordination and convening. Governance group. Influential champion(s) brings CEOs of orgs together. More likely to be a few large projects 1. Guiding Vision and Strategy 2. Aligning and Coordinating Activities 3. Creating and Supporting Shared Measurement 4. Partnering in the Building of Public Will 5. Advancing an Aligned Advocacy/ Policy Agenda 6. Mobilizing Funding to Support the Collective Effort	SMART NETWORK WITH WELL-DEVELOPED SUPPORT SYSTEM. Distributed and well-connected network leadership, especially to coordinate collaborative projects. Convene for understanding system, shared measurement and possibly reflection People work in the part of system that makes sense. Increasing numbers of self-organized emergent small projects build skills to organize large projects	Network emphasizes support and distributed "process" leadership as a way to eliminate costly coordinator role and spread engagement to individuals /residents not just organizations
How do we know if we are moving in the right direction or making a difference?	SHARED MEASUREMENT. Agree on what to track. Spot patterns. Learning. Developmental evaluation. Tracking shifts in relationships. Data collecting. Rapid feedback. Learning network-wide. Learn what is and is not working in the group's collective approach	DEEP REFLECTION, LEARNING, and IMPROVEMENT to identify better next steps and breakthroughs. TRACKING SYSTEMS and MAPPING. Social network mapping and metrics and network indicators help make the process transition.	BOTH emphasize learning, developmental evaluation, continuous reflection. BOTH de-emphasize Logic models and Theories of Change.

Common Element	Collective Impact	Network	Similarities & Differences
Who does what how?	MUTUALLY REINFORCING ACTIVITIES. Prioritized set of activities. Each participant undertaking a specific set of plan-based activities but scan for emerging opportunities. Cascading levels of linked collaboration.	SELF-ORGANIZING. Many people initiate opportunity-based collaborative action. People involved in many projects. Breakthroughs & innovations identified and spread through this overlap. Money needs to be restructured to support collaborative projects.	BOTH emphasize opportunity-seeking. Collective Impact emphasizes mobilizing scale of key influential organizations. Network has possibility of mobilizing residents in innovative, effective & empowering ways.
How do we know who is doing what and how do we learn from that?	CONTINUOUS COMMUNICATION	CONTINUOUS TRANSPARENT DECENTRALIZED COMMUNICATION. A network approach uses a wide range of mechanisms to ensure continuous communication takes place – it builds a communications ecosystem. Communication occurs less through any centralized group and more through use of multiple social media platforms and informal communication that occurs in collaborative projects and communities of practice. Network leaders need to be encouraging open sharing of what is happening in additional to setting up (often small Just-In-Time) trainings as needed in use of technology. Network leaders need to especially encourage sharing of mistakes, as processing these can often lead to breakthroughs and new insights.	

C. Second Year of Implementation: January – December, 2014

In 2014, the REACH Board approved $385,000 for the Rural Health Initiative. Grants to the local Counties totaled $200,000 and an additional $185,000 was provided to bring in technical assistance and other resources for the Counties, and continue the evaluation of RHI.

County Interventions (Theory of Change, Box 3). For Lafayette and Allen Counties, Implementation Year Two focused on their local work. In Lafayette County, a new initiative – Community Connectors – was launched as a pilot. In Allen County, Circles activities deepened. Both counties also worked to strengthen specific RHI components (e.g., diverse and inclusive core leadership team; workgroups; expanded and engaged network). Meanwhile, Cass County began 2014 with a reset of the Initiative as Connect Cass brought in new leadership and RHI was reintroduced to County leaders. Specifics of how each county strengthened RHI components through participation in RHI technical assistance is described below.

Technical Assistance During Second Year of Implementation (Theory of Change, Box 2). As mentioned above, the REACH Foundation recognized the need for more focused technical assistance in the areas of Network Development and Leadership Development and for the counties as well as a theory of change approach to evaluation. Each is highlighted below.

Network Development. Networks are sets of relationships and the patterns they create. The pattern or structure of those relationships influences the likelihood that effective collaboration and innovation will occur. The development of a network that leads to enhanced innovation – also known as a Smart Network structure – usually occurs in stages from isolated clusters to a hub and spoke structure to a multi-hubs structure and finally a smart network. This progression occurs as network leaders or weavers add more diversity to the core of the network, help people in the core connect to people outside their community to create a periphery of new ideas and resources, connect people with similar interests, and help people identify opportunities for change and self-organized working groups and projects. All of these activities add people to the network and increase the number and quality of the connections.

During 2014, network development consisted of two parts: network mapping/analysis and establishing network structures.

- ***Network Mapping and Analysis*.** The RHI Network Consultant worked with each county to develop a web-based survey, identify key community members to complete the survey, and implement a strategy for getting a 60% response rate. The surveys included basic demographic questions (about age, location, etc.) as well as questions about interests and willingness to get involved in RHI. Lafayette County also chose to learn how to use the software to generate the network maps.

  Once a set of maps was developed, each core team met with the RIH Network Consultant to analyze the maps and develop a plan for using the data. In Cass and Allen

the maps were shared with a larger stakeholder group. Core teams found the maps illustrating community member's areas of interest particularly helpful to use for recruiting new participants into RHI.

Another important map included zip codes of survey takers showing that community members who were most connected were from one or two central areas (e.g., Iola in Allen County or Lexington in Lafayette County), with those in more rural parts of the county less connected to the center of the network or to the RHI core team. Aggregate and individual metrics were generated for each county but these will be most useful when they can be compared with 2015 metrics.

Though the maps did help RHI participants see themselves as a network (rather than an organization) and helped them realize that there were specific steps that could be taken to help their network become "smarter," it is unclear how much the maps have been used after the initial core team sessions. The challenge for 2015 is to return to the network maps and explicitly request that core team utilize the maps to include a wider range of community members in key aspects of the Initiative. An overall summary of the mapping process as well as sample maps are included in Appendix 2.

- ***Network Structures.*** The network consultant also worked with each county to develop a more diverse core team with co-coordinators and one or more working groups with clear leadership and at least some participants who were not part of the core team. Efforts to reach out to a broader set of stakeholders was also strongly encouraged to make the RHI core team and working groups more diverse and inclusive of county members in terms of geography, socio-economic status, ethnicity, etc. Such expansion of the network leads to greater collaboration and innovation. Each of the counties started off with one working group:

    - Lafayette's Connectors working group was made up of participants from six organizations. They identified programs they wanted to learn about, brought in someone from that organization or program, and discussed how to better refer people to that program. This working group is expected to expand in 2015 and will need help in onboarding new Connectors.

    - In Allen County, the working group was a Circles Program. During the year, a substantial number of volunteers were recruited to help with mentorship, childcare and meals for meetings. However, the formation of a more explicit working group was needed to help strategize about the project and raise additional funds.

    - In Cass County, a mental health working group was being formed. The core team used the network mapping data and a Leadership Summit to identify a community need and recruit members to this working group.

- There were also smaller ad hoc working groups in all three counties for the Theory of Change work and the Mapping Project (although in Cass County, the mapping work was essentially conducted by a single individual). Allen County has also had a number of one-time working groups to solve local problems which has been very effective for the county.

In 2015, an increased focus will be placed on on-site and/or video conference coaching around working groups which will help the counties move from having the core teams dominate the formation of new work groups toward self-initiation of work groups from within the wider communities.

KEY TAKEAWAY

The decision for the Network Consultant to work primarily with the local RHI coordinator in each county proved to be problematic as all three RHI coordinators changed during the year and significant coaching was lost to the community. The TA Team has recognized the need to work with more members of the core team yet doing so by phone has proven to be too difficult even when pre-existing relationships between the TA provider and the county members exists. As a result, developing capacity for videoconferencing is critical so that consultant work with core teams is more effective when not on-site.

Leadership Development: In 2014, REACH asked the RHI Coordinator and staff at the Center for Community Support and Research at Wichita State University (the Center) to provide expertise in leadership development to the counties. Using the Adaptive Leadership approach to leadership development, leadership consultants were brought in to (a) provide either one-on-one leadership coaching with the county network weaver; (b) offer coaching to several individuals from the core team or (c) offer a group based approach. The counties were asked to select their preferred approach because the Center philosophy holds that leadership supports are not effective if the recipients are not fully engaged. In response to requests, the following leadership supports were provided to the counties:

- Lafayette County: Leadership consultants from the Center provided three three-hour leadership development workshops to Lafayette County: The first workshop had approximately 18 participants (HCC staff and community members) where they discussed challenges associated with implementation of RHI. Participants were provided with a framework for thinking about problems based on technical versus adaptive challenges. Session 2 had approximately 25 participants and included identifying the kinds of leadership needed to take on the challenges discussed in the previous session (e.g., how do you mobilize other people, how do you start where

others are and not where you are; how do you handle the pressure to do something quickly versus waiting to understand the challenge more deeply before jumping in with a band-aid). Session 3, with approximately 20 people, was designed as more of an individual coaching session to let participants work through why change is so difficult.

A small number of additional one-on-one coaching sessions were provided to the Executive Director and the RHI Project Director of HCC. During these leadership sessions, the main challenges identified by Lafayette community members included: (1) RHI is hard to get your head around, (2) there are multiple stakeholders, all of whom have different things to gain and lose by any RHI project; and (3) there is immense pressure to jump in and fix something now when the problems being addressed are really long term.

- Allen County: A leadership consultant from the Center was responsible for introducing leadership concepts via training and coaching in Allen County. This work kicked off with a full day on site working cooperatively with the Network consultant – half the day was spent training on the network mapping process and the remainder planning next steps. Participants included both core leadership team and additional community members. The leadership consultant held additional conversations with the Executive Director of Thrive along with other Thrive staff. The Allen team had difficulty finding a focus for the coaching conversations and mainly utilized the support to move the mapping work forward. Toward the end of the 2014 year, however Thrive's Executive Director and the new Allen County RHI Project Manager requested support from the Center around succession planning and talent development, based on their recognition that assistance with these topics could better support the work of RHI and Thrive in general.

- Cass County: The leadership consultant from the Center initiated work by holding introductory meetings with two key stakeholders in Cass County. The representative from the Raymore-Peculiar School District was very engaged in the work of RHI since the beginning of 2014 and was clearly acting as a leader without recognizing herself as such. In contrast, the new executive director of Connect Cass who was the recognized leader of the Initiative acknowledged that RHI was a low priority within Connect Cass. These conversations helped Foundation staff understand perceptions of RHI in Cass County and led to some hard conversations about what role Connect Cass should play in the Initiative moving forward. Ultimately, Connect Cass bowed out of the work and two new RHI leaders stepped up and have taken ownership of RHI in Cass County. Plans are moving forward to reinvigorate RHI and bring in new members for 2015.

Clearly, the technical assistance members providing leadership support needed a significant amount of time with county members to build the relationships necessary for effective coaching to occur. At the midpoint of the second year of implementation, the TA Team – with support from the Evaluator and Foundation Staff – recognized the need for more focused leadership coaching in the sites. The expectations associated with RHI required a new set of

leadership skills to more readily align with the Network Development approach and the communities needed additional support in this area.

Table 4 illustrates the different leadership behaviors associated with the Network Leadership versus Adaptive/Organizational Leadership approach.

Table 4. Adaptive/organizational leadership versus network leadership

Organizational Leadership	Network Leadership
Based on position, authority	Based on role, behavior
Few leaders	Everyone can take on leadership role as needed
Leaders tend to broadcast information in a one-way relationship	Network leadership is about engaging participants and two-way discussions
Leaders often tell others what to do	Many people initiate action on their own
Leaders tend to want to control actions and communication	Leadership provides facilitation and support so others can act
Leaders often withhold certain information from other employees	Leadership is about encouraging openness & transparency
Leaders often direct others to act	Leadership allows the network to be emergent and let things happen
Top down	Bottom up
Leaders make sure tasks completed	Leadership helps participants identify breakthroughs
Individual	Collective
Evaluation	Reflection
Planning	Innovation and Experimentation
Provide service	Support Self-organization

While the Adaptive Leadership approach and the Network leadership approach can function in conjunction with one another, the extensive work necessary to integrate these two approaches did not occur. Recognition of the lack of alignment between the kinds of leadership supports provided led to staffing changes for 2015 to better support counties "on-the-ground" while providing coaching around network leadership.

KEY TAKEAWAY

It would have been a valuable use of resources to spend a lot more TA Team and REACH staff time working together to clarify expectations, integrate concepts, develop shared language, and reflect on lessons learned. Examples of areas where such reflective activity would have served the sites more effectively include:

1. Integrating the network approach with the leadership approach so that they were in alignment. The concepts of adaptive leadership and related trainings were valuable and appreciated but did not connect directly with the network development work – or help the kind of structure emerge that led to more broad and diverse leadership.

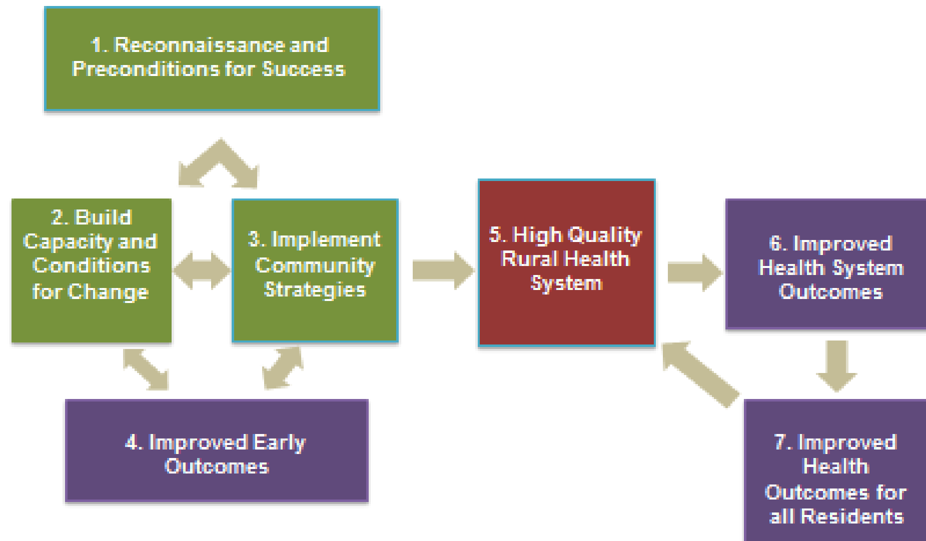
2. What the counties really needed was intensive coaching of the core teams in each project that was more "on-the-ground" – based on what was happening right then – to better help them understand how the network approach could be applied to their work. The resources were not available for on-site follow-up to help the counties implement what they learned.

3. TA team members had different definitions of what was meant by coaching. In many leadership approaches, coaching is a confidential process to help an individual grow; however, the kind of coaching needed in this project was coaching to support implementation of the new RHI concepts (i.e., network development – what are they doing? What challenges have they come up against?).

4. TA Team members needed clarity around the roles and expectations of the RHI structures and relationships among the structures. The team did not have a clear enough idea of what the relationship between backbone organization leadership and RHI coordinator should be and was therefore unsure of when and where to intervene.

VII. EVALUATION FINDINGS FOR IMPLEMENTATION YEAR 2

Data collected and subsequent findings for RHI Implementation Year 2 (CY2014) are presented through the lens of the 2014 theory of change (See Figure 3). A summary version of this theory of change is presented below for reference. Results will first be presented for Early Outcomes (Theory of Change, Box 4) followed by changes in the Intermediate Outcomes (Theory of Change, Box 6) and then Long Term Outcomes (Theory of Change, Box 7).



A. Data Collection Strategies

At the beginning of the 2014, a survey was administered to the core leadership teams of Allen and Lafayette Counties to establish a baseline for the current levels of RHI core concepts (see Theory of Change, Figure 3, Boxes 2-4). Follow-up interviews were then conducted to capture more nuanced information about RHI in each county. Because Cass County was re-starting RHI with a new team of county participants, they did not participate in the survey or interviews.

To continue to follow up on implementation of these core RHI concepts in a way that could simultaneously provide feedback to the county teams, the RHI Evaluator and RHI Rural Content Expert – with input from the rest of the TA Team – developed the Early Outcomes Meeting Checklist. Examples of topics covered included (but were not limited to): effective project management behaviors, structures and behaviors supporting a network culture, support for emergent leaders, diversity/inclusion of new members, use of data to inform decision making, and more. This tool was designed to be completed after each RHI meeting by a single individual from each county with input from other county members. The tool was introduced to the counties during the June 2014 Community of Practice meeting at the REACH Foundation. RHI members from all three counties had an opportunity to review the checklist, use it at the Community of Practice meeting, and recommend revisions. After the revisions were made, an electronic copy of the form was sent to all three counties to be used at the conclusion of all RHI meetings. Instructions as to how to use the form and a detailed set of definitions explaining the intent of each item were also sent to the counties (See Appendix 3 for a copy of the tool and explanatory document). Counties began using the checklist from July through December 2014.

Not only did this checklist support data collection but it also helped to clarify concepts for the counties. An Allen County RHI core member indicated that "the early outcomes checklist helped us better understand what it was that REACH expected to see with regard to implementation of RHI concepts."

During the six months that the counties have used the checklist in 2014, 20 checklists were completed – nine by Lafayette County; seven by Allen County; and four by Cass County. Of the 20 meetings represented in the data collected, half were core and half were working group. The working group meetings focused on the following topics: three ACA meetings, two Circles meetings, one Community Connectors meeting, and four Theory of Change meetings.

In addition to the data collected from the counties, archival data from public databases (e.g., County Health Rankings) will be collected to keep track of longer-term outcomes related to health and health access (Theory of Change, Boxes 6-7).

Findings from the data collected and analyzed in 2014 are presented below.

B. Improved Early Outcomes (Theory of Change, Box 4)

According to the 2014 RHI theory of change, the first alterations expected within the RHI Counties are changes in behavior, perceptions, and skills produced as a result of (a) county-level interventions introduced and (b) technical assistance provided by the RHI TA Team. These early outcomes include:

1. **Stronger Relationships.** Trusting, mutually-established relationships among county participants as well as between county, Foundation, and TA Team members.
2. **Increase in Participants/Leaders**. Identify and engage new community participants and leaders (i.e., increase diversity of RHI stakeholders).
3. **Network Supportive Culture.** Participants' values and behaviors show increased collaboration, inclusivity, innovation, initiation.
4. **New Skill Sets in Networks and Project Management.** Individual and organizational skills are strengthened in: existing and emergent leadership; project management; communication; network development; and resource development.
5. **Progress Observed.** Measurable progress is made toward goals.

At the beginning of Implementation Year 2 (CY2014) the communities had made tremendous strides in implementing the key structures associated with RHI – a backbone organization and core leadership team. These structures and the people within them were instrumental in building stronger relationships among partners, changing the culture, and developing a more diverse and inclusive approach to membership. At the same time, the counties were still struggling with bringing in a more diverse constituency and with changing the culture of their organizations toward a more network-friendly culture. Growth in these key early outcomes can be seen over the course of 2014:

- **Early Outcome 1: Stronger Relationships.**
  The core leadership team was the original strategy for building stronger relationships among existing – and eventually new – partners in each county. Half of the RHI meetings in 2014 included a report of someone reaching out to a new person to support a new activity. And anecdotal evidence suggests that greater levels of trust were growing among the core leadership team members in Allen and Lafayette Counties.

- **Early Outcome 2: Increase in Participants and Leaders**
  Increased RHI Membership. As 2014 opened, the core leadership team was also the main strategy for bringing on new RHI members. The RHI concept also included opportunities for community members to participate in RHI via working groups or extended stakeholder groups:

  a) Each working group was designed to focus on a specific identified need of the community (e.g., ACA Enrollment, Migrant Workers, or Mental Health) and participants worked together to identify strategies to resolve that need.
  b) The extended stakeholder group was initially designed to be a space where key community stakeholders who do not have time to be more involved in the work of RHI can be kept informed and offer support or resources as needed.

  The baseline survey in early 2014 indicated that there was a lack of clarity around how to engage diverse community members. For instance, some county participants were not clear what the role of the extended stakeholder group was or even whether their county had one. There seemed to be some agreement about a lack of communication with the greater community and even the extended stakeholder group. Considering the level of confusion around the stakeholder group, it is not surprising that there was not yet a system for communicating with them or recruitment materials to reach out to new members. There were also no fully functioning workgroups at the beginning of 2014 (though Circles and Connectors each had a quasi-workgroup to help get the programs up and running).

  During Implementation Year 2 (CY2014), all of the counties held stakeholder meetings at some time during the year to help grow diversity and inclusivity of their stakeholder groups, though they had varied ideas about what stakeholders meant. Cass County had a Leadership Summit for 30 individuals. The stakeholders groups of Lafayette and Cass were somewhat smaller. In addition, both Lafayette and Allen Counties used the network mapping process to identify new workgroups and community members who might lead those groups. They also worked to bring in new partners to their core leadership team. Data from the checklists indicate that in the latter half of the year, 30% of RHI meetings included new members and 65% of RHI meetings included discussion of or plans for bringing in new members. And while none of the meetings captured by the checklists included consumers (e.g., un/under-insured); Allen County

now includes a Circles member on their core leadership team and utilizes the Circles participants as a focus group for assessing the viability of new ideas.

Leadership Development. From the outset, one of the goals of RHI was to encourage the development of emergent leaders so that the weight of the RHI work didn't continue to fall on the shoulders of the same individuals within these small rural communities. Yet, according to the baseline data in early 2014, there was still a clear need for the counties to provide opportunities for new individuals to move into leadership and positions of responsibility for an RHI project. With assistance from the technical assistance team, some support for emergent leadership was seen. According to the early outcomes checklist, while almost two-thirds of the RHI meetings conducted during the last six months of 2014 continued to be run the leaders of the backbone organizations, three new leaders emerged within this six-month period – two in Cass and one in Allen. And while Lafayette did not have any new leaders, five of Lafayette's nine meetings offered opportunities for people to step into new leadership roles indicating recognition of the need for new leadership. Essentially, the checklist data indicates that while there is a movement toward bringing on new leaders, there is still a tendency to use a top down approach to decision-making. Anecdotal evidence lends additional credence to this finding – it appears that the senior leadership (e.g., executive directors) continue to make the nuanced decisions about the work while the rest of the RHI members focus on more technical decisions about program implementation.

- **Early Outcome 3: Network Supportive Culture**
  A network supportive culture is one that encourages collaboration, self-initiation of new projects, and innovation that emerges from outside the core team. At the beginning of 2014, there was no evidence of these practices in the counties other than a strong tradition of collaboration within each of the backbone organizations. There were no clear working groups in either county or clear processes for establishing new working groups. According to the Early Outcomes Checklist, by the end of 2014, increasing levels of collaboration, innovation, and self-initiation were apparent:

  Collaboration. The big first step that all three counties (especially Lafayette and Allen) made toward creating a culture of collaboration was to bring people from a number of organizations to the same table to talk about the issues of their community. For example, Allen County has a large core team (10+ people) who are meeting monthly and making decisions together; though these meetings were still usually led by the executive director of Thrive according to the data collected. In addition, the network maps from the three counties showed that a small but significant number of people in the counties had collaborated already and in Cass (the only county that asked the question) a substantial number of people were interested or very interested in working collaboratively on increasing access to healthcare.

> It's all about building culture – being proactive and collaborative… It is modeling what you expect. If we are going to talk about collaboration, you have to do it… It's really hard to coach a culture. You need the right ingredients.
>
> Lafayette Core Team Member

Innovation. There was a clear move toward increased innovation in the counties. For instance, Lafayette's Connectors program came from a project in Arkansas that they modified to fit their needs. In addition, according to the Early Outcomes Checklist:

- 83% of the RHI meetings encouraged and considered new ideas; and
- almost 2/3 of the RHI meetings – both core and working group – included brainstorming for new ideas and or new strategies.

Self-Initiation. A network culture encourages members to identify areas that need attention and then to bring together other community members who are passionate about the topic to identify and implement innovative solutions. According to the Early Outcomes Checklist, half of the RHI meetings included ideas for new working groups and/or outreach to new members. Examples of new actions underway in Allen County underway include: Outreach and money-making projects; Veteran's Affairs clinic exploration along with inclusion of mental health center technology person in Veteran's Affairs clinic telemedicine discussion. In Lafayette County, some new actions underway include: reaching out to University Extension and moving forward with the theory of change process. Furthermore, 20% of the RHI meetings have a concrete plan for acting on the innovation planned – a key next step to move from idea to implementation.

Network Outreach. In addition to expanding their network within each county, a long-term goal is to expand their network outside their county to bring in new resources and ideas. The first step was cross-county meetings to learn from other RHI partners. The TA Team brought the three counties together on three separate occasions to build relationships and help grow their networks across the counties. In addition, backbone CEOs of Thrive and HCC had informal discussions. Allen County has also taken steps to adapt Lafayette's Connector Project for implementation in their area.

- **Early Outcome 4: New Skill Sets in Networks and Project Management**
  One of the skill sets that the RHI facilitator worked with the core teams to implement were effective, action-oriented meetings. To that end, the early outcomes checklist shows that by the end of 2014, all three counties engaged in project management behaviors designed to run more efficient meetings and communicate more effectively with members. Specifically:
    - 84% shared an agenda at the meeting or in advance; 70% of meetings had agendas that identified topics with key points to address; however, only 10% included desired meetings outcomes.
    - 94% of the RHI meetings reviewed previous activities (half of them in light of prior action plans).
    - 95% kept the conversation focused on the agenda topics keeping in mind prior action plans (though only half included discussion of assignments and timelines).
    - 100% reflected on progress to date and 60% made an intentional decision to stay the course despite challenges. Of those meetings where RHI participants opted to stay the course in the face of challenges, 70% used data when making that decision.

  The only meeting behavior that participants did not consistently engage in was around the sharing of meeting notes with only 40% sharing meeting notes. Of those who distribute notes, only 16% included agreements reached, tasks to complete, responsible party and timeline.

  Finally, the topics of conversation at most RHI meetings continued to focus on the specific programs being implemented with RHI dollars (e.g., Circles in Allen and Connectors in Lafayette) with the majority of meetings discussing barriers encountered and problem solving to alleviate those barriers.

- **Early Outcome 5: Monitoring Progress**
  According to the baseline survey at the beginning of 2014, there was not a process for monitoring implementation and updating the core team on the progress of implementation in either county. By the end of 2014, 63% of RHI meetings had some type of data to inform their discussion/decision-making including program enrollment numbers, mapping data, budgetary information, survey data, etc.

Early Outcomes Summary. Relative to where the counties started at the beginning of 2014, the communities are more inclusive and diverse. By the end of 2014, Lafayette and Allen had strong Core Leadership Teams (Cass was in the process of forming a new one). Working groups were formed in all three counties. The network maps show that each of the three counties had early stage smart networks with small cores. Although they had peripheries, these consisted more of local individuals and organizations rather than national organizations that are more useful for innovation. In addition, the counties are looking for new people to bring on in leadership roles via the network mapping activity, have a process for introducing workgroups, and are starting to use data (i.e., mapping data, connectors data) to inform decision-making.

With this newly built foundation, Implementation Year Three (CY2015) is primed to be the year when this work is taken to the next level. With some on the ground support from TA Team members, the core teams can more actively utilize the workgroup structure to follow up on identified needs and more actively mentor emergent leaders. Clearer language and communication systems need to be developed to better engage community members. Finally, measures identified through the theory of change process can be collected and used to make decisions about how to more effectively implement change.

C. Intermediate Outcomes: Improved Health System Outcomes (Theory of Change, Figure 3, Box 6)

According to the RHI Theory of Change, as Counties implement structures, strategies, and processes designed to create a more effective rural health system (Theory of Change, Boxes 2-5), they should begin to see improvements in the following intermediate outcomes:

1. Increased access to healthcare services
2. Improved quality of care
3. Better resource utilization by community members
4. Better coordination of health services by community agencies

Allen and Lafayette Counties each added additional intermediate outcomes:

- Allen County: Decrease Poverty, Create a Culture of Health
- Lafayette County: Create a Culture of Prevention

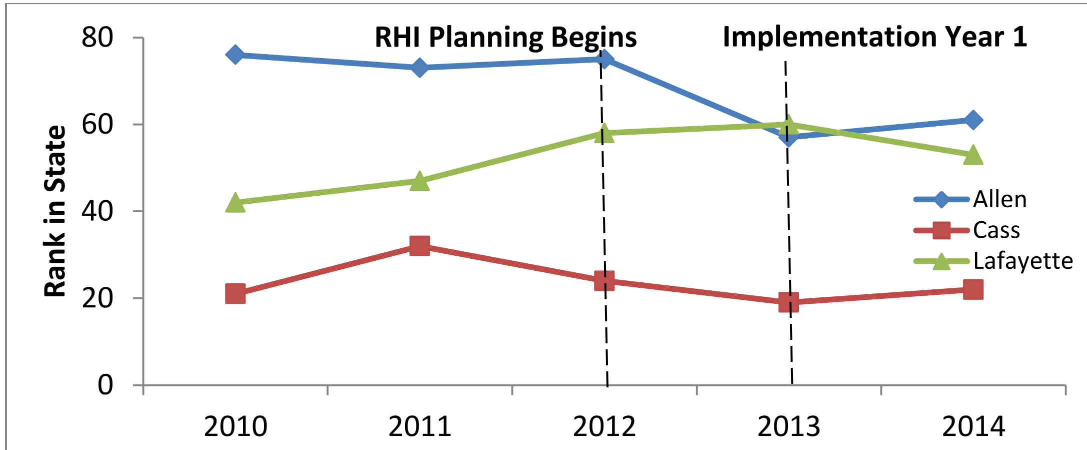
These outcomes are not expected to improve immediately as it takes time to create the kinds of changes in a health system that would increase access to services or improve quality of care. However, some improvements in these outcomes have been seen mainly in response to the opening of two FQHCs in Lafayette and a new regional hospital and expansion of an FQHC in Allen County. Below are changes in intermediate outcomes that have occurred to date:

- **Intermediate Outcome 1: Increased Access to Health Care Services**

  There are many different metrics that can be used to examine changes in access to health care services over time. Some examples include County Health Rankings for: (a) Access to and Use of Clinical Care; (b) Ratio of Persons to Primary Care Physicians; and (c) Access to Health Insurance.

  (a) The county health rankings for Access To – and Use Of – Clinical Care has improved in all three counties since the beginning of RHI (see Figure 4).

Figure 4. Access to – and Use of – Clinical Care: Rank in State (Lower is Better)



(b.) Ratio of Persons to Primary Care Physician is another metric collected as part of the County Health Rankings data that has shown improvement since the beginning of RHI (see Table 5 below). Lower ratios indicate that each professional has fewer patients to serve and is thus more accessible to his or her patients.

Table 5. Ratio of Persons in Primary Care Physicians (Lower Ratio is Better)

	2012	2013	2014
Allen	**6634:1**	**3337:1**	**3331:1**
Lafayette	**4689:1**	**3340:1**	**3321:1**

Improvements in these access metrics have been influenced by a variety of factors related to RHI implementation in the counties including:

- HCC in Lafayette County was the first rural health care network in the nation to open its own safety net clinic, Live Well Clinic in Waverly Missouri, providing new access to care for underserved and uninsured individuals and families. Their second Live Well clinic was opened in Concordia, Missouri in March, 2014. Number of medical and dental patients served can be seen in Table 6 on the following page. Though not a direct result of the RHI, HCC utilized the resources from RHI to help open these clinics.

Table 6. Number of Patients Served in Live Well Clinics in Lafayette, MO

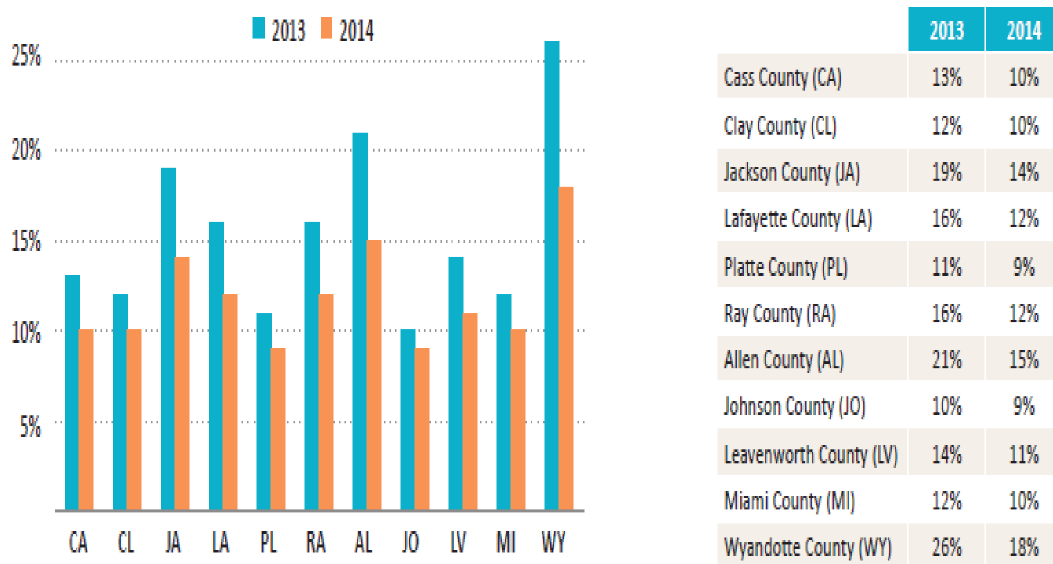
	2013	2014
Medical Patients	3091	6084
Dental Patients	65	979

- Allen County RHI Leadership played a critical role in ensuring a new regional hospital successfully opened in the county seat and facilitated the expansion of the Southeast Kansas Community Health Center (FQHC) into Iola. Again, neither the FQHC nor the hospital was the direct result of RHI but the RHI leadership team played an important role in supporting their opening.

(c) Access to Health Insurance via the Affordable Care Act. Significant outreach and enrollment efforts funded through RHI resulted in larger average reductions in the uninsured in REACH rural communities (mean = 4.33%) than in other rural areas (mean for non-REACH = 2.5%) in the Kansas City region (see Figure 5). ACA Enrollment is a working group in both Lafayette and Allen Counties with participants meeting to discuss strategies for how to be more effective in reaching the uninsured in their counties.

Figure 5

Change in Percent Uninsured by County, 2013–2014



	2013	2014
Cass County (CA)	13%	10%
Clay County (CL)	12%	10%
Jackson County (JA)	19%	14%
Lafayette County (LA)	16%	12%
Platte County (PL)	11%	9%
Ray County (RA)	16%	12%
Allen County (AL)	21%	15%
Johnson County (JO)	10%	9%
Leavenworth County (LV)	14%	11%
Miami County (MI)	12%	10%
Wyandotte County (WY)	26%	18%

- **Intermediate Outcome 2. Improved quality of care**

As with Access to Health Care, there are many different measures from the County Health Rankings that can be examined to assess quality of care. Examples include preventable hospitalizations, years of potential life lost, and self-reported perceptions of health.

Table 6 below presents improvements in preventable hospitalizations for all three counties. Preventable hospitalizations refer to cases where well-managed, ambulatory-care conditions can be handled in outpatient settings. As with growth in other

intermediate outcomes, RHI may have contributed to the conditions that led to these improvements in preventable hospitalizations but is not directly responsible.

Table 6. Number of Preventable Hospitalizations Between 2011-2014

	2011	2012	2013	2014
Allen	110	104	95	91
Lafayette	91	94	98	82
Cass	78	77	70	73

Note: First year of RHI Implementation was 2013

To date, no meaningful improvements in other county measures of "improved quality of care" such as years of potential life lost or self-reported perceptions of health have been seen. Local measures of improved quality of care that will be collected and analyzed in the future include (but are not limited to): hospital readmissions, increases in mammography and diabetes screening, and increases in immunizations.

- **Intermediate Outcome 3. Better resource utilization by community members**

Data is not yet available on this outcome. In the future, metrics to be examined include the impact of the Community Connectors program on better resource utilization in Lafayette as well as Allen County (pilot planned for 2015). Table 7 summarizes information about Lafayette's Connectors Program in 2014:

Table 7. Lafayette's Connectors Program

	2014
Number of Connectors	**8**
Number of Organizations Represented	**3**
Geographic Diversity of Connectors within Lafayette County	**North, South**
Number of Clients	**59**
Number of Encounters	**130**

At present, Lafayette has eight community connectors who helped 59 county members. 130 contacts were made with those 59 members, averaging approximately two per person. Each person helped by a connector received a follow up call to verify their satisfaction with the supports provided. Types of Connector referrals included: Primary Care, Behavioral/Mental Health, Dental, ACA Enrollment, Transportation, Food Pantry, and Clothing. Lafayette has started to see that with connectors in non-medical places, they are able to overcome barriers to health access because there is a connection to healthcare that otherwise would not have been there. Also the Connectors are providing supports/referrals to non-medical issues that impact health such as food, clothing, shelter; issues that are particularly relevant for families in poverty.

Other metrics that may be used to assess better resource utilization include (but are not limited to):

- Increases in use of FQHCs by under- and un-insured community members.
- Decreases in unnecessary use of the hospital emergency room.

- **Intermediate Outcome 4. Better coordination of health services by community agencies**

  Examples of metrics that will be used to assess this intermediate outcome include (but are not limited to):

  - increases in "warm handoffs" (i.e., health care facilities help patients to make appointments with specialists); and
  - sharing of data among county health providers such as the hospital, clinics, health department, mental health facilities, and so on via Electronic Health Records.

  To date, anecdotal evidence of increased coordination in health service by community agencies have found that:

  - Both Lafayette and Allen have gotten Certified Application Counselors to support insurance marketplace enrollment in the county. Allen also led a grassroots writing campaign in support of Medicaid Expansion.
  - RHI is slowly growing in importance for Thrive Allen County. Relationships dormant for over a decade are being rekindled around strategic priorities. Public health, mental health, the hospital, and the FQHC are at the same table for the first time and beginning to think as partners and collaborators.
  - In both Allen and Lafayette, RHI created a "table" at which to gather key community stakeholders with the common goal of collaborating to improve health outcomes. In this way, the Initiative created a space for learning and innovating. And while the mapping data shows that there are still pockets in each county that have not yet been brought in (e.g., the people currently participating in RHI tend to be from Iola in Allen or Lexington in Lafayette rather than the whole county), they are now getting those people to the same table to talk and share information in ways that did not happen prior to RHI.

> *"Even if RHI went away tomorrow, [the core team] would keep meeting. We've seen how much we can get done by meeting regularly."*
>
> Lafayette Core Team Member

"What we had was a fragmented network -- people and organizations doing good work but not in a coordinated way. RHI helps us help more and in better way and we are more effective. In the beginning, hospital, community mental health, and health department didn't talk outside of RHI unless there was something urgent that forced them to. The fall back is to do their own thing. People are busy. So we are creating a new normal – we talk; this is what we've done. Talking is to be seen as part of work. They used to feel as though we were making them go to these meetings. But they are starting to see the value now."

Allen County Core Team Member

- **Intermediate Outcomes 5. Decreasing Poverty (Allen County only)**

  Allen County RHI began its second year of implementation of the Bridges out of Poverty/Circles program and enrolled their second cohort of economically disadvantaged/medically underserved participants to begin addressing the root causes of having no insurance and lack of health care in the county. As part of their Theory of Change, Allen County is working to identify measures that will capture improvements in this outcome over time. Examples of metrics include (but are not limited to): reduction in county poverty measures such as % Children in Poverty, Food insecurity, Limited Access to Healthy Food, inadequate social support, unemployment levels, and so on. A local measure might include new lives served in the FQHCs in Iola and Wynette.

Quotes from Circles Participants

"When you're in poverty, you are used to bad things happening. When good things happen, it is not expected and you question it. Circles tells you it is okay to accept the good too."

"Circles is a great program. It made me hopeful again. Before I would have wallowed. Now Circles offers support and gives motivation. Many people going through the same thing. As a group there are many ideas. Circles is like a stairway – you just don't know where it is leading."

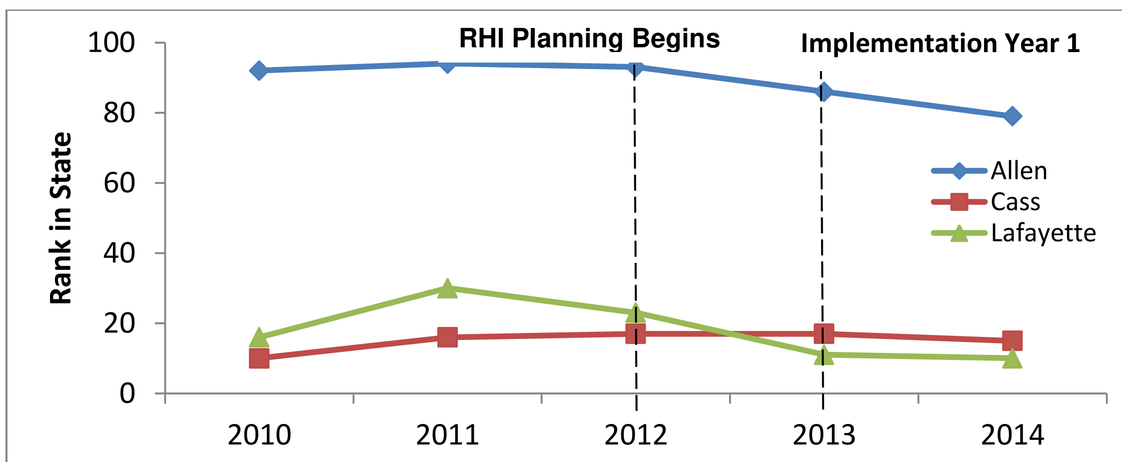
C. Long Term Outcomes: Improved Health Outcomes for All Residents (Theory of Change, Box 7)

As the Counties implement components of their ideal health care system and see movement on the intermediate outcomes, this will in turn, improve the long-term outcomes:

1. Improved health outcomes
2. Reduced health disparities

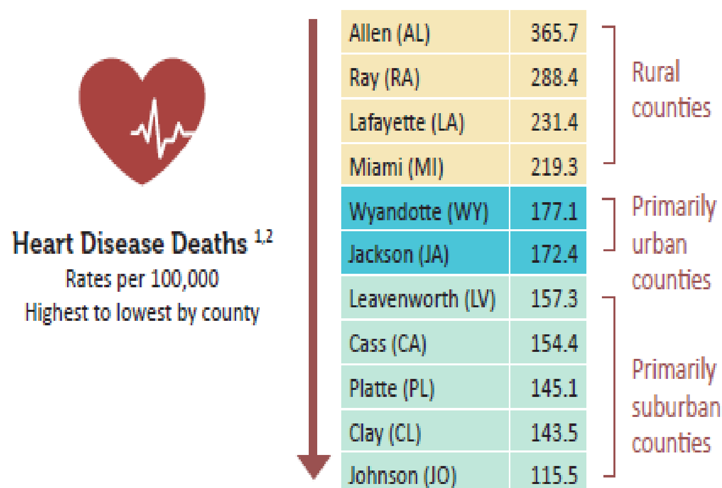
With an initiative as complex as the Rural Health Initiative, long-term outcomes are not typically attained for five to ten years – or even longer in the case of some outcomes such as reducing rates of heart disease. However, because of the increase in access that was seen in these counties, it is not surprising to see some improvements in overall health outcomes for the communities (as measured by the County Health Rankings, see Figure 6). And while improvements in these long-term outcomes cannot necessarily be attributed to RHI, all of the partners acknowledge that RHI has played a role in helping to move forward the clinics in Lafayette and the hospital and FQHC in Allen County, which, in turn, improved access to services.

Figure 6. Health Outcomes: Rank in State (Lower is Better)



Over time, other outcomes that the counties may target include specific chronic diseases that are particularly persistent such as diabetes and heart disease. For example, death rates for heart disease are higher in rural counties that urban or suburban counties reflecting larger older populations, lower incomes and poorer access to health care (see Figure 7).

Figure 7. Deaths Due to Heart Disease in REACH Healthcare Foundation Counties



VIII. LESSONS LEARNED

LESSON 1. You Can't Change the System Without a Focus on Changing the Culture

The attitudes and daily routines of rural community members are based on generations of forebears. Attitudes toward health behaviors (e.g., annual doctor appointment for preventative care; going to the doctor when sick before hospitalization is needed) and toward health insurance (i.e., it's a luxury we can't afford) are as generational as poverty. Creating the opportunities for increased access such as new hospitals, FQHCs, tele-health centers, etc. will only be effective if the community members avail themselves of those opportunities. To create a culture of health requires a change in ingrained behaviors and the only way to change ingrained behaviors is to change the underlying belief structures. We need community members to change their belief away from only going to the doctor (or, more typically, the ER) when you're critically ill.

> *To change behavior requires a change in the belief structure that you only go to the doctor (or, more typically, the ER) when you're critically ill.*
> *Allen County RHI Participant*

One hypothesis posed by Allen County RHI participants is that to change the culture toward one that is more health focused will require a new kind of outreach in which influential community members model desired attitudes and behaviors. But the definition of "influential" needs to be broadened beyond elected officials, judges, police, and well-off community members. For families in poverty, influential community members may be a minister, a grandmother (i.e., Nana), or someone from the community who has become successful but continues to live within the community. An example of a successful change in

culture in Allen County can be seen in an extension of the Circles program to reduce generational poverty. Allen County began implementing the Circles program in 2013. Since the launch of Circles, key faith-based volunteers who had been involved took their work to the next level by opening a Soup Kitchen to feed families in poverty. This was a direct result of their work with Circles and recognizing the great need in the community and how valuable their support could be to families in poverty in Iola, Kansas.

The cultural change also applies to the way people work together to create a culture of health. The challenge is that this kind of culture change requires shifts in individuals' behavior but also to the patterns of behavior that have been adopted by organizations because they have proven effective in the past. Research on effective networks has shown that to create meaningful change requires network members to work collaboratively as peers, identify opportunities, be open, transparent, and inclusive, experiment and innovative and learn (Plastrik, Taylor, Cleveland 2014). As the organizations participating in RHI begin to embrace and model a network culture, the likelihood of such a culture spreading throughout the county increases.

In both cases, the identified key to behavior change is having someone trusted model the desirable behaviors. In this way, the dual motivation of having the behavior demonstrated so direct consequences can be seen as well as having the trusted/influential person providing positive affirmation of the new behavior serves to sustain the change.

KEY TAKEAWAY

It would have been useful for both the TA Team, REACH staff and the county RHI members to spend time talking about network culture and determining how they could better model this for the county networks. Moving forward, we might consider taking the Network Culture Assessment (see Appendix 4) as an individual, group and network and then put together a plan for what parts of the culture can be worked on together.

Recommended Next Steps. Looking forward to Implementation Year Three (CY2015), the RHI TA Team will begin by working with each other to ensure that all of the TA Team members have a thorough understanding of and can model the network culture. Then the TA Team will work with the core leadership teams and workgroups to:

a. support the shift toward more of a network culture through on-site modeling during meetings, tools to support the shift, and ongoing cross-county conversations to share lessons learned (e.g., via virtual community of practice).

b. develop new outreach strategies such as the use of storytelling, videography, etc. as well as the use of network mapping to identify new community members to engage in the Initiative.

c. Identify areas of network culture where each county is particularly strong (e.g., using the network values checklist) and help them to videotape examples to document and highlight those strengths and share the video clips with the other counties. This process will serve to both acknowledge areas of strength but also highlight areas that need additional work. TA team members can then coach sites to identify major patterns that are constraining their implementation of RHI.

LESSON 2. An anchor institution – such as a Foundation – can provide the external influence necessary to begin the change process. An outside entity can help a community create urgency, express clear expectations, and provide needed resources. At the same time, Foundations also need to be flexible in how they do business or risk undermining the Initiative.

Foundation expectations drive behaviors. Foundation expectations drive grantees behavior until the behavior becomes the norm. For example, Lafayette's RHI participants really owned the mapping data and were very excited about using it to identify workgroups and workgroup members – to the point of using it during a core meeting. However, when they held a year-end planning meeting to discuss who else to invite onto the core team and the various workgroups, the mapping information was not identified as a resource. Changing norms is challenging and it is very easy to fall back on prior approaches to identifying new members. Having Foundation Staff provide a clear message to counties about the importance of network mapping reinforces the use of new network behaviors.

Throughout the Initiative, Foundation staff and TA Team members have strived to find the right balance between telling the Counties what RHI is and how to implement it and allowing the Counties to help shape RHI based on their understanding and experiences. The original intent was that with the right framework and a small planning grant, the Counties could use the opportunity to innovate and develop creative ways to increase access to health care in their rural communities. This plan did not come to fruition because additional time and supports were needed for the County leadership to be able to function in that manner. Historically, the process was to be given a specific goal and they would figure out how to implement that goal: "Just tell us what to do and we'll do it." Again, learning a new approach to utilizing grant funds in an innovative manner requires time together to understand what needs to change as well as the modeling of these new behaviors.

As the REACH team and the RHI TA team watched these dynamics play out among the counties in the early years, adjustments to expectations were made based on these learnings. At times, these adjustments were perceived as the Foundation "changing what you want" rather than

mid-course corrections to improve long-term outcomes. This disconnect between perception and reality may have been due to lack of communication or possibly to the fact that the cultures of the rural counties and the Foundation were so different that the same words were interpreted differently by the people in each setting (see section on Language below). This disconnect took time to understand and overcome as trust grew among the RHI partners. Partners – whether funders, service providers, or consumers – need to be on the same page in order to work effectively together.

Another disconnect that was identified was between the traditional Foundation funding stream and the needs of rural community-change initiatives. The traditional Foundation initiative funding stream typically begins with a large investment to support the building of capacity among participants followed by a reduction of monies each consecutive year. However, the rural communities that have been engaged throughout the life of RHI (Lafayette and Allen) are just hitting their stride with the Initiative at the end of Year Three. With a consistent revenue stream, they could expand the work and bring in new players; however, the traditional funding for initiatives calls for a reduction in grant monies which has caused the communities to need to think about sustainability and changes in programming just as the work is taking off.

At the outset of the Initiative, Foundation staff recognized the need for such changes to occur. Specifically, a 2012 funding request to the REACH Board included moving away from the status quo as a guiding principle of RHI, specifically stating that "the Foundation will be rethinking our grant making approach – doing single grants to single entities for a single year in our rural communities – because our limited investments to single agencies will never achieve dramatic change unless we strategically position and leverage our investments toward supporting meaningful targeted efforts that have demonstrated a better than chance probability of achieving high impact in rural settings."

While the level of change represented in the quotation above was not achieved (i.e., RHI continues to be funded on a year by year basis), the Rural Health Initiative continues to represent a significant departure from the norm for the REACH Foundation with regard to the size of investment, increased involvement of the program officers, and ongoing reinvestment for five years. As of January 2015, over a million dollars has been committed to the Initiative – going into some counties that had not received more than a small amount of money previously. And this money was placed in the counties in a very intentional way to bring about systemic change.

Recommended Next Steps: Ongoing support of the counties beyond the traditional life of an Initiative will send a message to the field that this kind of investment in learning and systems building is both a priority and requires a long-term investment strategy. One potential strategy may be to more explicitly structure the RHI grants as a pool of funds for (1) co-coordinator stipends; (2) communication system development, (3) training; and (4) an innovation fund that distributes money among working groups and projects. At this point, the backbone organization can become more of a fiscal sponsor and less of a lead implementer.

LESSON 3. There is a need to create more of a Smart Network with a core of collaborative relationships, a periphery to bring in new ideas, and a set of working groups with expanding leadership.

During 2014, considerable time was spent in mapping the county networks – the process took approximately four months for the sites (or longer in some cases). The maps illustrated that (a) more people are needed in the core of the county networks, (b) there are not yet enough people in the periphery of these networks, and (c) many of the individuals currently in the periphery need to be invited into the core.

Once this information was collected, TA team members met with each county to help them use the information to strengthen their networks. Changes in county staff and technical assistance providers meant that sites were not as well supported in using the maps to build a Smart Network as they needed to be. Building a Smart Network requires staff well versed in network development who can continually point out places where network thinking can be applied as well as use the maps in network building. However, growing such competency in network development is something gained primarily through practice and reflection.

Recommended Next Steps. During 2015, the TA Team will have more direct contact with the sites through the support of a new TA Team member whose focus will be on Network Coaching. In addition, the TA Team plans to spend more time articulating the components of RHI, especially the network aspects, so that they can better model and explain network structure and development. In addition, the Network Coach will work with sites to complete a network assessment to show where they are in terms of moving toward a smart network as well as provide them with concrete examples of how they can move closer to a smart network – for instance, use tracking tools to help sites see how they are bringing in new people and what role they would like those people to play.

LESSON 4. Changing behavior requires regular and clear communication with a shared language that is meaningful to all participants. Language can both clarify and obfuscate a shared language can help to compare innovations across communities but can also make the innovation less accessible to community members.

A. Shared Language. As mentioned above, an ongoing challenge throughout the life of the Initiative has been ensuring that RHI participants – whether county partners, Foundation Staff, or TA Team members – mean the same thing by the same words. And by extension, the language – or terminology – needs to be meaningful so that everyone is willing to use it. For instance, a goal of RHI is to develop “emergent leaders” so that the same people are not the ones responsible for the work of improving the system and creating change. We found that this term does not resonate with the rural community members the way “grow your own” leaders does. Many of the terms that the TA Team and Foundation Staff have used such as culture of

self-initiation, network weavers, collaboration, or theory of change are not the language of the rural community members. For instance, during a conversation about theory of change, several Lafayette County participants acknowledged that the term itself caused them to avoid the meetings. There have even been instances where the TA Team and Foundation staff have had misunderstandings about what is meant by certain terms, such as "network weaver."

Such miscommunication is unnecessary and makes challenging work even more difficult. Whether the miscommunication was originally caused by a cultural divide or lack of definition, an initiative as complex as RHI requires a common language that everyone can agree on so that barriers are caused by real dilemmas and not by misunderstandings.

This is one reason why more resources for technical assistance and adequate allocation of staff time are so critical. New perspectives and new consultants bring in new language – and time needs to be spent by the TA Team on understanding and integrating (and de-jargonizing) language before the project begins. However, this integration is unlikely to be fully complete before interaction with grantees begins so continual checking in on assumptions about meanings is essential. With grantees, adoption and clear understanding of new terms will also take time.

Recommended Next Steps toward a Shared Language. The first step to resolving this is to identify problem areas and then work together to craft common language that can be accepted by all. For instance, Allen County's Theory of Change is now referred to as a Roadmap. Such clarity will also help everyone to understand expectations. For instance, the very process of concretizing what early outcomes the TA Team was looking for in the form of a checklist has helped the counties to understand what the Foundation expected to happen. And if that tool is used by the TA Team to coach onsite work, then tools and TA can work together in support of implementation. In addition, the TA Team needs to help co-create other tools with the counties (such as one page summary documents) that are used to explain the Initiative by all RHI participants.

B. Communication Strategies. As might be expected with an Initiative that is attempting to implement a completely new approach to investing in rural counties along with multiple participants from a range of organizations, communication has been a challenge throughout the Initiative. 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. Box 2 on the following page provides an example of how a need for clarity and shared understanding impacted implementation of RHI in the counties and the subsequent response from REACH and the RHI TA team.

BOX 2. NEED FOR CLARITY AND A SHARED UNDERSTANDING OF THE STRUCTURAL COMPONENTS OF RHI: AN EXAMPLE

A core leadership team and the backbone organization are key components of the collective leadership framework and perceived as necessary to the success of community change efforts. In addition to setting the expectation that each county would establish these structures at the outset of the Initiative, the Foundation staff also encouraged the counties to separate the backbone organization and the core leadership team. The theory was that the core leadership team provides the vision while the backbone organization provides the support for the efforts. However, the counties felt an urgency to "get the work done" and they saw the backbone organization as providing the staff, facilities, and time to achieving their goals along with the leadership to keep the work moving forward. This led to core teams with heavy representation from the backbone organization.

What is not yet clear as of the end of the second year of implementation is whether the rural culture <u>needs</u> the core leadership team to live within the backbone organization – especially at the outset of the Initiative. According to stakeholder interviews, a main reason that organizations such as HCC, Thrive Allen County, and Connect Cass apply for grants such as RHI is to fund existing ideas for projects that further their mission. For instance, Lafayette had always intended to open one or more new clinics in their county and RHI provided the funds to do so. At the same time, the RHI grant offered HCC an opportunity to strengthen their network in new ways – a very appealing outcome. To try to separate the leadership for RHI from the backbone organization that has the staff to implement the new RHI program(s) might not be effective in rural counties with their limited resource pool.

However, it has also been suggested by RHI county leadership that while it helped to keep the leadership within the backbone organization at the outset of RHI, these roles may need to evolve over time. For sustainability of RHI to occur, there needs to be a transformation in the culture away from using the backbone organization to get the work done and toward community engagement with a broader group of people who haven't traditionally been at the table. If the backbone organization was allowed to continue to make all the decisions and implement the strategies then there's no reason to expect that anything will change.

A major goal of the Initiative is to identify emergent leaders who will step up and take on new roles so the same individuals are not taking on all of the responsibility and, ultimately, burning out. Over the course of planning period and first year of implementation, Foundation staff recognized that the backbone organizations in all three counties would benefit from additional support in identifying and mentoring new leaders. As a result, Foundation staff changed the direction of the TA Team toward supporting leadership development and network development in 2014.

Communication Tools. The distances involved in getting TA Team to the counties, and for the counties to meet with each other, are substantial. The TA Team is experimenting with the use of video-conferencing for its calls, and hopes to use this technology for a virtual Community of Practice session among the three counties. The TA Team are also attending core and working group sessions via Skype to observe progress and problems and provide more

targeted TA. The TA Team is meeting more frequently for short calls so that everyone is aware of interactions that have occur and the team can build on each other's work more seamlessly.

Is RHI a Project or a Process? Another clarification that occurred during Implementation Year Two is the distinction between RHI as a process or approach rather than as a typical project. While REACH did fund a program in each county as part of RHI, the intent of the Initiative was not to fund programs but to fund a process for bringing together a community to create change in new and different ways. The money to support a program (e.g., Community Connectors in Lafayette and Circles in Allen) provided the counties with a milieu in which to develop the structures and processes that make up RHI. The counties had to define RHI in order to staff and communicate with others about it and the means to do that came together around a project.

It has taken the counties, TA team, and Foundation staff time and discussion to truly understand this distinction. This language of RHI as a project rather than an approach to doing business was recognized as an impediment to full implementation by the end of Year Two. The Foundation staff and TA Team agreed that until RHI is perceived as the process through which space is made for innovation and collaboration, it will be hard for the counties to implement the Initiative with fidelity.

Effective Communication among TA Team and Foundation Staff. The RHI investment made by the REACH Foundation transformed not just the communities but also the Foundation and the TA team. For instance, the RHI counties are expected to develop systems of communication that allow them to share information openly and interactively with other health service partners, funders, and consumers. They are also asked to work collaboratively so all voices are heard and partners have input on nuanced decisions (and not just around technical decisions or "how to").

Typically, a Technical Assistance Team for an initiative will model the behaviors asked of the participants. However, this was not the case with the RHI TA team as the TA team did not have a clear system for letting each other know who was on site, when, and what was learned. The team was also functioning more as a hierarchy than a collaborative. Upon recognizing that the team was not effectively modeling their expectations for the counties, processes were revisited and changes made.

Recommended Next Steps to Support Communication: Several strategies have already been mentioned regarding how to improve internal communication throughout RHI participants. Recognizing the need for a shared language and shared communication tools among the TA Team as well as among all of the RHI participants has been the first step. The TA Team is currently working on putting together such clarifying documents and tools.

Training (and modeling) on the use of video conferencing to support meeting participation by people located too far away to meet in person (a typical problem in rural communities) is also underway in Year Three. The TA Team will also spend more time clarifying assumptions and

interacting to share what they are learning. Finally, a matrix summarizing clear roles and responsibilities is also helpful to make sure everyone knows who should be involved in different internal communication strategies. For external communication, the TA Team and Foundation staff are beginning to explore new approaches to outreach such as storytelling, videography, and social media to help each RHI County engage more community members.

LESSON 5. Networks in the throes of innovation need the space in which to make mistakes, learn what they need to learn, and have time to grow the trust necessary for meaningful improvement to occur. However, too much time on process can stop forward momentum in its tracks. It is imperative to find the right balance between time to build capacity while simultaneously implementing a change strategy that makes a visible difference.

At the conclusion of Implementation Year 2, REACH staff and the TA Team now have a better understanding of the kind of investments county participants must be willing to make to create meaningful change including:

- Passion/Commitment;
- Dedicated staff time;
- Willingness to try new things and be wrong; and
- Willingness and capacity to reflect, learn, and change as the Initiative progresses.

At the same time, ongoing conversation with REACH Staff, TA Team members, and RHI county participants has helped to clarify the specific supports needed by the RHI participants including:

1. A new space in which innovative dialogue can occur.

Time and again, RHI participants have identified the need to create a new normal for meaningful change to occur. For this new normal to take root it may require a structure such as the core leadership team, a process such as regular meetings, or the creation of working groups to pursue new ideas. To break free from the status quo, communities need opportunities for face-to-face conversations with clear goals and expectations for how to implement those goals. Rural community members tend to know each other well which can be both an incentive for working together and a deterrent if a new project makes waves in other areas of the community. An initiative such as RHI needs a way in which participants can create a safe space in which to be innovative. Helping communities to develop a network culture will begin the process toward developing this safe space.

Having a safe space for innovation applies equally to the program officers and TA Team. How does the foundation develop a new initiative? Other foundations are doing collaborative "discoveries" before they begin a new initiative[1]. A discovery process is a period of collaborative learning and joint design with a variety of stakeholders – including both outside experts and people in communities – who collaboratively learn about networks and identify a

[1] June Holley is working with the Robert Wood Johnson Foundation on such a discovery process.

course of action. For future Initiative launchings, the Foundation might want to open with a year of convening collaborative learning sessions in lieu of a planning period, so that concepts such as networks and collective impact can be explored before the actual Initiative begins.

Recommended next steps. The new TA Team Member – the RHI Network Coach – will model and support the development of a network culture. The TA Team, including program staff, will spend time learning about and practicing network culture and reiterating to the counties the need to experiment and possibly make mistakes.

2. A TA Team with the appropriate combination of expertise, time on site as well as off, etc., right from the outset, coaching coordinators, working groups and core team.

A great deal has been learned about what is necessary to help implement an Initiative as complex as RHI. One of the most important lessons we have learned from this project is that everyone on the TA Team (including program officers) needs to understand, model and reinforce the changes they are asking the counties to make. For that to happen, much more learning and discussion is required than initially anticipated.

In addition, facilitation can help to create a new culture. Close-knit communities need time together to work through their own internal dynamics and better understand not only who needs to be at the table but how they need to work together to be effective which may involve a new kind of collaboration, shared leadership and approach to innovation than might have previously been used.

Success also requires new network skills, enabling participants to reach out and engage community members in new and different ways. Implementing a network approach also requires a new set of leadership skills. But we have found that people in communities of all sizes need coaching along with training so they don't revert to a traditional leadership mode. This is why ongoing coaching by technical assistance staff and program officers is so critical. New skills need to be supported within the natural environment through coaching, modeling, and advising. At the same time, any technical assistance provider must have a thorough understanding of the local culture to be seen as a trustworthy partner in the change process.

Furthermore, few organizations have the expertise to regularly collect and analyze data to inform daily decision-making. Organizations need specific technical assistance in data collection in support of their theory of change. At the same time, data collection in rural settings includes a unique set of challenges tied directly to cultural norms. Grantees need support in learning new and different strategies for gathering data such as using online surveys or texting questions to large audiences in order to obtain information from the wider community.

*Recommended Next Steps***.** Though challenging, it is imperative that sufficient time be spent prior to the launch of an Initiative to ensure that a TA Team is developed that incorporates the kinds of skills mentioned above. Hindsight allows us to recognize the value of the TA Team in moving the work of RHI forward in a way that wasn't possible at the outset of RHI. Looking

forward, the Foundation needs to continue to act on the annual learnings and change the TA team members as needed if the work is not being supported effectively.

One of the practices the TA Team plans to spend more time on is deep reflection – taking time to look at how the Initiative is doing and learning from that before taking a next step. This way we will discover ways to make our work more effective. For example, this type of reflection has led the TA Team to develop a one-pager to describe various aspects of this Initiative so that we all understand them before we share this with the counties.

3. Trust between Funder, Grantees, and TA Team

Though the REACH Foundation launched RHI with three organizations they knew well from prior work, the depth of interaction had not been at a level to generate the kind of trust necessary to take a leap into the unknown. While everyone recognized that this would be a different experience, no one knew just how much of a learning experience it would be. At the same time, there was an unrecognized divide between the rural community members and the mainly urban/suburban Foundation and TA Team members. As a result, a great deal of time went into understanding how to talk to each other; how to communicate effectively:

> *It took [the REACH program officer] and me three years before we could have exchanges in a productive way. [At first] we didn't understand each other. A lot was urban versus rural. They were used to free clinics. When outside KC Metro, your level of leadership is DIFFERENT (i.e., it is not less.) We make do based on our resources. We don't have buses and barely have a taxi. When I explained what we need, they didn't understand. We were learning from each other.*
>
> Lafayette County RHI Participant

What was clear was that intentions were good – everyone wanted to see meaningful changes in the health outcomes of these communities, and, as a result, were willing to work through the miscommunications to pursue this lofty goal. One of the most significant areas of growth over the course of the Initiative can be seen in the strengthening relationships:

> *I've done a 180 in appreciating this Initiative. Now when I'm asked by REACH to have faith, I'm willing to take that leap even if I'm not entirely sure it's the right step to take.*
>
> Allen County RHI Participant

These relationships are essential to the success of any Initiative as complex as RHI – norms need to change, people have to move outside of their comfort zone, and prior experiences are not always representative of what needs to happen in the future. Trusting relationships are a necessary foundation upon which change can occur.

Recommended Next Steps. Continue to build relationships. Spending time on site and demonstrating an interest in truly understanding the culture is essential. It may also be helpful to create opportunities for funders to listen to grantees in an open and safe forum where concerns can be voiced without fear of reprisal (i.e., loss of future funding).

4. A clear set of tools and processes to use and onsite coaching to support use of them.

The Network Weaver Handbook is a valuable tool but too much for most people in one serving. With more technical assistance capacity at the outset, the TA Team could have slowly introduced activities from the Handbook such as the Network Values Checklist (see Appendix 4) so that the network culture was more digestible.

Part of what a TA Team needs to do is provide training and coaching in processes such as:

1. collaborative visioning, planning, and work;
2. understanding and improving their network;
3. learning and reflection to make sense of what they have done;
4. seeking out new ideas from other communities;
5. building a network culture of peerness, openness, inclusion, and collaboration;
6. developing network leadership skills and competencies.

Tools to support these processes include:

- What are the network elements and how do we create them? (Network Elements)
- What leadership roles do we need in a network? (Network Leadership Checklist)
- How much do we, our organizations and our network reflect a Network Culture? (Network Culture Assessment)
- How do we know our meetings are functioning in these new ways? (Early Outcomes Meeting Checklist)

Recommended Next Steps: Looking forward to 2015, the TA Team has plans underway to identify two to four specific tools for use during the year. In this way, data can be collected around the key issues and utilized to inform decision making with the support and encouragement of an on-site TA Team member.

IX. CONCLUSION

The Rural Health Initiative has made tremendous progress in understanding what is needed to create and support meaningful change in rural communities. RHI participants – Foundation, TA Team and community participants – now understand in a much deeper way that systems change requires a focus on culture change – a shift to more open, inclusive, innovative and experimental ways of acting and interacting. We have seen how working with the counties to build a network that includes a core of connected and engaged community members helps counties shift their culture. But it is the development of working groups to organize action that has started what we hope will soon be a quantum leap in the capacity for change. As we build on the training in adaptive leadership provided in 2014 with more group and co-coordinator coaching in 2015, we expect to see an increased number of skilled network leaders initiating many more experiments in access to healthcare.

The external influence of an anchor institution to build urgency and hold communities accountable for innovation is important; however, we now see that the influence of such institutions is greater when that institution is modeling change in its own behavior and integrating lessons learned into how it does business. Furthermore, time spent on developing a shared language to make the process more concrete, along with a clear communication system – both internal (within the Initiative) as well as external (with the wider community and field) – is essential to success and needs to continue in 2015.

Finally, one of the most challenging learnings for all partners is, in order to create meaningful and sustainable change, you have to be willing to take time, make mistakes, self-correct and try again. This is true at all levels of the Initiative – Foundation staff, TA Team members, and County participants. Having a well-developed Theory of Change – at the foundation and the county levels – to help plan and evaluate the Initiative is necessary right from the outset of an initiative. By helping to surface underlying assumptions about what structures and processes lead to the desired outcomes, the TA Team can more clearly capture what is occurring on the ground and why. In a world focused on visible outcomes, it is hard to accept that the very process of revising a theory of change to more accurately represent the reality of HOW to create change is an outcome to applaud.

Looking forward, the question of what we mean by "sustainable" continues to be an open question. According to a REACH staff member,

> *If this Initiative is able to build sustainable leadership and networks, then we've been successful. To the extent that they outlive us as an RHI investment, then we've been sustainable. The be all, end all is that we have to have capacity to leave a county….For them to be able to sustain leadership, network, and other processes without us there. Without [those processes], the counties are less likely to be able to establish health care systems that will remain effective and sustainable.*

The third year of RHI implementation is poised to be the year when all of the pieces come together – structures in place, networks more fully developed, leadership more diverse, and theories of change utilized to assess improvement. With the continued support of REACH, the RHI may in fact produce the kinds of innovative strategies that result in meaningful improvements in the health outcomes of rural counties – and, at the same time, build long term capacity for change.

X. REFERENCES

Clancy, C. Munier, W., Brady, J., et al., (2013). 2012 *National healthcare quality report.* Rockville, MD: Agency for Healthcare Research and Quality.

The Commonwealth Fund. (2009). *Quality Matters: Innovation in quality health care improvement.* Accessed on 1/21/15 from http://www.commonwealthfund.org/publications/newsletters/quality-matters/2009/november-december-2009/in-focus.

Holley, June. *Network Weaver Handbook* (2012) Network Weaver Institute.

W.K. Kellogg Foundation (2008). *The Rural People, Rural Policy Initiative Overview*. Author.

Rural Health Research and Policy Center. (2009). *Profile of Rural Health Insurance Coverage: A Chartbook*. Author.

Plastrik, P., Taylor, M., and Cleveland, J. (2014). *Connecting to Change the World: Harnessing the Power of Networks for Social Impact*. Island Press.

Appendix 1: 2011 Demographics of Counties

	Allen County	Lafayette County	Cass County
2011 Population	13,411	33,287	100,052
Median Household Income	$40,275	$50,648	$53,936
Poverty Rate	15.4%	7.8%	9.0%
Unemployment Rate	5.8%	6.5%	6.4%
Total Uninsured	1, 677	3,779	12,314
Percent of Uninsured	12.5%	11.6%	12.4%
Percent of adults who could not see a doctor in the past 12 months because of cost	12%	15%	13%

Additional Information About Health In RHI Counties

Allen County. Within Allen County, a declining rural population and low numbers of providers per capita make access to health care more difficult. Allen County's high percentage of older adults strain the health care system. The county, like the nation, continues to see rising obesity rates from 31.3% in 2010 to 34.3% in 2012. More than one-third of Allen County residents live below 200 percent of federal poverty level. Births to teen mothers are higher than the national average, and the percentage of mothers with inadequate prenatal care is rising.

Lafayette County. The projected increase in the county's older population will likely strain the health care system. Like many other rural counties, Lafayette County has fewer health care providers per capita, which limits access to health care. In the past year, Lafayette County, like the nation, has seen rising obesity rates. Auto crash deaths are higher than the national average. The County has the 11th highest incarceration rate in the state (2012) and 4th highest felony sentencing rate in state.

Cass County. The projected increase in the county's older population will likely strain the health care system. The county's percentage of adults who smoke and adults who are obese exceed national averages. With no psychiatrists based in the county, residents lack easy access to mental health care. Benefit from urban sprawl as exurban communities grow near rural parts of the state.

Appendix 2: Sample Network Maps

Final Report on Network Mapping in RHI Counties 2014

Summary

County	Mapping Period	Number Sent Survey	Response Rate	New Names Added
Lafayette	March - June	143	74%	86
Allen	May - August	129	76%	125
Cass	June - November	174	43%	19

Purpose

- To provide county RHI projects with information on the state of their Access to Healthcare Networks
- To work as a collaborative
- To use maps to enhance their networks through strategic outreach

Process

- Pulled together mapping working group
- Jointly developed a survey
- Gathered a list of names and emails
- Followed up to get 60% response rate
- Lafayette: made maps
- Reviewed maps
- Shared with core team and/or stakeholder group

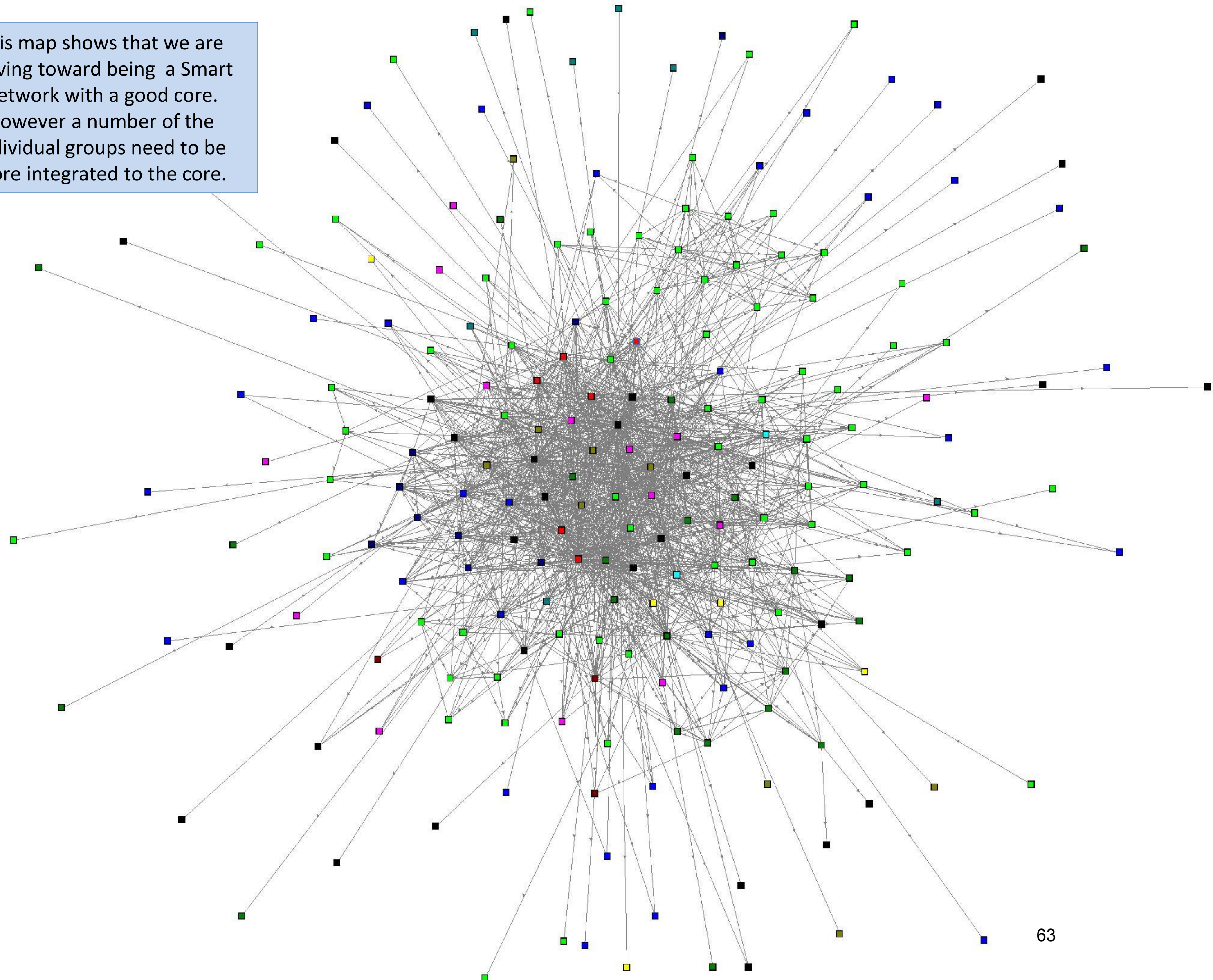
Current Collaboration Networks

Both Lafayette and Cass have the start of a Smart Network, though most people in the periphery should be drawn into core and more people from other communities should be added to periphery.

(Allen did not do this question)

Lafayette Map 1: Total Current Network

This map shows that we are moving toward being a Smart Network with a good core. However a number of the individual groups need to be more integrated to the core.



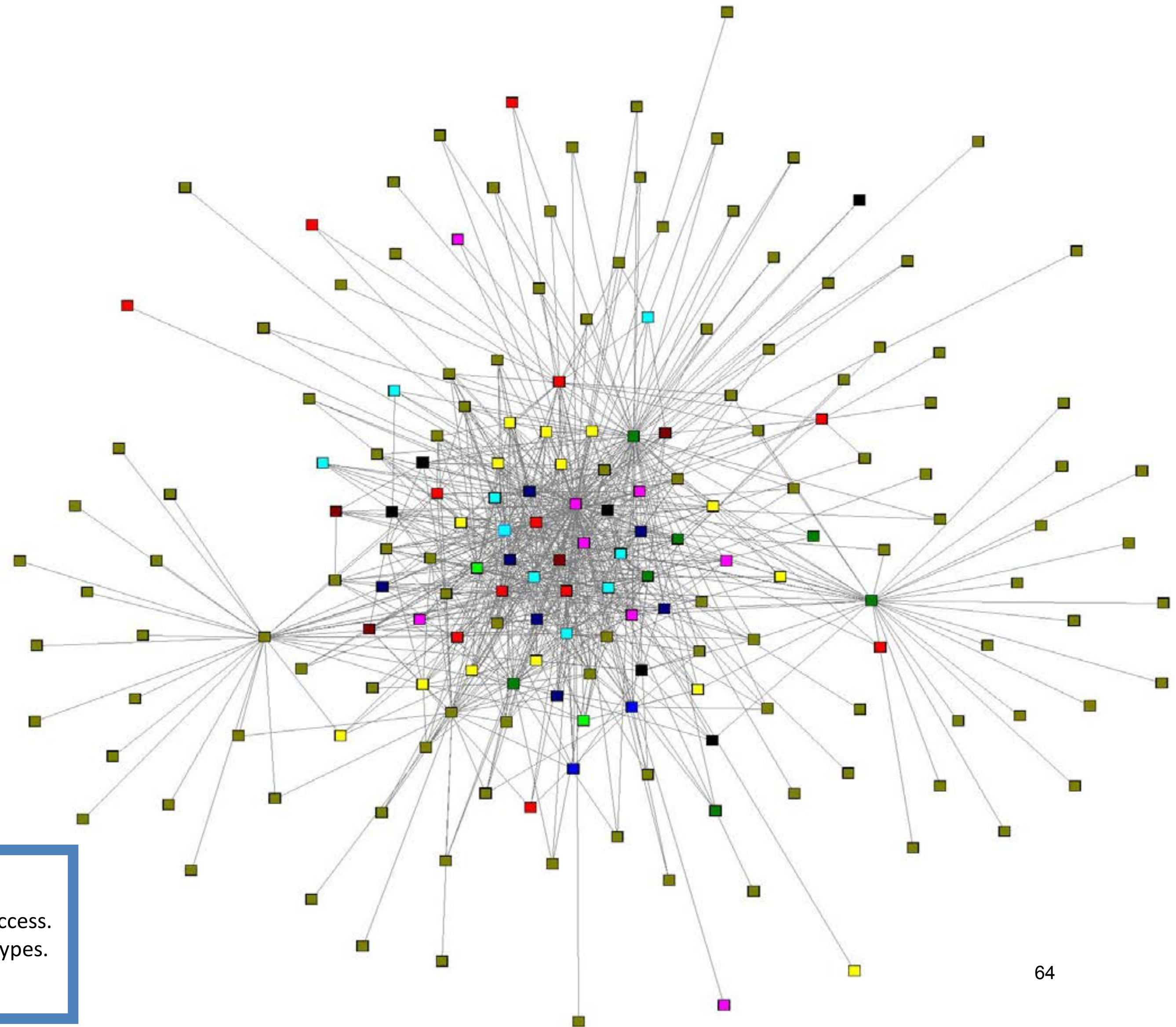
Legend

- MH Services
- Migrant Services
- HCC
- Government
- Healthcare
- Senior Services
- Education
- Religious
- Social Service
- Individual
- Disability Services

Allen: Who Would You Like to Work with on Health Access?

Legend

- Social Service Agency
- Non-profit
- Government
- Non-profit healthcare
- Other
- Did not answer
- Educational institution
- For profit biz
- Healthcare

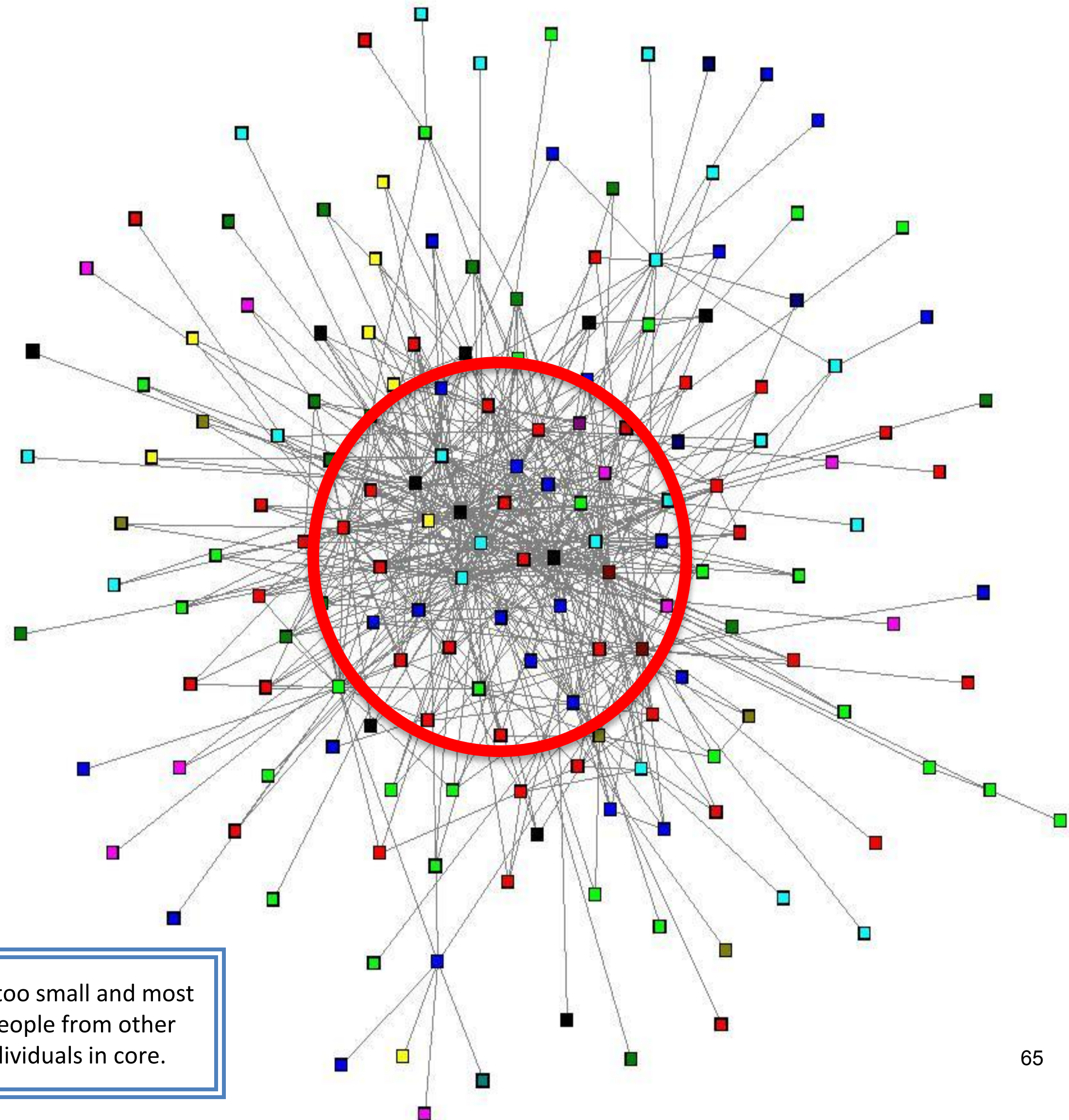


People want to work together on health access.
They want to work across organizational types.

Cass Collaboration Network for Health Services

Legend

- Medical
- Non-profit
- Government
- Education
- Hospital
- Public Health
- Business
- Oral Health
- Private Individual
- Religious

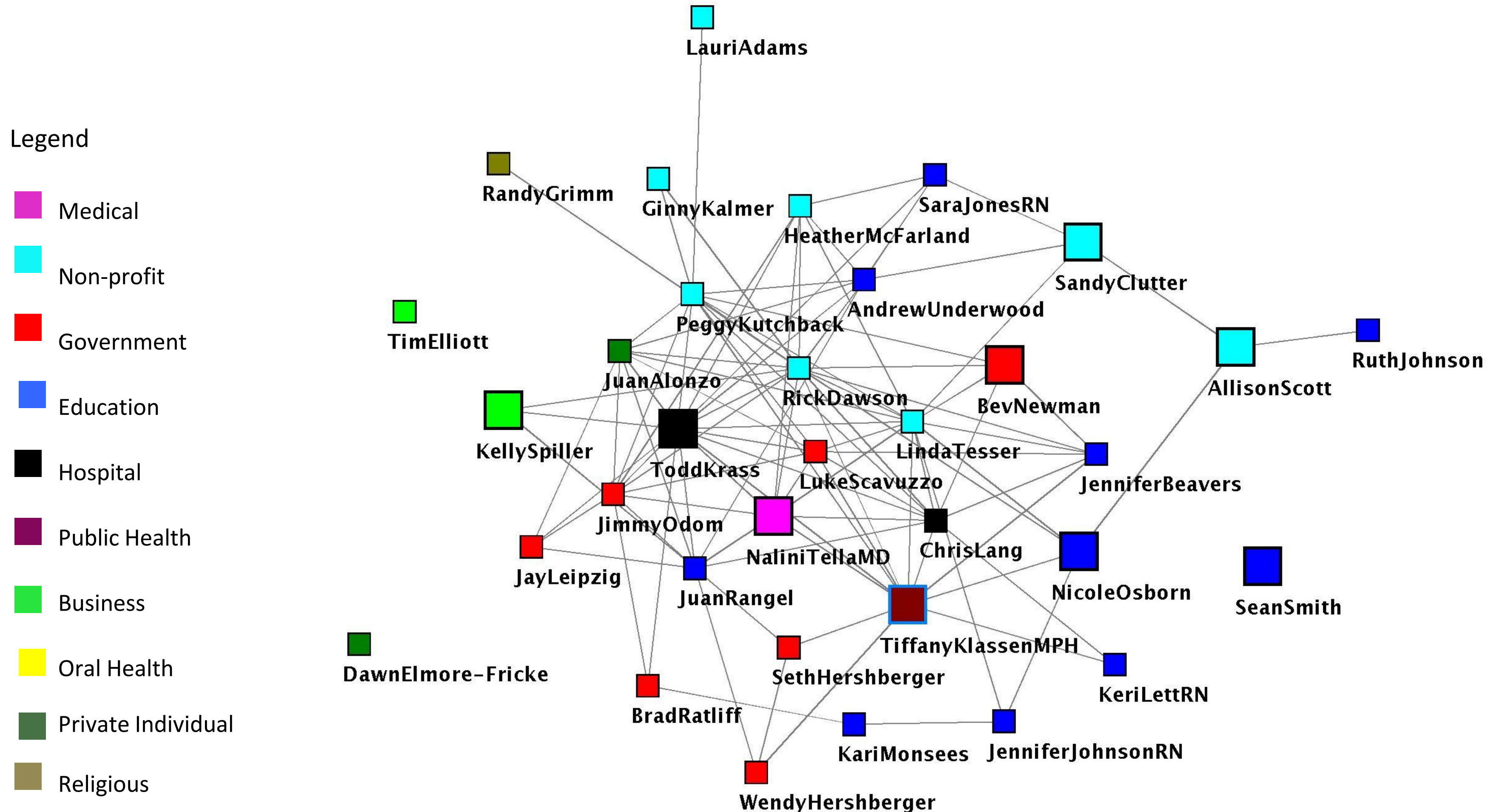


This map shows the start of a Smart Network but core too small and most of periphery should be in core. Periphery should be people from other communities. Few oral health, hospital or private individuals in core.

Clusters

- All three counties identified clusters that could be used to add new people to working groups or to form new working groups.

Cass: Would like to work on Mental Health Access

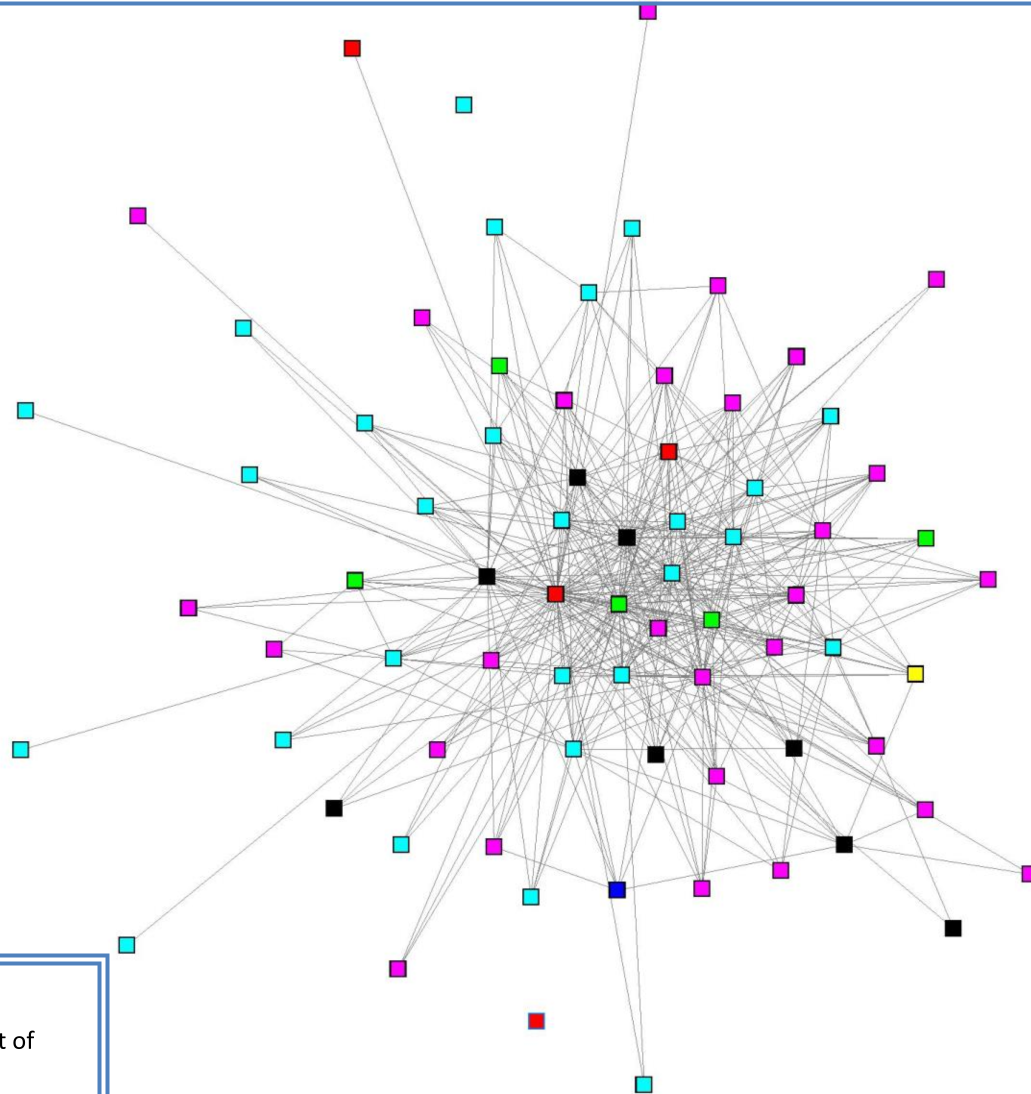


Large squares are people who said they were VERY WILLING to help convene a group to work on mental health access. Will need to do some connecting, as group loosely connected.

Allen: Circles Interest

Legend

- Not Interested
- Willing to help periodically
- Willing to be coach
- Other
- Interested
- Currently active
- No answer

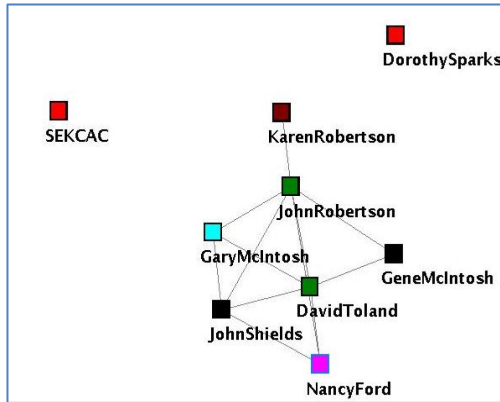


Many people are interested in being part of circles, especially periodically.

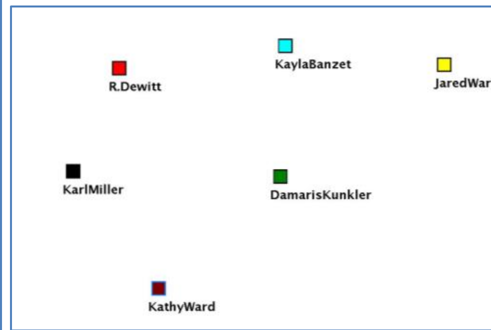
Allen: Interested in working on….

Legend

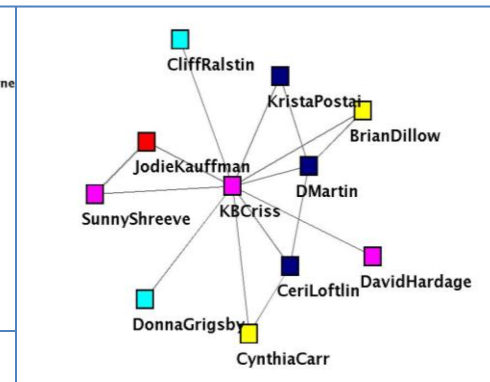
- Social Service Agency
- Non-profit
- Government
- Non-profit healthcare
- Other
- Religious
- Educational institution
- For profit biz
- Healthcare
- Funding



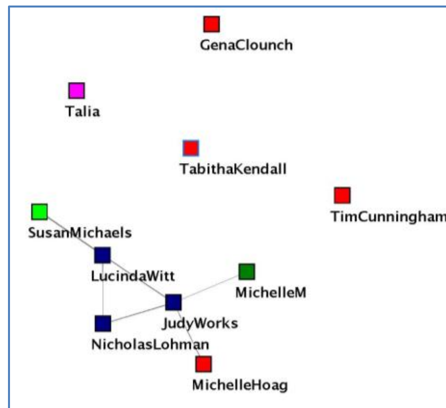
ACA



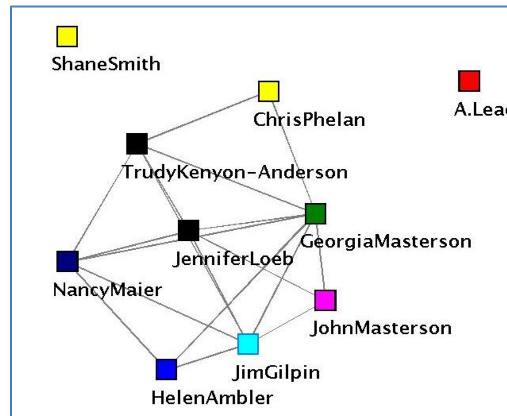
Behavioral Health Stigma



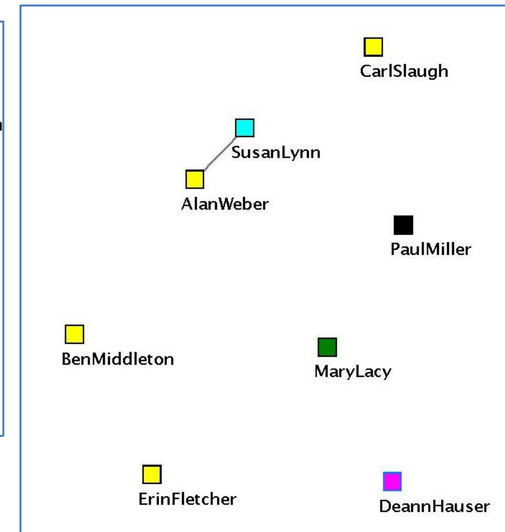
School Health



HC Coordination



Circles



Health Literacy

HC Transport

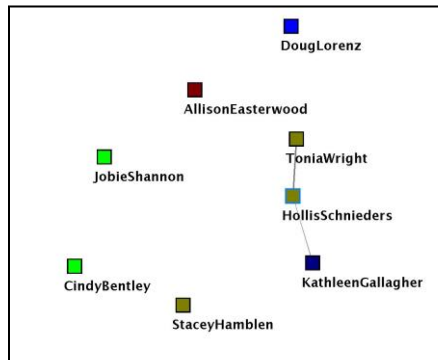
Lafayette: I'm Interested in Working On…

SuzanneGladney

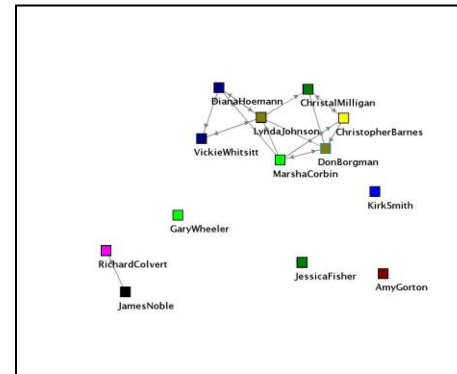
Migrant Health

Legend

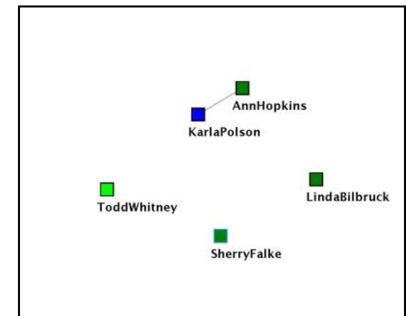
- MH Services
- Migrant Services
- HCC
- Government
- Healthcare
- Senior Services
- Education
- Religious
- Social Service
- Individual
- Disability Services



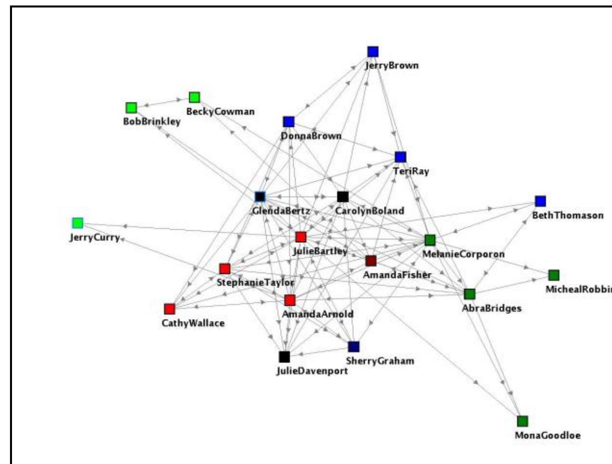
ACA



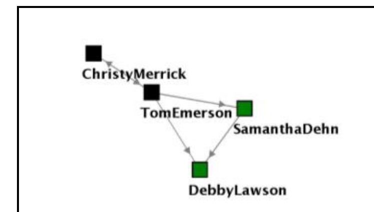
Care Coordination



Behavioral Health Stigma



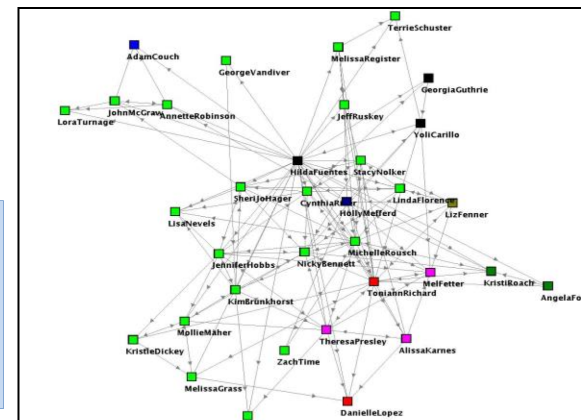
Connectors



Health Literacy

Transportation

Shows which areas are of greatest interest, how well connected they are and how many sectors are represented. Working on care coordination would connect people from different sectors. May need to educate people about migrant health and transportation.



School Health

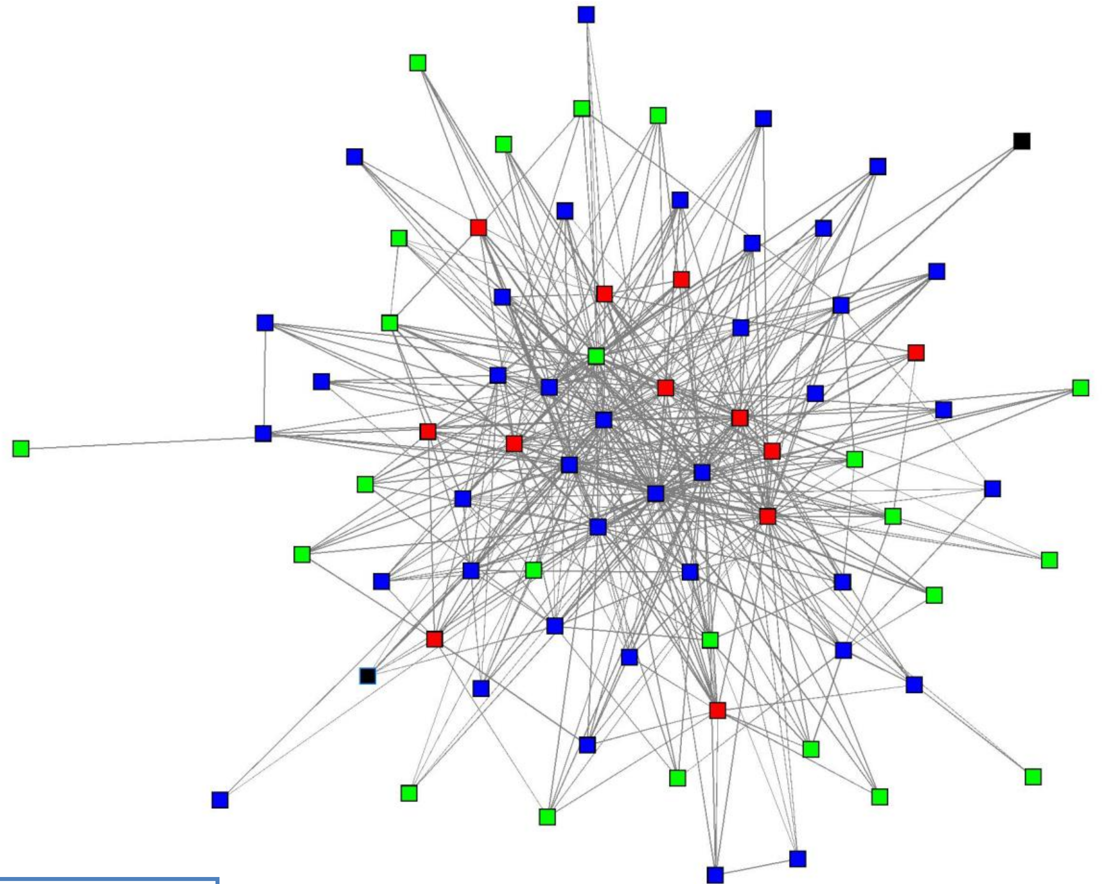
Other interesting Questions

Cass found out that many people did not know about their network, and that many people were interested in working on access to healthcare.

Among Those Who Took Survey
How Well Do You Know the Cass Rural Health Initiative?

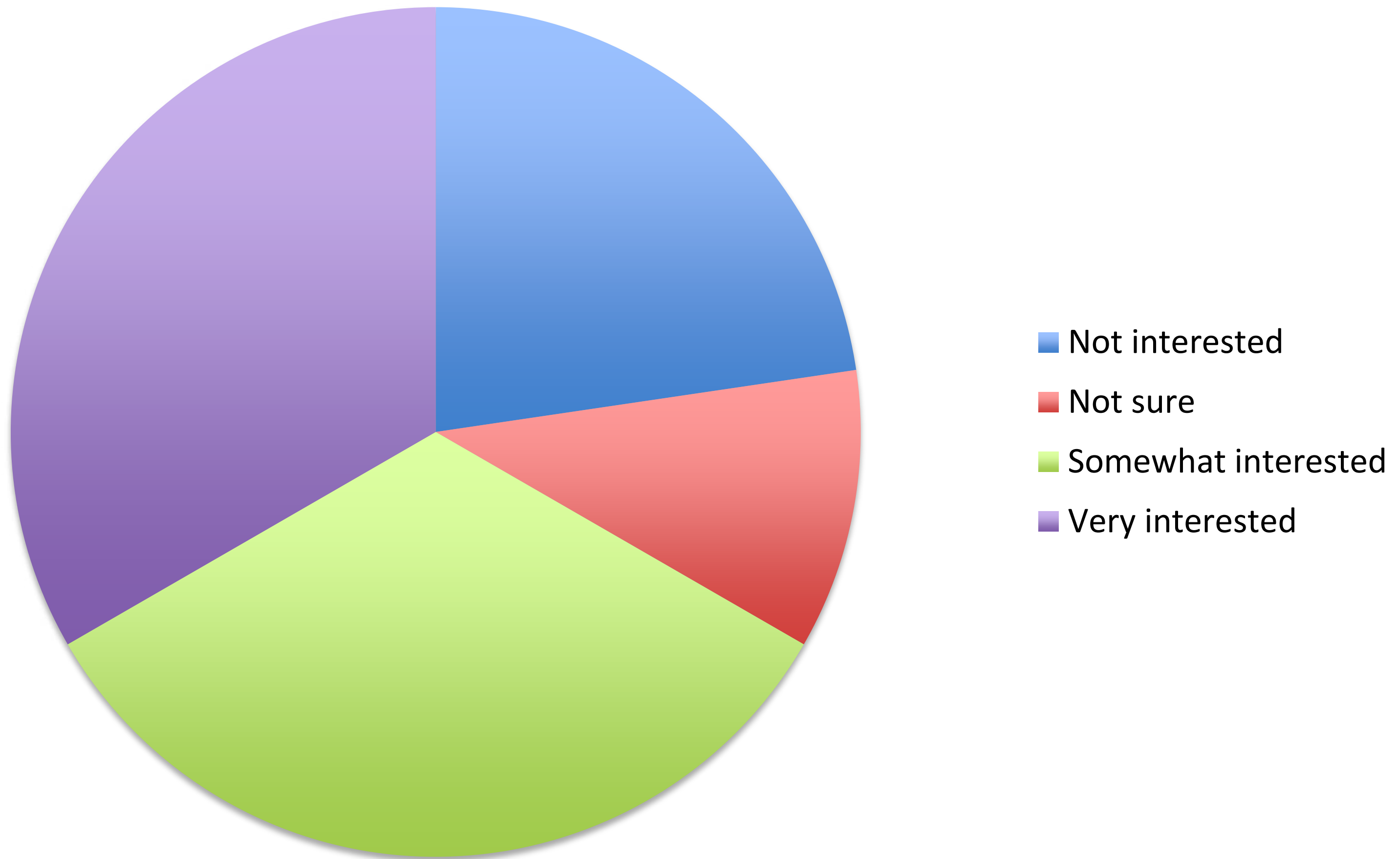
Legend

- Very familiar w RHI
- Somewhat familiar
- Not at all familiar
- Did not answer



Many of those surveys are not familiar with RHI, especially those not well connected to the core.

Cass: Among Those Who Took Survey How Interested in Working on Health Access



Using Maps

- Lafayette did use maps to identify people outside their urban hub and to identify new people for school clinics
- Not sure of usage in all counties but working with TA Team on this

Metrics

- Individual and network metrics are available for each network but are better when used as a comparison with metrics from a second mapping

Appendix 3: Early Outcome Checklist and Explanation

Rural Healthcare Initiative (RHI) Checklist: Capturing Progress on Early Outcomes 7.14.14
Explanation of The Purpose and Intent of Each Checklist Question

Purpose of Checklist: To verify that the structures, strategies, and activities implemented as part of the Rural Health Initiative are having their intended impact, we have developed a checklist to capture progress on the RHI early outcomes. Specifically, it is intended to help you and the TA Team see where your county has made progress on supporting emergent leaders, building larger networks, establish effective communication strategies, building the capacity of RHI partners to become even stronger project managers, developing additional resources, and creating a culture of innovation, collaboration, inclusivity, and self-initiation and where support may still be needed. Because much of the work of RHI occurs in meetings (core, stakeholder, and working group), this checklist is designed as a quick screen of what occurred during any one of those meeting as a way to capture progress and measure change over time. The goal is to be able to review this information with your RHI team on a regular basis as well as look at the data over time to know where mid-course corrections or more supports are needed to strengthen implementation of your RHI projects.

Below is the question title followed by a description of what the question is intended to capture. Note that the term "stakeholder" is used throughout the document and refers to organizations and individuals that are in some way impacted and/or serve people around the topic of access to health. This includes consumers (un/under-insured as well as service providers, volunteers interested in the topic, etc.

Question	Explanation
1. Group Type	This provides information on the type of meeting involved – core, stakeholder, or working group. We can look over time at whether the answers vary depending on what type of group is meeting.
2. Agenda: Process	This section is checking whether the person convening the meeting (e.g., meeting facilitator, chairperson, etc.) is using the agenda as an effective management tool. Effective project management requires that you have a clear set of expectations for what each meeting should accomplish and have communicated those expectations to meeting participants. The agenda is a tool for doing so. By including a timeframe for each agenda item, it allows the meeting facilitator to keep the meeting focused on the intended goals.
3. Agenda Quality	For the agenda to help meeting participants understand the purpose of the meeting and come prepared, it needs to clearly articulate the meeting goals, intended outcomes, and topics to be covered. Timelines next to each topic provide guidance regarding the importance of each topic during the meeting.
4. Meeting Summary Notes	Meeting summary notes are another essential project management tool to help keep the initiative/group running smoothly. Summary notes help keep a running record of topics discussed, decisions made (and why), assignments and dates for deliverables. With the information, participants who attended the meeting can keep track of this information and meeting members who could not attend can read the notes to stay informed. Summary notes (and/or the action plan) can also be used as an accountability tool to hold participants accountable for their commitments. Finally, summary notes can be shared with others such as the RHI TA providers so they can keep up with what kinds of supports might be helpful.
5. Facilitation of Meeting	One of the underlying goals of RHI is to build the leadership skills of a wider array of community members so that the responsibility for implementing new projects doesn't always fall to the same people. This question allows you to track whether there is someone identified to guide the meetings and if it is typically the same individual/perspective (e.g., the backbone

Question	Explanation
	organization). Encouraging other members (e.g., working group coordinators or other core team members) to step up and lead meetings can be very empowering – especially if the more experienced team members provide coaching to support the success of the new facilitators.
6. Review of Previous Activities of the Group	Revisiting prior activities is another project management strategy for holding partners accountable for doing what they agreed to do. By checking in on the status of activities, the team can celebrate successes and discuss challenges that need collaborative problem solving. An action plan or documentation in the meeting summary notes is an effective tool for keeping track of what partners agreed to accomplish and by what time. Reviewing prior activities also provides an opportunity to remind partners of the connection between individual activities and projects and the larger RHI vision. This helps the group stay focused on the overarching goals/outcomes you are working toward and how you plan to get there.
7. Conversation During Meeting	This question speaks to the quality of the discussion that occurred during the meeting. A strong facilitator will help the conversation stay focused, aligned with the agenda, and ensure activities/projects always have a responsible party and timeline assigned. (Making sure all voices are heard is included in "Participation" below). The agenda is an effective tool for the facilitator to sustain focused conversation and bring the group back to the intent of the meeting if the conversation gets too far off topic. Of course, if the conversation is off topic but essential to furthering the needs of the RHI initiative then the facilitator can quickly adapt the remainder of the agenda to allow the conversation to continue. If this occurs, it is important that the facilitator acknowledge the change to the agenda and indicate which topics will be reserved for future meetings and which topics (if time-sensitive) will need to be addressed via email, phone, etc.
8. Participation	To ensure that RHI meetings reflect increased inclusiveness, members need to understand why it is important that they are at the table, understand the overall vision so that they can participate, and feel comfortable sharing their perspective. At the same time, inclusiveness means that partners are not just involved in the technical aspects of projects but also in the more nuanced, adaptive conversations (e.g., what projects to prioritize and why).
9. Diversity of stakeholder representation	This question follows up on the value of inclusivity by capturing how intentional the group is about including a wide range of stakeholders – including consumers (i.e., the under/uninsured) as well as partner organizations – on the team.
10. Reflection on progress/ activities during meeting & adjustments made as needed	An important component of any meeting is to make the time to learn from one's experiences. By reflecting on progress and challenges, it allows the team to make mid-course corrections to existing projects that aren't progressing as intended. Data makes this conversation even richer.
11. Use of data and/or other information to guide conversations and/or decisions	A learning organization is intentional about their goals and the outcomes they are trying to accomplish and collect data to inform progress toward attaining those goals and outcomes. A learning organization also reflects upon what they've learned from prior activities and use data to determine the effectiveness of those activities. Any activities that are not producing the intended outcomes need to be changed or more fully implemented.
12. Decision-Making Process	The decision-making process within a collaborative team involves offering opportunities for everyone's voice to be heard and to be sure that innovative alternatives have been considered. Final decisions are made in a transparent fashion so that meeting members understand how the decisions was reached – and can live with it – even if the decision isn't the one they would have made themselves.
13. Opportunity for others to step into leadership role	As mentioned previously, a common dilemma faced by rural communities is that the same people take on leadership roles for new programs. Through core, stakeholder and working group teams, there are many opportunities for the current community leaders to encourage new RHI

Question	Explanation
	participants to take on leadership roles such as becoming a member of the stakeholder group or becoming a working group coordinator. This question represents different levels of support for emergent leaders from encouraging others to be a new leader to providing support and/or coaching for a new leader. Such mentoring of new leaders may not be visible during the meeting but may be discussed to be clear that mentoring of new leaders is very intentional within the group (e.g., through co-coordinator roles); thus encouraging more individuals to step up into leadership roles. Additionally, leadership does not need to occur through a formal role – someone may agree to take on a task he/she previously had not done (e.g., taking meeting notes) or participate in the conversation in ways that help move it forward (i.e., displays leadership behavior outside of a formal role.)
14/15. Culture of Collaboration and Innovation	A goal of RHI is to bring new partners to the table, provide opportunities for them to work together, and allow innovation to arise through these new connections. To do so, a key function of the core leadership group is to create opportunities (i.e., meetings, projects) for individuals AND organizations to join the conversation around improving health outcomes. The culture encourages trying out or piloting new ideas and creating even more opportunities for working together to create a more effective, efficient health system. Network mapping is a tool for helping to identify individuals and organizations with which to partner.
16. Culture of Self Initiation	As mentioned previously, rural communities tend to have a small handful of energetic individuals who take responsibility for initiating new projects. The network approach and working group structure provides an opportunity for new individuals to step up and lead relatively small projects they feel passionate about to help them gain the skills and/or confidence they need to play a larger role in the county. By creating the structure (working groups) and process for individuals to play a lead role, the core leadership team encourages a culture of self-initiation which ultimately facilitates further collaboration and innovation as well.
17. Development of Resources	The RHI initiative aims to encourage the utilization of new RHI collaborations to identify, develop, and obtain resources that weren't previously available and/or accessible prior to RHI. Resources may include new grant opportunities, leveraging existing grants/resources to bring in new resources, new partnerships, time, facilities, etc.
18. Topics of conversation	The intent of this question is to capture the topics that are consistently discussed by each type of group (core, stakeholder, working) over time. With the information, we can look at the connections between the types of conversations being held, implementation of new projects, and change in outcomes over time. This will help us all understand the different roles that each group plays within the RHI system.

Rural Healthcare Initiative (RHI) Checklist: Capturing Progress on Early Outcomes 7.14.14

Instructions: Please have one person complete this form immediately following an RHI meeting. Check the appropriate box/es. Fill in clarifying information (e.g., which?, why not?). Scan and email form to: (a) RHI point person and (b) Adena Klem (RHI evaluator) at adenamklem@gmail.com.

Date:

County (Circle one): Allen Lafayette Cass

Time Since Last Meeting of This Type:

Method: In-person By Videoconference By Phone

1. Group Type

- ☐ Core
- ☐ Stakeholder
- ☐ Working Group: (which: ____)
- ☐ TA Call

2. Agenda: Process

- ☐ Not shared
- ☐ Written agenda shared at meeting
- ☐ Written agenda shared in advance (in body of email or as an attachment)
- ☐ There is time set aside at the beginning for participants to add agenda items
- ☐ There is time set aside at the end for participants to help create next agenda

3. Agenda Quality

- ☐ Not shared
- ☐ Agenda clearly identifies desired meeting outcomes
- ☐ Agenda identifies specific topics of conversations with key points to address
- ☐ Agenda provides a general timeline for each topic to keep meeting moving smoothly

4. Meeting Summary Notes

- ☐ No summary notes shared from last meeting
- ☐ Summary notes from last meeting were distributed in a timely manner to partners
- ☐ Notes included a listing of specific agreements reached during the meeting, tasks to be completed, who was to complete the tasks, and by when
- ☐ Last meeting notes were reviewed today for accuracy
- ☐ Note-taker for current meeting is identified

5. Facilitation of Meeting

- ☐ Who took the lead for guiding this meeting? ______________________________
- ☐ What agency/perspective is that person from? ______________________________
- ☐ Membership on other RHI groups? (list:___________________________________)

6. Review of Previous Activities of the Group

- ☐ Not done
- ☐ General review of previous activities completed but not tied to previous assignments in summary notes or action plan
- ☐ Previous activities reviewed in light of assignments in summary notes/action plan
- ☐ Not applicable (Why not? ____)

7. Conversation During Meeting

- ☐ Conversation generally not related to agenda and/or not goal oriented
- ☐ Focused conversation but not with assignments and timelines identified
- ☐ Focused conversation with assignments and timelines noted on action plan or summary notes

8. Participation

- ☐ Participation and conversation mostly limited to meeting facilitator/guide
- ☐ Participation of meeting members limited to questions/clarifications
- ☐ Participation and conversation inclusive but narrow and technical (e.g., how tos)
- ☐ Participation and conversation inclusive and emergent (i.e., allowing new ideas to emerge from the conversation) or adaptive (i.e., being willing to modify what you're doing based on the reality of the situation)

9. Diversity of stakeholder representation

- ☐ Limited representation and/or attendance of multiple stakeholder groups
- ☐ Diverse attendance – no plans to expand
- ☐ Plans and/or strategies underway and discussed to bring in new members
- ☐ New members present at meeting
- ☐ Consumer (i.e., un/underinsured) representative(s) present at meeting

10. Reflection on progress/activities during meeting & adjustments made as needed

- ☐ Reflection not done
- ☐ Reflection done in general way
- ☐ Reflection done with intentional decision to stay the course or make adjustments
- ☐ Not Applicable (Why not?:____)

11. Use of data and/or other information to guide conversations and/or decisions (e.g., network maps, surveys, participation/attendance, demographics, etc.)

- ☐ Yes (identify data used:____)
- ☐ No
- ☐ Not applicable (Why not?:____)

Rural Healthcare Initiative (RHI) Checklist: Capturing Progress on Early Outcomes 7.14.14

Instructions: Please have one person complete this form immediately following an RHI meeting. Check the appropriate box/es. Fill in clarifying information (e.g., which?, why not?). Scan and email form to: (a) RHI point person and (b) Adena Klem (RHI evaluator) at adenamklem@gmail.com.

12. Decision-Making Process

- ☐ Everyone is given opportunity to voice opinion/thoughts prior to making decisions
- ☐ Pros and cons of alternatives are considered
- ☐ Decision is made in the meeting or a date is set by which the decision will be made if additional time or research is needed
- ☐ Once a decision is made, team members are asked whether they can live with the decision (not whether they like it)
- ☐ Specific steps and lead person identified to carry out the decision

13. Opportunity for others to step into leadership role

- ☐ Leadership is status quo – Same individuals are leading all or most of the work
- ☐ Encouragement expressed for others to take on leadership roles
- ☐ At least one or more people are actively in a new leadership role(s)
- ☐ Active coaching and/or mentoring to support new leaders is visible or discussed
- ☐ Not applicable (Why not?____)

14. Culture of Collaboration

- ☐ Brainstorming ideas/ways to *work together*
- ☐ Small groups or pairs form to complete tasks and projects
- ☐ Concrete plans developed for how groups will work together to support implementation of RHI strategies
- ☐ Reporting of new collaborations that have occurred (List: _____________________)
- ☐ Not applicable (Why not?: ____)

15. Culture of Innovation

- ☐ Brainstorming ideas/ways to *innovate and try new strategies*
- ☐ The group encourages and considers new ideas
- ☐ Evidence of getting ideas from places outside the group or the community
- ☐ Concrete plan for acting on innovation is discussed
- ☐ Reporting of new innovations that have occurred (describe:___________________)
- ☐ Not applicable (Why not?____)

16. Culture of Self Initiation

- ☐ Ideas suggested for new working groups and/or process
- ☐ Individual(s) from the group take responsibility for moving ideas into a new working group or activity
- ☐ Individual(s) reach out to others to support a new activity
- ☐ New actions underway (describe:_______________________________________)
- ☐ Not applicable (Why not?____)

17. Development of Resources

- ☐ No discussion about identifying/pursuing new funds or resources
- ☐ Identification of desire for new resources but no plans
- ☐ Work underway to identify and/or secure new resources
- ☐ New resources obtained (describe: ______________________________________)

18. Topic(s) of Conversation. Please check all that apply. Then CIRCLE the two topics you spent the most time on.

- ☐ Logistics of RHI program (e.g., Circles, Connectors, etc)
- ☐ Barriers encountered
- ☐ Problem solving of barriers
- ☐ New project brainstorming
- ☐ Creation and/or support of workgroup(s)
- ☐ Bringing on new partners/stakeholders
- ☐ Innovative strategies for working together as partners
- ☐ Resource development
- ☐ Office business (e.g., copier protocol, reimbursements, report completion, etc.)
- ☐ Non-RHI business
- ☐ Communications
- ☐ Relationship building among RHI participants

Appendix 4: Network Culture Assessment

Use the worksheet Network Culture Assessment, with a group. Did it create new awareness? Were people willing to work on shifting their culture?

Check in with the group a week later. What did they do to change their culture? What challenges did they face?

Network Culture Assessment

For each meme, put a number between 1 and 5 to describe how characteristic this is of yourself, your organization or your network. 5 means this meme is very characteristic of you or your organization or your network and 1 means that it is not yet expressed.

Cultural Meme	Personal	Organization	Network
Open			
Inclusive			
Transparent			
Noticing			
Accepting			
Value diversity and difference			
Turn conflict to breakthroughs			
Unattached			
Listening			
Innovative			
Opportunity Seeking			
Embracing errors			
Learning			
Experimental			
Exploring			
Comfortable with uncertainty			
Value reflection and learning			
Resourceful			
Playful and fun			
Initiating			
Interact as Peers			
Give and receive			
Appreciative			
Listen			

Cultural Meme	Personal	Organization	Network
Collaborative			
Interdependent			
Connected			
Engaged and engaging			
Communicating			
Mutual			
Share			
Reciprocate			
Symbiotic			
Transformative			
Spreading			
Amplifying			
Coaching			
Insightful			
Cascading			
Expansive			
Connective			
Connecting			
Reaching out			
Including			
Closing triangles			
Swift trust			
Caring			
Aware			
Self-aware			
Self-caring			
Centered			
Work/life balance			
Caring of others			
Other			

Once you have completed the chart, talk over what you discovered.

Select three you would most like to work on in the next month. Try keeping a journal on your progress.