REACH
healthcare foundation

Rural Health Initiative

Lessons from an intensive investment in community capacity building

October 14, 2016

# What is the Rural Health Initiative?

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Backdrop

- Since inception REACH has funded in three rural counties in our service area – Allen in KS; Lafayette and Cass in MO – collectively millions of dollars

- Rural applicants competed for program and core operating grants along with all of other applicants

- Lots of good work – mostly in a few organizations; silos

- Trends in health outcomes and access to care were not markedly better after almost a decade of funding by REACH and other health funders

- Slow recovery from Great Recession, declining employment, challenging to recruit new providers, additional health care access points needed, greater support needed for consumers

- Double-digit uninsured, pockets of isolated minority populations disconnected from community and regular health care

- A general sense that we needed a more strategic, focused and intensive investment in these three communities to change the trajectory of health

Who are the key partners in the RHI?

SIX-COUNTY SERVICE AREA
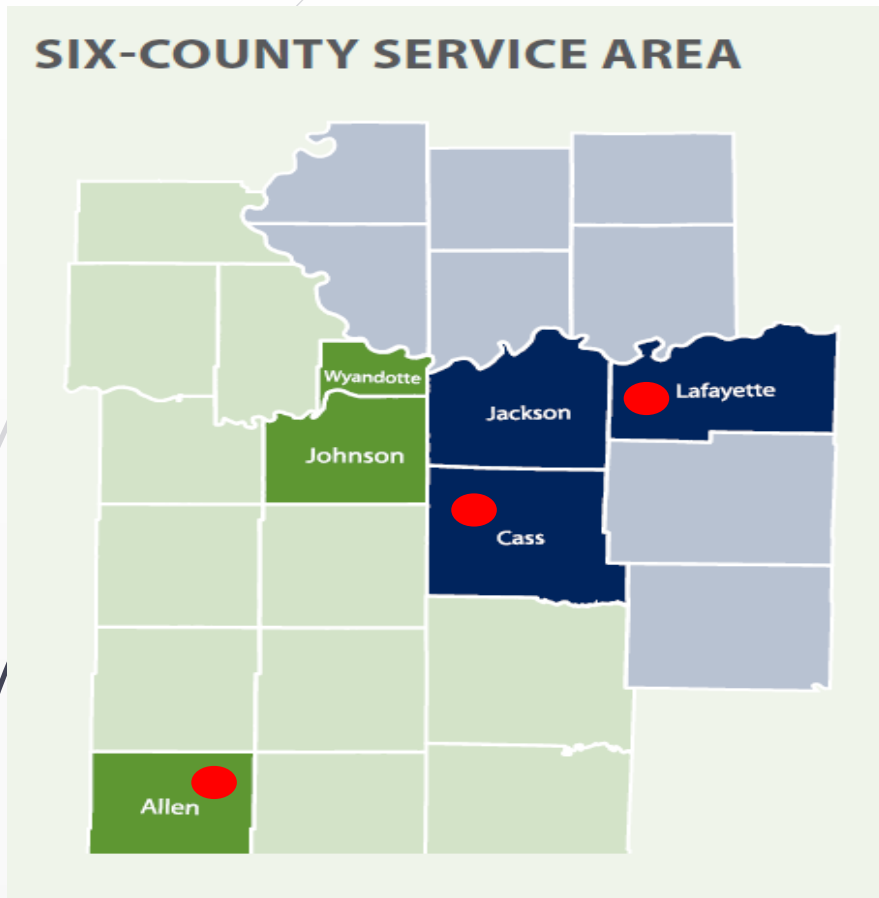
The RHI Network (Rural Grantees)

- Health Care Collaborative of Rural Missouri (Lafayette Co)
- Thrive Allen County (KS)
- Cass Community Health Foundation (MO)

Current and Former Key Partners (Technical Assistance)

- Kristin Johnstad, (Johnstad and Associates, LLC)
- June Holley, (Network Weavers, LLC)
- Cheryl Holmes, (KU– School of Social Welfare)
- Scott Wituk, (WSU – CCSR)
- Melissa Ness, (Connections Unlimited, Inc.)
- Adena Klem, Ph.D, External evaluator

Advisory

- REACH National Rural Advisory Team
- White House Rural Council Partnership (35 Foundations, GIH, Fed Office Rural Health Policy)
- National Rural Health Association

The Triggers for Change

After a thoughtful review of our decade of investment in the Foundation's three rural communities, we found:

- No measurable change in most health outcomes
  - Trends worse than the national benchmark in: premature death, adults reporting poor or fair health, and mental health days, low birth weight babies, adult smoking, adult excessive drinking, adult obesity, sexually transmitted infections, and teen birth rates – all exceeding national benchmarks
  - Policies in local communities that potentially harm the health of residents
- No strategic focus for our investments
- No new partners had emerged
- Limited innovation opportunity or capacity
- No articulated vision for the future health of these communities

Guiding Principles of the RHI

- Sharing and promoting a bold vision of dramatically improved access to health care

- Rejecting the status quo so RHI partners could craft a systemic approach to community-wide change

- Engage local leadership from multiple sectors

- Be entrepreneurial in spirit and approach; willingness to take risks – try new approaches, innovate

- Promote and foster community engagement and collaboration; bring new voices to the planning – include consumers and the silent suffering

- Seek out and establish new relationships and partnerships to create and grow a dynamic network

What were the Foundation's Goals for the Rural Health Initiative?

- Strengthen the capacities and cultivate the conditions necessary for our rural partners to implement innovations in system-wide community change *and* ready to take on future community-wide efforts

- Increase access to care through new access points, improved outreach, increased coverage, and a more coordinated health and social services system

- Begin addressing disparities in health outcomes for rural populations living in poverty

- Identify and strengthen the capacity of *new* potential partners for the Foundation in our rural communities

What are the conditions and capacities for community-wide change?

Conditions

- **Supports for implementation** – resources, on-site and virtual coaching, professional development, technical assistance, and funding are essential to sustain a multi-year community change process; technology

- **Foundational structures** – community leadership team, semi-autonomous but well-supported work groups, a dynamic and strategic network, and an influential champion. May require a backbone organization.

Capacities

- **Community engagement** – growing the diversity of the network within, across and outside the county; strategies to identify and engage passionate community volunteers

- **Processes and Skills** . . .(focus of capacity building)

Processes and Skills

Presence of effective action-oriented meetings with accountability

Cultivation of opportunities for emergent network leaders

Implementation of Network Approach

Establishment of a communication system and strategies to keep residents engaged

Creation of community vision of health and future system of care

Presence of Semi-autonomous, community co-led working groups

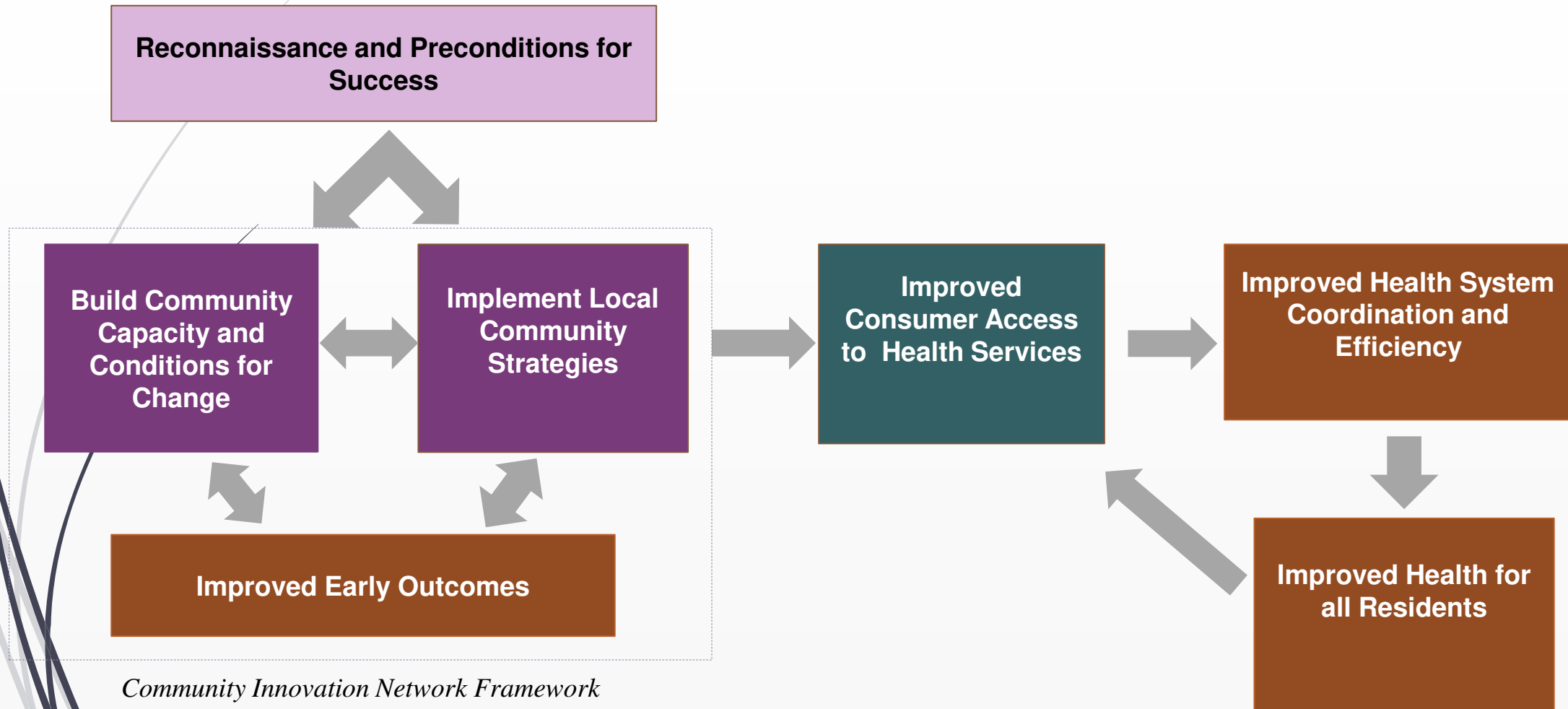Implementation of a shared and common system of reflection and learning

Broad Areas of Capacity

➡ Network Development & Relationships

➡ Network Leadership/Emerging Leaders

➡ Community Identity and Engagement

➡ Sustainability and Leveraging Resources

How do we know if we are making progress?

- **RHI Theory of Change** (as well as locally-developed TOCs)
  - Have the **conditions** (sufficient resources, sense of urgency, political will) and the **capacity** (skills, experience, leadership, connected) of the community developed to address barriers to innovation?
  - Are **new leaders emerging** and taking on leadership roles?
  - Are **more organizations collaborating and coordinating change** in the system? Are the key health organizations meeting regularly?
  - Are there **continuous opportunities** to take stock, identify barriers and solutions, and collaborate with others also interested in change?
  - Are **new health-related dollars leveraged** by REACH investments?
  - Are there **more providers and new access points**?
  - Are we beginning to see movement in one or more **health outcomes**?

Rural Health Initiative Theory of Change

Reconnaissance and Preconditions for Success

Build Community Capacity and Conditions for Change

Implement Local Community Strategies

Improved Consumer Access to Health Services

Improved Health System Coordination and Efficiency

Improved Early Outcomes

Improved Health for all Residents

Community Innovation Network Framework

Why use a network approach?

June Holley – Network Weavers Institute

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Why use a network approach?

▶ Please see supplement RHI Gathering Part 2 slide deck from June Holley with Network Weavers Institute

What does RHI mean to the field?

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Rural Health Initiative of Allen County

David Toland – Executive Director, Thrive Allen County
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Lisse Regehr – Community Healthcare Educator, Thrive Allen County
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Overview of Allen County RHI

- Allen County is located in southeast Kansas and has a population of 12,717.

- Allen County RHI is comprised of a core team that has representation across multiple sectors – hospital, mental health, health department, social services etc.

- We have multiple active work groups including Poverty, Navigators, Medical Recruitment, and Connectors.

How did the work change with RHI?

- It was a fragmented system and weak communication among partners.

- We've gone from being fragmented to creating a network.

- We've engaged new organizations and individuals.

- We have trust among the partners, so it's a resilient network.

How did relationships change with RHI?

- Mental Health center, Health Department, and 911 Center were not engaged, and are now leading partners.

- Partnerships through RHI came together to create Humanity House.

- Our network is not only stronger inside the county, but we've also built a strong relationship with Lafayette. We even stole their idea for Connectors!

- Network Guardianship: Thrive's job is to make sure everyone comes together.

How did leadership change with RHI?

- The hospital leadership has moved to a sliding scale fee for uninsured patients in their clinic.

- Expanded hours at the FQHC and soon to be expanded hours and locations of Allen County Regional Hospital clinics.

- Humanity House

- Department of Children and Families (DCF)

- ACA Navigators

Take-away Thoughts

- The connections are now organizational as opposed to individual relationships (and we like each other!!)
- RHI has created a strong network that is capable of creating policy changes in our community such as: Cold Weather Rule, Tobacco 21, DCF
- This is a long process. It's an organic process. What works for one county might not work for another.
- Action removes doubt (Ready. Fire. Aim.)
- The end of RHI as a Reach initiative does not mean the end of RHI.

Rural Health Initiative of Lafayette County

- Toniann Richard, Executive Director, Health Care Collaborative of Rural Missouri toniann@hccnetwork.org

- Suzanne Smith, Director of Network Development, Health Care Collaborative of Rural Missouri Suzanne@hccnetwork.org

Overview of Lafayette County RHI

- Lafayette County is located in western Missouri, about an hour outside downtown Kansas City. It has a population of 32,943 that is spread across 16 communities.

- Lafayette County RHI has had a variety of work groups but one of its signature and most active is the Live Well Connectors group.

How did the work change with RHI?

- Collaboration among Network Members has increased.
- The Network has grown from 18 members to 40 members.
- People are trained to "Connect" people to already existing resources
- Developed the idea of the "Live Well Health & Wellness Community"
- Working together in new ways such as the Warehouse and Project Connect came from the Social Services Committee.
- Helped support creation of 4 new access points

  due to identified needs.

How did relationships change with RHI?

- Connectors has created not only enhanced ways to connect clients to services but it has also developed new and strengthened existing relationships among providers in the county. There are now food pantries working together, social service agencies offering their services through local resource agencies, front line staff at clinics calling social service agencies to help their patients.

- The work of RHI has also provided the county with resources to identify potential new connections and opportunities for working together.

Live Well Connectors

Connecting patients to ALL needed resources

Results:

- 2014 - 8 connectors – 60 people connected to resources (130 total encounters)

- 2015 – 50 Connectors – 202 people connected to resources (over 450 total encounters)

- 2016 Goal: Connect 300 people **YTD Totals**: 315 people connected to resources with 723 encounters!

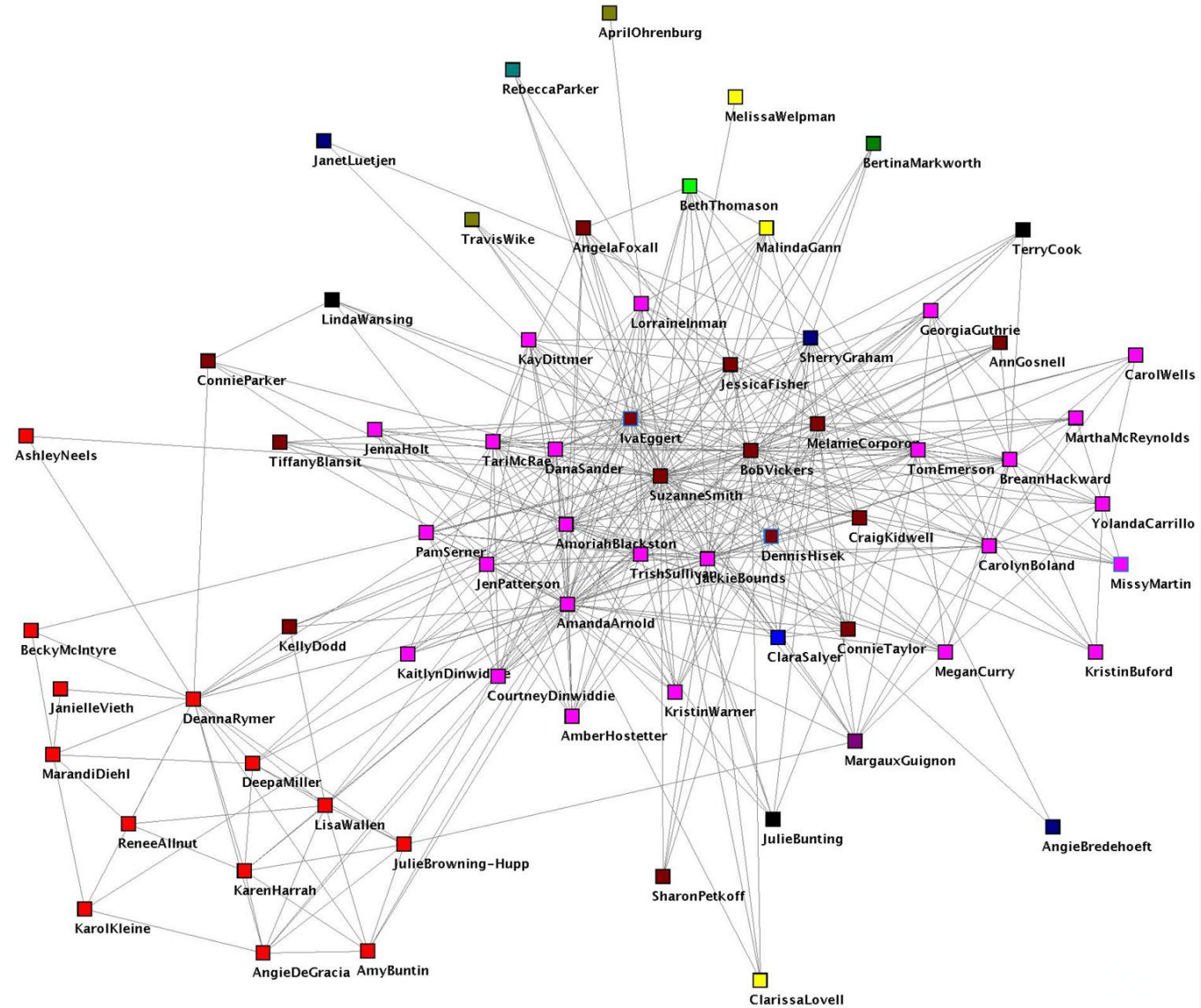Local organizations are also better utilized once individuals are aware of the services in their communities.

Connectors Network 2015
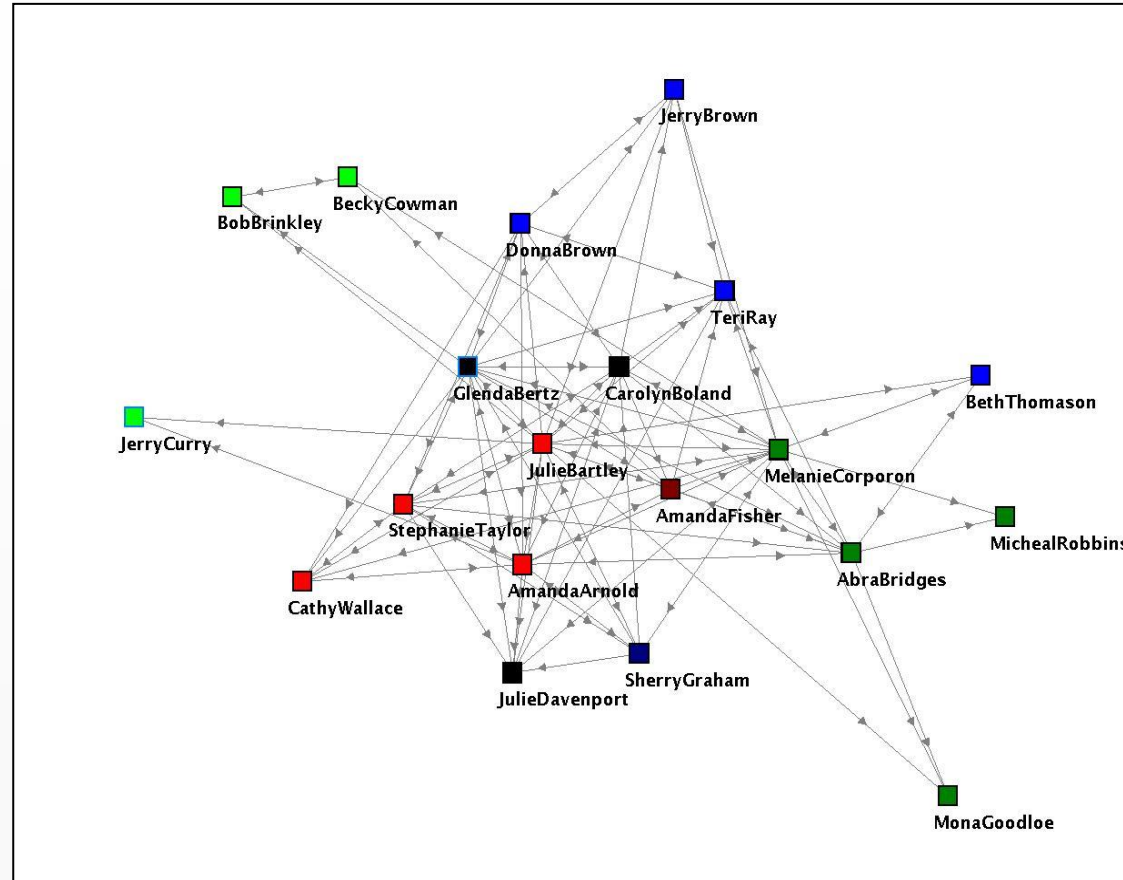
2016 Connector Ties

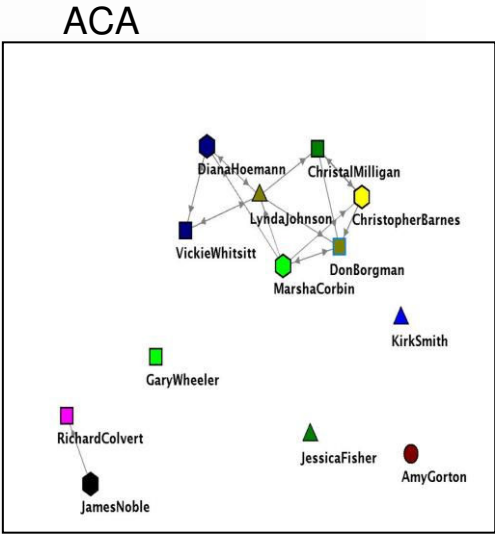# Map 2014: I'm interested and willing to convene

Not Willing
Not Sure
Somewhat
Very Willing

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

ACA

School

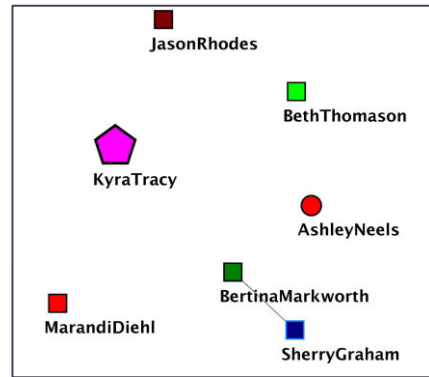CARE Coordination

Behavioral Health Stigma
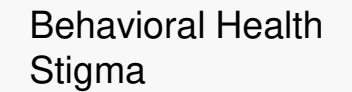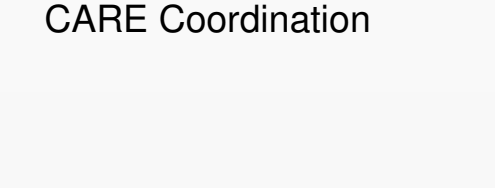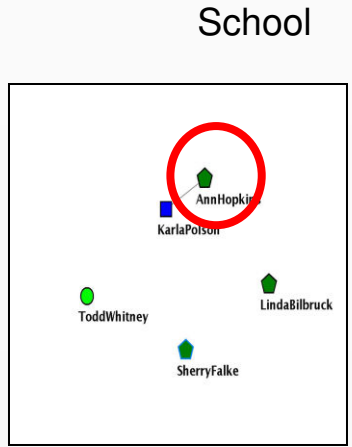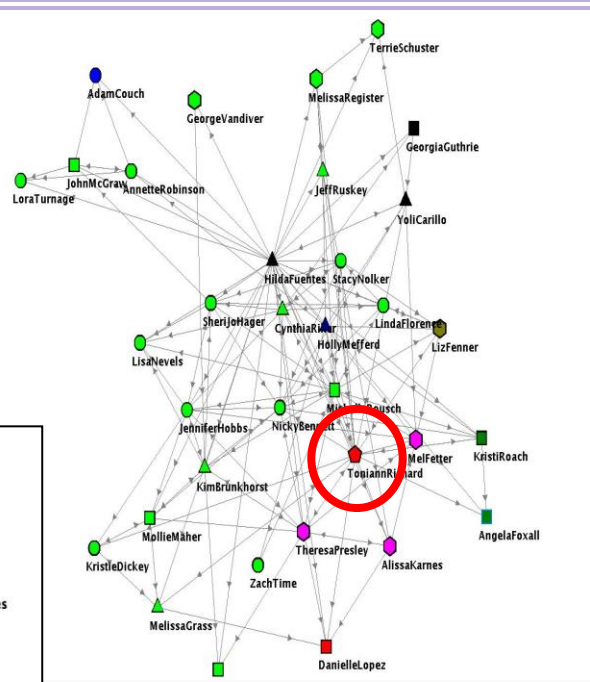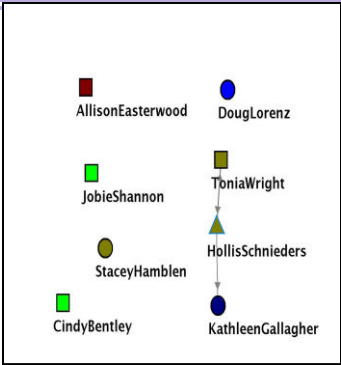
Potential Projects and Potential Leadership

Transportation

Homelessness

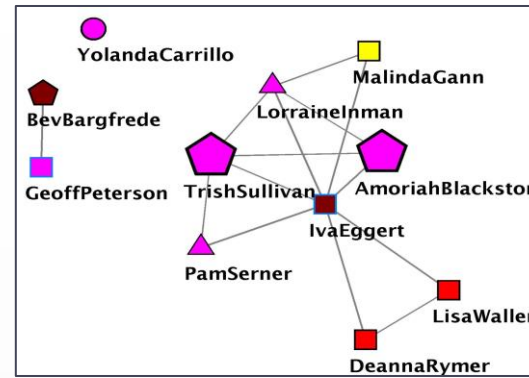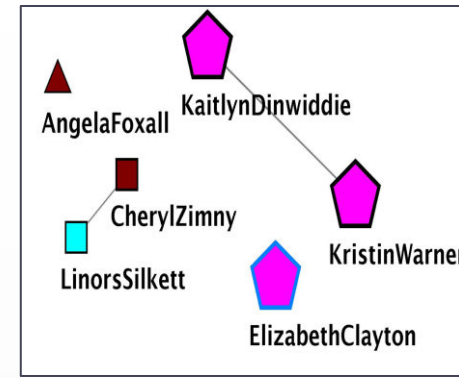Veterans
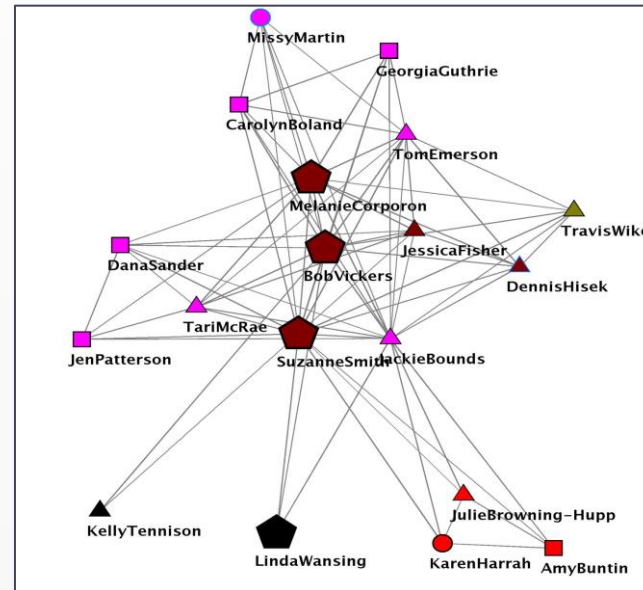
Connector

Warehouse Project

Legend

- ■ Healthcare
- ■ Social Services
- ■ Education
- ■ Special Needs
- ■ Faith based
- ■ Nursing Home
- ■ Children's Services
- ■ Mental Health
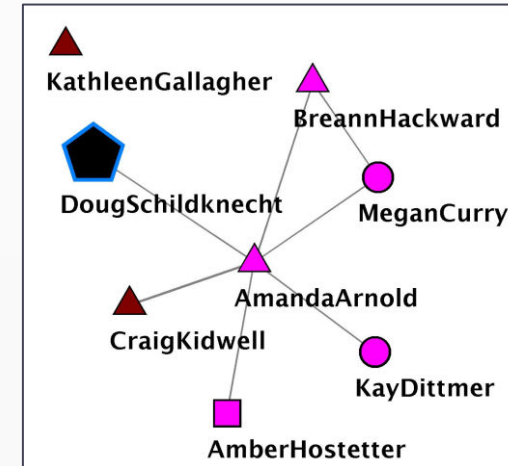
How did leadership change with RHI?

- New and more leaders are using collaborative processes to respond to community needs.

- Decrease in fragmented services and less re-inventing the wheel or because of communication and coordination

- Deeper and trusting relationships have developed across agencies and sectors so gaps are identified and addressed more quickly, there are less "cold" calls, and the end results are more effective,

Take-away Thoughts

- The most valuable aspect of our involvement with RHI has been the **ability to change relationships** within our community and to help those in need find access to local healthcare and needed resources.

  - We have built intentional connections across the county by going out and talking with different organizations and other businesses to let them know what we have to offer.

- We have **taken the services out to the people** with the Project Connect events and **encouraged them to follow up** with our local clinics. Each person at the Project Connect also gets a follow up call from one of our Connectors to make sure they received all of the services that they came for.

  - We have been asked to share our delivery system at National conferences and by attending these and other conferences, we have been able to improve and implement new ideas that we have gotten.

Take-away Thoughts

- Don't be afraid to try something new just because that isn't the way it has always been done.

- Gather ideas from other communities and adapt them to fit your environment

- Never work alone as an agency. Involve other people from different organizations and different communities. Try things, learn by doing and improve together.

- It is about building relationships, listening and being responsive.

- Communicate progress so people can be inspired and confident that they are making a difference. Being clear about how the activity fit with the larger vision and mission, This will keep people focused and invested.

Take-away Thoughts

- Thank you to REACH for being open to the ideas that came from our networking with other agencies that the social determinants of health sometimes are the contributing factor to failing health among people in the rural community.

- Thank you to Carla for accompanying Amanda and Suzanne to the National Rural Health Conference to present on the Connector's program.

- Trust is the experience and wisdom of your grantee partners and learn together.

- Network building comes naturally to some people – so hire staff with those skill sets so they can spread it to others.

Rural Health Initiative – Program Officers' Perspectives

Carla Gibson and Dawn Downes, REACH Healthcare Foundation

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Changes in REACH-County Work Approaches and Relationships

➥ Increased time – "On the Ground" (planning meetings, partner recruitment, presentations, etc.)

➥ Utilization of various supports-targeted technical assistance, seed money/mini-grants, programmatic dollars

➥ Increased emphasis on becoming reciprocal thought leaders

➥ Greater understanding and appreciation for local context (history, culture, relationships) and its influence on the work

Key Take-Aways

- Acknowledge the time it will take for change to occur

- For system change, provide an ample planning period and engage community partners as thought leaders from the beginning

- Need to be responsive and nimble (at County and Foundation levels)

- An open mind is critical for success – community partners, technical assistance team, and Foundation staff

Rural Health Initiative – Evaluation Lessons Learned

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Evaluation – Lessons Learned

➤ **Consider the structure**: traditional structures encourage traditional change.

➤ Working groups provide an effective avenue for **community engagement.**

➤ **Implementation supports are necessary** – a diverse technical assistance team that encourages a culture of collaboration and innovation is essential to supporting meaningful change.

Evaluation – Lessons Learned

➤ The **shift toward a network culture** is challenging but opens the door to innovation.

➤ **Language is a way of creating and reinforcing identity** – it's important to allow local tailoring of terminology and concepts when possible.

➤ Initiatives require a **new way of working** among initiative participants as well as between funders and grantees.

➤ **Community change initiatives are hard to do but fertile ground for learning together.** RHI was a moving target making it challenging – yet essential – to track how relationships, structures and processes changed over time to lead to the desired outcomes.

Lessons for Philanthropy and Nonprofits

William Moore, Ph.D. – REACH Healthcare Foundation

Lessons for Nonprofits

RHI revealed that . . .

- Creating, growing and supporting a network of passionate, engaged organizations and volunteers is a deliberate process that requires regular attention, specific behaviors and actions, and accountable roles and responsibilities that are enacted daily

- Deep community engagement only occurred when our partners implemented semi-autonomous, community co-led working groups that focused on the interests of group members

- Truly innovative ideas and potential solutions to pressing health and social problems only emerged once the working groups were fully operational

- Foundations can foster and support this kind of community innovation when they provide seed money for pilots of innovations, demand that working groups are co-led by community volunteers, and are given substantial autonomy

Foundation Learnings – Systemic Change

- **System-level change** is complex and sensitive work in any community setting. All systems are resistant to change. Our challenge was how to stimulate innovation in relatively closed systems that resist changing?

- **Models for stimulating change** can't just be airlifted into a community– it must be built from the ground up or adapted to be locally-relevant and aligned with known conditions and capacities

- **Cultural beliefs and behaviors are the biggest barriers to change** – supporting community change must take into consideration historical and cultural antecedents that form the basis of community (and that are essential to the status quo and comfortable to local communities); are often counterproductive and must be recognized and replaced with behaviors that open up opportunity and new thinking

- **Empowering communities to change** isn't just giving a check and encouraging them to think "outside the box." Having the space to innovate.

Foundation Learnings – Internal Capacity

- Foundations – often operating with the best of intentions – must **recognize their own hubris** and lack of experience and knowledge of the local culture

- Set aside **at least one year of learning** for both the local community and the foundation and its partners before firmly committing to a specific course of action; visit, observe, listen, talk – it takes longer but is essential

- Systemic change demands a **greater investment of foundation dollars, time, and commitment** – POs will find the need to be on-site and present in the community as essential to a deeper understanding of the complex work

- **This kind of work is emergent** – if your foundation does not already have a deep knowledge of the local community its hard to know beforehand how to proceed and predict where the real needs and pitfalls are – to some extent its good practice to let it unfold in locally-defined and relevant ways

Foundation Learnings – Reality Check

- As a foundation shifts its investment strategy – in this case from competitive responsive grantmaking to targeted strategic investments – lots of issues emerge:

  - Expectations – "Just tell us what you want us to do, and we will do it."

  - Trust – "What do they **really** want . . . And why are they doing this?"

  - Shared language and understanding– "We are already a network – why do we have to do network development?"

  - SOPs – whats the new normal now? "We thought you meant that all future rural grants would come through the RHI so we didn't even think we could apply for that grant."

  - Opportunity and relationships- As local communities become more collaborative and capacitated – as they become empowered to have greater control over their future – new opportunities for partnership and new ways of relating emerge.

For More Information

Visit: https://reachhealth.org/goals/ruralhealth/

Article: Moore, William P.; Klem, Adena M.; Holmes, Cheryl L.; Holley, June; and Houchen, Carlie (2016) "Community Innovation Network Framework: A Model for Reshaping Community Identity," *The Foundation Review*: Vol. 8: Iss. 3, Article 5. DOI: http://dx.doi.org/10.9707/1944-5660.1311 Available at: http://scholarworks.gvsu.edu/tfr/vol8/iss3/5

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