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RESULTS

Community Innovation Network Framework: A Model for Reshaping Community Identity

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Keywords: Innovation, rural, capacity building, community engagement, community identity, network development

Key Points

- The REACH Healthcare Foundation created its Rural Health Initiative to encourage the development of innovative strategies to improve access to health care and reduce health inequities in three rural counties in Missouri and Kansas. The intent was to develop a systematic, sustainable, and coordinated approach to community change that would increase the odds of breaking through the persistent barriers to health care access for the rural poor and medically underserved in these counties.
- This article discusses the foundation's original approach to the initiative and how it adjusted that approach in response to its rural partners' experiences. It reflects on the challenges encountered in rooting the four conditions and capacities of community change and innovation – supports for implementation; foundational structures; skills and processes; and community engagement – into the work of community health improvement.
- The article also describes lessons learned and new roles for funders interested in assisting communities that are seeking to deepen and extend capacity and innovation and forge a new identity.

Introduction

In 2012, the REACH Healthcare Foundation created the Rural Health Initiative (RHI) with the goal of breaking through persistent barriers to health care access for rural residents who are poor and medically underserved. After more than four years of implementation and refinement, the structures and processes used in the RHI have formed the foundation of the Community Innovation Network, a promising framework for growing sustainable innovation capacity. Starting with a composite of core features from several models for stimulating and supporting community change, the framework evolved into four conditions and capacities as well as associated early outcomes that must be in place for meaningful change to occur. The network has been found to engage community members and to bring in additional stakeholders and thinkers to grow and sustain innovation throughout the community.

The cornerstone of the network is an approach that required our local partners to effectively build and support a community culture that prioritizes collaborative work in nonhierarchical community change efforts. This is a central focus for community capacity building around which the necessary conditions exist for successful and sustained community change. Those conditions are financial and human supports for implementation; foundational structures that support the growing network and its semiautonomous groups in their efforts to innovate; proficiency with new skills and processes for relating, working, and leading networks; and engagement of residents through a constellation of strategies.

For rural communities to have a sustainable future, they need to find innovative approaches to engaging residents, leveraging civic resources, and attracting investors and businesses.

While the framework and lessons learned emerged through our work in rural communities, we believe the Community Innovation Network is applicable to all types of communities seeking solutions to pressing problems and will help them to create more opportunities for their residents to be part of identifying and implementing innovative solutions. This article describes the original approach to the RHI and how the REACH Healthcare Foundation and its advisors adjusted the approach in response to our rural partners' experiences, and shares reflections on the complexities and challenges encountered in rooting the four conditions and capacities of community change and innovation into the work of improving community health. It also describes lessons learned and new roles for funders interested in assisting communities that are seeking to deepen and extend capacity and innovation and forge a new identity.

Background

Rural areas are in the midst of a historically significant transformation that is producing serious threats to the well-being of residents and the viability of communities. While nearly 50 million people live in rural America – approximately 17 percent of the population – rural counties are losing population for the first time (U.S. Census Bureau, 2012). While there has been a long history of rural flight to urban centers, mostly among adults seeking jobs, recent data indicate that baby boomers are not retiring to rural communities and that job growth in rural areas has not recovered from the Great Recession. The culture and identity of rural America has been slowly eroding due to federal policies such as farm subsidies; to cultural fragmentation exacerbated by the loss of key community institutions such as family farms, rural hospitals, businesses, banks, and schools; and to demographic shifts that have increased the number and diversity of low-income residents and the demand on social services.

Limited access to health care – due to fewer providers per capita, the need to travel for regular and emergency care, and lack of insurance – has produced rural communities whose residents are older, poorer, sicker, and have a life expectancy that is two years shorter than their urban counterparts (Agency for Healthcare Research and Quality, 2014; National Rural Health Association, 2016; Stephens, 2014). Warnings about how these threats have been undermining the spirit of innovation and self-sufficiency in rural communities have been issued for decades (e.g., Kotkin, 2002).

How communities decide to respond to these changes will determine what "rural" means and looks like in the future. Creating a vibrant, sustainable community requires high levels of civic resources, including a strong sense of cooperation; community trust and involvement in local community organizations; and confidence in local government. For rural communities to have a sustainable future, they need to find innovative approaches to engaging residents, leveraging civic resources, and attracting investors and businesses (Dillon, 2011; Dillon & Young, 2011).

The successful transformation of declining rural communities is important for the well-being of residents and, more broadly, for the nation's future. Fortunately, there are many potential opportunities for that transformation that reflect rural identity and culture and capitalize on the strengths of rural communities – including a significant and underutilized potential for innovation – if community leaders have the necessary skills and a framework to focus and guide their efforts (Easterling & Millesen, 2015).

The Rural Health Initiative

The REACH Healthcare Foundation created the Rural Health Initiative to encourage the development of innovative strategies to dramatically

improve access to health care services and reduce health inequities in Missouri's Lafayette and Cass counties and in Allen County, Kansas. The intent of the RHI was to develop a systematic, sustainable, and coordinated approach to community change that would increase the odds of breaking through the persistent barriers to health care access for the rural poor and medically underserved in these counties.

The RHI focused on creating an action orientation using a network approach that empowered local stakeholders to identify and carry out new strategies to increase access to health care services and supports. The rationale for using a network approach was the foundation's belief in the need to substantially change the process of community problem solving to engage a wider cross-section of passionate stakeholders ready to embrace new ways of relating and working together to bring in new ideas, energy, passion, and human capital.

At the same time, the foundation wasn't seeking to promote the creation of more activities and events to attend in rural communities, but, instead, to build local capacity to innovate, which would ultimately result in new solutions to persistent problems. By innovating in the process of work – how our rural partners related to one another, worked together, and led the work – we believed that the likelihood of surfacing innovative solutions would be greater.

Recognizing that rural communities are not homogenous, the foundation began the initiative acknowledging each county's unique history, resources, and existing challenges. Prior to the launch of the RHI, the 2011 Robert Wood Johnson Foundation County Health Rankings for the three targeted counties indicated several barriers to health care access – several of which are common in rural communities nationally. (See Table 1.) All three counties had high rates of poverty and uninsured residents, and a shortage of medical providers – factors associated with poorer health outcomes (Agency for Healthcare Research and Quality, 2013).

Compared to national rates, the foundation's rural counties had higher rates of preventable hospital stays, premature death, and chronic and/or preventable conditions such as colon cancer, coronary heart disease, lung cancer, vehicle injury, and stroke; lower rates of mammography and diabetes screening; and lower life expectancy (Mid-America Regional Council, 2013).

Despite almost a decade of philanthropic investment in these counties, the foundation could see little meaningful improvement in health access and outcomes. After taking a hard look at these

TABLE 1 2011 County Demographics Prior to Launch of Rural Health Initiative

	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 Number of Uninsured	1,677	3,779	12,314
Percentage of Uninsured	12.5%	11.6%	12.4%
Percentage of Adults Who Could Not See a Doctor in the Past 12 Months Because of Cost	12%	15%	13%

Source: Mid-America Regional Council, 2011, cited in Klem & Holley, 2015, p. 57.

findings, the foundation recognized that a different investment approach was needed.

Evolution of the RHI

The foundation's long history of investment in its rural communities revealed that our investments were supporting the status quo. Proposals were becoming noncompetitive for our limited investment budget, and the same organizations were applying to do the same thing year after year. Consequently, the foundation decided to focus the RHI on growing the capacity for innovation. The foundation's goals for the RHI were to invest in the process of solving community problems such as poor health outcomes, create new community capacity to innovate and compete that could be sustained long after the initial investment ended; and create new partnerships and opportunities for investment in the health and health care of the community.

To create the original RHI design, the foundation began by partnering with known and trusted organizations in the three counties, forming a national rural health advisory council, and reviewing models of innovation and community change. The research and planning helped formulate guiding principles and a set of change models, along with other supports. The foundation committed to a multiyear investment in locally identified projects, along with technical assistance and coaching to ensure that rural partners would have the skills to plan, implement, and lead their innovation efforts and be more competitive for future funding opportunities. The guiding principles for this initiative were:

- sharing and promoting a bold vision of dramatically improved access to health care;
- engaging strong leaders from a range of sectors;
- rejecting the status quo so that the RHI could craft a systemic approach to communitywide change;
- being entrepreneurial in spirit and approach, and seeking ways to innovate and be flexible with regard to solutions, strategies, and investments; and
- promoting and fostering community engagement, cooperation, and collaboration.

The change models that were factored into the overall design of the RHI were:

- *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 (Kania & Kramer, 2011).
- *A network approach:* a strategy to create the capacity for continual innovation and action, accomplished by building a network of people and organizations interested in a common issue or social problem, encouraging many people to initiate collaborative action, and spending time on tracking, deep reflection, and learning to allow residents to transform their community (Krebs & Holley, 2005).
- *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 (Aspen Institute, 1996).

As local planning processes unfolded, foundation staff and the initiative's technical assistance (TA) team saw that a relatively narrow group of stakeholders were making most of the local decisions. The foundation and TA team worked to understand and identify the essential conditions and capacities that would lead to greater collaboration and community engagement. Ultimately, a hybrid of the change models emerged that eventually coalesced into the Community Innovation Network, reflected in the initiative's theory of change. Over time, the predominant strategy for change in the RHI moved from collective impact

to a network approach that involved creating new relationships and collaborations to leverage individual and collective strengths and interests (Holley, 2012). Specifically, network leaders would strive to 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, help people identify opportunities for change, and initiate self-organized working groups and projects. All of these activities add people to the network and increase the number and quality of the connections within and across communities. These relationships influence the likelihood that effective collaboration and innovation will occur (Walzer & Cordes, 2012).

The RHI/Community Innovation Network Theory of Change

As the three participating communities began to engage around identifying priorities for improving health, it became clear to the TA team that certain skills and conditions for meaningful change were absent in the planning stage. In addition, it was evident that our rural partners were struggling to find their starting point for creating new solutions to the pressing health problems in their communities. The foundation identified "theory of change" as a tool to communicate and focus technical assistance – a tool that is particularly effective for creating a shared vision for change. It provides stakeholders with a specific and measurable description of their community change initiative that forms the basis for strategic planning, ongoing decision-making, and evaluation. A basic theory of change explains how early and intermediate accomplishments set the stage for producing long-term results (Anderson, 2015). Because any good theory of change evolves to integrate new learning, the current iteration also represents the theory underlying the Community Innovation Network. (See Figure 1.)

The long-term outcomes of the RHI are to improve health outcomes and reduce disparities in those outcomes within rural communities. For those long-term outcomes to be achieved,

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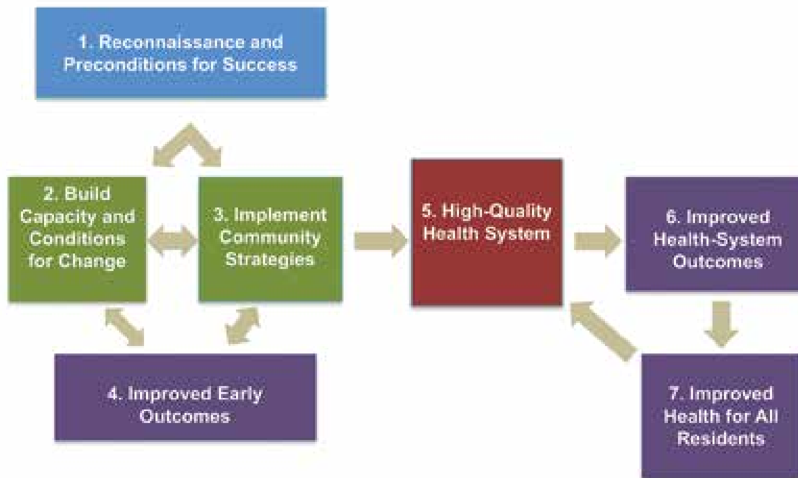
however, intermediate outcomes must improve, which means increasing access to health services, improving quality of care, and establishing better coordination among services and more-informed utilization of those services by consumers. The foundation recognized that these health-system structural changes are part of a larger set of influences on the health of residents (e.g., social determinants and individual behaviors). But given the core mission of the foundation to address health care access and quality, a relatively short time frame, and limited resources for this investment, the foundation and its national advisory team believed the best chance at improving health outcomes would occur through improvements in the health care system. The RHI stakeholders also recognized that these long-term outcomes required a re-visioning of the existing community health care system and an ability to adapt

FIGURE 1 Community Innovation Network Theory of Change



to changing community conditions. Among the features of this ideal health care system:

- Each consumer has a designated medical home.
- Each community has a designated health care navigation resource.
- Hospitals have established systems to divert high utilizers of inappropriate emergency room use to more appropriate services.
- Outreach to and education of the uninsured, underserved, and unserved are a funded structural feature of the health care network.
- Tele-health and other place-based strategies are implemented.
- Safety net clinics, community mental health centers, and hospitals have established referral systems and "warm handoffs" (i.e., follow-up appointments made for consumers by service providers) are the expected norm.

While this part of the theory has remained consistent throughout the initiative, our understanding of the foundational capacities and conditions that move stakeholders toward collaborative problem solving and innovation evolved and are now reflected in the latest iteration of the theory of change. The capacities and conditions are:

- *Supports for implementation:* A variety of resources – such as facilitation early in the process, coaching, professional development, and money – are essential for sustained efforts to bring about community change.
- *Foundational structures:* These include community leadership teams, semi-autonomous but well-supported working groups, a growing network of individuals and organizations interested in finding new solutions to community problems, and an influential champion to start the work in the community. Rural communities may require a backbone organization – one that is a trusted community resource known for supporting collaboration. Backbone organizations provide the necessary logistical and practical supports to ensure that funding is appropriately distributed, minutes and notes are kept, meeting locations are secured, and communication with stakeholders occurs.

- *Processes and skills:* Communities struggling toward a new vision of the future often find themselves stuck in a cycle of talking without action and follow-up; lacking accountability for implementing actions; and closed-system thinking, where the same small group of individuals are leading and representing the views of the community on a variety of public issues. New processes and skills must be taught, modeled, supported, and reinforced to ensure (1) a community-driven vision of priorities and of the future; (2) a network approach to supporting a culture of collaboration, self-organizing, and innovation; (3) opportunities for the development and support of emergent network leaders; (4) effective, action-oriented meetings with accountability and ownership; (5) a communication system and strategies to keep residents engaged; and (6) a shared system of reflective measurement and evaluation.
- *Community engagement:* This entails growing the diversity of the network within, across, and outside the community to increase participation and bring in new ideas and resources. Consistent community engagement (i.e., active and regular participation in the planning, doing, and reflecting on the work) is particularly challenging for volunteers in small, rural communities. A network approach that engages passionate community residents in ways that allow their interests to be reflected in community change efforts attracts additional residents and volunteers who share the work load and insert new thinking and potential innovations into the system.

Our experience suggests that these conditions are not optional and that high-fidelity implementation of these structures, skills, and processes will lead to greater local capacity to create and support innovation.

To ground these RHI structures and processes within a project, rather than asking counties to create them in the abstract, the foundation funded each county to identify and begin to implement one or more community strategies for improving health care. A range of projects were implemented through the RHI, including supporting the process to secure new federally qualified health centers in two counties; a Community Connectors program to link residents to local resources; a program to assist families emerging from generational poverty by increasing their social connectedness with their more affluent cohorts; expansion of a dental clinic; an innovation fund to support community mental health projects; and a leadership summit to facilitate network development among organizations that had not worked together in the past. These early projects evolved through the life of the initiative to become more innovative and collaborative as the structures, networks, and skill sets of the community members strengthened and deepened. For example, two rural counties have collaborated to propose a rural Uber transportation system to address a lack of reliable transportation – a persistent barrier to health care access.

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Clearly, the RHI model is complex and could take decades before realizing significant improvement in the long-term outcomes. This said, the foundation anticipated seeing progressive and developmentally appropriate improvements in the early outcomes within the first two to three years of implementation, with positive change in the intermediate outcomes occurring by year four.

As the conditions and capacities are fully implemented, the earliest signs of change emerge:

- Trusting, mutually supportive relationships are formed.
- Network expansion and adoption of network supportive roles begin to occur.
- Increased collaboration, inclusivity, innovation orientation, and self-organizing are demonstrated through participants' values and behaviors.
- Individual and organizational skills in leading networks, supporting emerging leaders, communication, building network connections, and sustainability are strengthened.
- Measurable progress toward new capacity and project goals is seen.

Clearly, the RHI model is complex and could take decades before realizing significant improvement in the long-term outcomes. This said, the foundation anticipated seeing progressive and developmentally appropriate improvements in the early outcomes within the first two to three years of implementation, with positive change in the intermediate outcomes occurring by year four. The assumption was that with the necessary support to implement new skills, structures, and processes, as well as funding to support a handful of collaborative early innovations, the intermediate outcomes would show improvement. The foundation had no expectation at the outset that the long-term outcomes would be achieved during the active investment period. The anticipation was that the conditions and capacities for community change and innovation would be in place before the end of the funding period. The next section presents the stages of the RHI: how the initiative shifted, expanded, and was implemented.

RHI Development

Stage One

At the start the RHI was intentionally amorphous, with the goal of using the change models of collective impact, robust networks, and capacity building to embed supporting structures in communities that would then foster the creation of innovative solutions by communities themselves. This caused some confusion regarding the foundation's expectations, because our rural health partners were accustomed to following a defined set of contracted deliverables. Because the foundation saw the RHI to be a groundbreaking initiative with staff learning alongside the RHI participants, it was not comfortable being prescriptive about what innovations would emerge – only that the process would be implemented with fidelity.

This early stage saw the establishment of core leadership teams in the three rural communities: stakeholders building relationships and developing basic collaborative processes, conceptualizing local projects, identifying a backbone organization, and engaging a larger group of stakeholders in the work. Two of the counties moved quickly to implement a project to kick off the RHI; the third had a change in the core leadership team

and, therefore, extended its planning process. Though time-consuming, this protracted process was essential for community participants to learn a new way to work collaboratively on unconventional ideas.

With the emphasis on collective impact and capacity building, the network approach was pushed to the back burner. As foundation staff and the TA team worked to revise the RHI theory of change in late 2013, it became clear that collective impact and the network approach were at odds with each other: Collective impact has a more traditional approach to leadership and project management, whereas the network approach utilizes semiautonomous working groups to provide opportunities for emergent leaders to initiate projects and take on new roles in the community. As a result, the RHI teams had fallen into more traditional and comfortable patterns of leadership and group behavior, while the foundation and TA team had hoped to see emergent network-based leadership. The rural partners were also struggling to address their lack of capacity in surfacing innovations and growing a robust network of stakeholders from which to mine new solutions. In response, technical assistance was adapted to better support network and leadership development in 2014.

Stage Two

In the second stage, the RHI moved away from collective impact as the guiding framework and more toward a network approach, including growing network-leadership skills, identifying and supporting emergent leaders, and reflective evaluation. The network concept of working groups was introduced where self-organized, semiautonomous collaborative teams come together around a specific community need to develop new solutions. One of the challenges in rural communities – and a reason for the focus on growing networks and building leadership skills – is that there tends to be a small handful of leaders within rural communities who are responsible for most of the community planning and decision making. This, in turn, tends to make burnout more likely, ensure that history and tradition trump innovation, and limit opportunities for new thinking.

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One example of a process innovation that changed the composition of the network was an intentional decision by the core leadership team in Allen County to engage participants who typically would not have a place at a leadership table, specifically individuals living in generational poverty. While not necessarily innovative in all communities, those voices had not been included in Allen County. Other innovative activities included social-network mapping and analysis to help expand networks and identify new working groups. The RHI convened "communities of practice" events that brought together foundation staff, the TA team, and representatives from each community to share ideas and experiences. This format generated new relationships and cross-county collaborations.

Finally, the second stage included a strong focus on having stakeholders craft their own RHI theories of change to create a more localized and

collaborative vision of their own ideal health care system and what they needed to do to create that system. The theory of change process helped communities prioritize their capacity-building efforts and visualize how they could grow their expertise in designing and leading innovations.

Stage Three

In the third stage, the RHI evolved to include an even more intentional focus on the network approach to community change, reflecting the growing recognition by community leaders of the value of a robust and engaged network of individuals to stimulate ideas and innovative solutions. The foundation added a network leadership coach to the TA team to assist its rural partners as they strived to implement working groups as centers for innovation. The TA team also began to model a fully operational network approach by building deeper working relationships, reflecting what it was learning from the rural communities and by taking on more collaborative TA roles.

By the end of stage three it was obvious that a more rapid feedback loop was needed for the local stakeholders and the TA team to support network implementation and change in the conditions and capacities at the local level. Working with the rural partners, the TA team developed an online survey to capture network behaviors and practices such as levels of participant engagement and trust to inform planning and improvement. Information from the survey helped direct attention to areas needing improvement.

Also, after years of struggle, it had become clear at this stage that Cass County, for historical and cultural reasons, was unable to maintain momentum with the RHI. Ultimately the foundation encouraged Cass County to reconsider its involvement, the county agreed, and the TA team refocused its attention on the remaining two counties.

Stage Four

For the current and final stage of RHI funding, the focus is on deepening and sustaining new process innovations and prioritizing local innovations that offer the greatest potential for strengthening community identity and the long-term health of residents. With the creation of the network practices survey and a focus on building capacity for data-based decision-making, our rural partners have become more effective at using data to monitor and adjust implementation of their local innovations.

After four years, the RHI leadership teams have been able to build working groups as well as a reputation in their communities as leaders in community conversations on health. In Allen County, the RHI leadership team is now seen as the go-to entity for those who want to bring about meaningful health and social change in the county. For example, the leadership team was instrumental in facilitating a community dialogue that prevented the closing of an important state social service agency in the county.

The Lafayette County Connectors program has greatly expanded its collaborative effort. In stage four, there is a movement underway to create a new leadership team out of the Connectors working group, which grew from eight to 70 members and now spans three communities. The working group has adopted network-oriented practices focused on collaborative problem solving to address local health and human service needs.

These and other innovations provided successes for our rural partners that helped motivate participants to stick with the hard work of community change.

Outcomes and Innovations

The following improvements in early outcomes provide evidence of the effectiveness and sustainability of the Community Innovation Network framework:

1. *Trusting, mutually supportive relationships are formed and forming.* The core leadership teams have built more meaningful, strategic relationships – Allen County's core team has grown from five to 20 regular members, Lafayette's Connectors group has grown from eight to 70 participants.

These relationships provide a more solid foundation for future work in improving health. Organizations that have not been engaged in the past are now joining the networks to capitalize on opportunities to collaborate and build new efficiencies in the health care system.

2. *Participants' values and behaviors demonstrate increased collaboration, inclusivity, innovation orientation, and self-initiation/organizing.* Our rural partners have changed how they work together. They are more collaborative, have engaged additional stakeholders, and have adapted and expanded leadership. New leaders have stepped forward to lead work groups and major initiatives. There is an emphasis on growing not just a network of organizations, but also a network of individuals with different skill sets and interests to inform thinking about future work.

3. *Individual and community skills strengthened in resource development and sustainability.* The foundation's total investment in the RHI was $1.45 million over four and a half years for local projects, technical assistance, and project costs. At the outset, it had hoped the funding would leverage other resources; that goal was achieved. Allen County secured $844,550, on a total foundation investment of $330,000, to support community engagement and healthy lifestyles, trails, and food-scarcity projects. Lafayette County secured $2.67 million, on a foundation investment of $380,000, to support a new federally qualified health center and four new health care access points.

4. *Networks have expanded and network-supportive roles have been adopted.* Both rural communities have dramatically increased their networks from a handful to dozens of organizations. Additionally, the TA team provided extensive coaching for individuals who wished to support the network; they, in turn, played critical roles in leading network recruitment efforts, building new relationships within the network, and protecting the network from counterproductive influences and mission drift.

Both as a direct result of the RHI and through leveraging initiative supports, improvements are already emerging for several of the intermediate outcomes. These include an increased number of access points via new federally qualified health centers in both counties and a new hospital in Allen County, additional providers, and increased access to health insurance through intentional outreach and enrollment innovations.

5. *There is measurable progress toward new capacity and project goals.* Both as a direct result of the RHI and through leveraging initiative supports, improvements are already emerging for several of the intermediate outcomes. These include an increased number of access points via new federally qualified health centers in both counties and a new hospital in Allen County, additional providers, and increased access to health insurance through intentional outreach and enrollment innovations.

Lessons Learned and Implications

Foundation staff and the TA team gained new insights into investing in rural communities and supporting community change as the RHI benefited from the Community Innovation Network framework. Throughout implementation, the

four foundational capacities and conditions of the original RHI framework were shown to be sound, though we gained a greater understanding of what each should entail:

1. *Supports for implementation.* Supporting a network approach to community innovation requires a range of technical assistance roles, such as a network mapping expert, a network coach, an open-minded evaluator, a TA team coordinator, and a content expert (e.g., health access). It also requires the TA team to develop its own culture of collaboration and innovation. Additionally, it is imperative that the team includes local partners in its reflections and draws upon their expertise and knowledge of their community and culture.

2. *Foundational structures.* Backbone organizations play an essential role in catalyzing network initiatives because they can help bring key organizations and individuals into the project. However, it is important to ensure leadership doesn't remain solely with the backbone organization and core leadership team. It was through growing working groups that innovations and emerging leaders were identified and developed.

3. *Processes and skills.* Shifting to a network culture – and particularly letting go of control, being open to uncertainty and possibility, expanding leadership, and appreciating diversity – opened the door for innovation and collaboration. Modeling, talking, and tracking these values through our data-collection tools seemed to accelerate the process. Supporting people to identify, collect, reflect on, and analyze data – such as the network maps – also helped participants visualize and adopt a network mindset.

4. *Community engagement.* Although the foundation and TA team initially believed large stakeholder gatherings would be the vehicle for network recruitment, this was not the case. Instead, creation of working groups became a way to engage new people on a problem or issue around which they were committed to finding a solution. Expanding working groups to other communities provided another avenue for growth. These approaches are more effective than simply gathering people for information-sharing events.

Implications for Community Change and Identity

Through the RHI, each community experienced changes and gained insights that informed its evolving identity. Stakeholders from two counties saw themselves as having a particularly robust network prior to the start of the RHI. While that was true in terms of traditional leadership, the use of working groups provided a catalyst for inviting individuals not typically engaged to contribute. The already acknowledged leaders continued to remain relevant as they expanded their vision and contacts, allowing them to coach others and approach leadership and problem-solving in new ways.

Framing the RHI around a complex and action-oriented identity using collaboration to identify innovative solutions worked, but it required serious and committed learning and dialogue with foundation staff, TA providers, and stakeholders to understand how this approach would translate at a local level. Communication and the terms used to present a model or framework are important in any community work. Language is a way of creating and reinforcing identity, so it is important to give careful attention to how concepts are framed – allowing local tailoring of terminology and concepts whenever possible. As we improved in this area, our rural partners became more open and engaged.

Finally, it requires resources and time to support a shift from a hierarchical, closed leadership structure reflective of community history and status to an approach that calls for expanding the boundaries of leadership, working openly and collaboratively, and acting on opportunities. The Community Innovation Network provided a framework, coaching to support adoption of new ways of working, funding, and opportunities for stakeholders to learn from other communities.

As a result, the network has proven to be both a process and a road map for communities to begin visioning and shaping a future not previously considered or even viable in the past.

Foundation-Level Perspective

Foundations interested in stimulating innovation in communities can learn from the RHI experience. Foremost is the recognition that systemic community change is complex and sensitive work in any community setting, but perhaps particularly challenging in rural communities with long-standing leaders and traditions. Little is known about effective processes to stimulate innovation in rural communities and services. Research and our experience suggests that existing models cannot be transplanted into rural settings until they are adapted to be more locally relevant and aligned with known conditions and capacities of rural leaders and the community (Poole & Daley, 1985). The RHI encountered challenges early in the initiative when it became apparent that our rural partners' desire to handle local problems in familiar ways was counter-productive to the intent of the RHI to collaborate and innovate. This cultural roadblock to progress was deeply entrenched and required more than two years of on-site modeling, coaching, and technical assistance by experienced network leaders. This necessary shift in ways of relating, working, and leading was essential to the progress made to date.

Funders must also be prepared to acknowledge their lack of understanding of local, but particularly, rural culture; be willing to listen and observe before diagnosing problems and solutions; be flexible regarding how they invest; and be open to revising their operating theory of change based on learnings. Funders frequently fall prey to common pitfalls when supporting community change initiatives: unrealistic expectations, lack of understanding and shared language, mistrust by local leaders and residents, issues of control, and a tendency to place the foundation's agenda over local needs and vision (David, 2008). All of these pitfalls were encountered in the first years of the RHI. Significant reflection and engagement of foundation staff and community leadership was needed to gain a more nuanced appreciation of how the community's history and culture shaped its receptivity to engage in new ways of relating, working, and leading. And while place-based, multisector community change efforts are relatively new to health funders, the lengthy history of philanthropic investment in complex change initiatives is important reading for foundations interested in embarking on sustained place-based investment (e.g., Brown & Fiester, 2007; Sojourner, et al., 2004).

The Community Innovation Network provided a framework, coaching to support adoption of new ways of working, funding, and opportunities for stakeholders to learn from other communities. As a result, the network has proven to be both a process and a road map for communities to begin visioning and shaping a future not previously considered or even viable in the past.

Another critical learning was the markedly different level of engagement that foundation program officers and leadership encountered in our first effort to engage in a complex community-based change initiative. Foundations must enter into these commitments with a clear understanding that new skills, additional resources, and extensive time spent in the local communities will be required. The foundation was unprepared for the amount of time and the different roles program officers would need to play to ensure that the initiative would be

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implemented as envisioned. With the RHI, we often found ourselves "flying the airplane while we were building it." The adaptive nature of this type of investment required flexibility and reflective learning discussions to test our understanding and adjust our approach. Using theory of change enabled our rural partners and other stakeholders to better understand our vision, the assumptions we were making, the strategies we would implement to bring about early outcomes, and the necessary early conditions and capacities we believed were essential for other elements in the pathway to change.

Finally, the foundation realized one of our most important goals through this initiative: identifying funding opportunities and partners in our rural communities and deepening our relationships with all of our rural partners. In the middle of the fourth year of the RHI, where community networks are now deeply embedded into the fabric of how our rural partners operate, the foundation can count many new partners in our rural communities. The initiative has been remarkably successful in creating new ways of relating, working, and leading – coalescing around a new community identity and belief in the power of passionate people to work collectively toward a new vision for their community.

Conclusion

Changing the way community stakeholders relate to one another, work together, and create innovation is extraordinarily complex and must take into consideration historical and cultural antecedents that form the basis of community identity. How foundations enter into that dynamic is very important. The foundation entered the work of the RHI believing we had a solid understanding of the sociocultural influences operating in the community, and found after two years of struggle that we knew very little about how our community partners thought, worked together, and planned for change. Only after watching, listening, and contributing to an ongoing dialogue about their communities, and clarifying intent, shared goals, a common language, and ultimately building a trusting, mutually appreciative relationship, was the foundation and our TA team able to bridge the large chasm. One simple quote from a key rural community leader in this effort illustrates how much change has occurred. In the first year of the RHI, he said: "Just tell us what to do. If we know what you want, we will do it." Symbolic of the historical and traditional relationship between grantee and grantor, the rural leader was accustomed to seeking a grant to implement a priority of the foundation. As we shifted the way the foundation approached investment in these rural communities to be more open to innovations emerging within the local community, there was significant initial misunderstanding and distrust. Over time, this sentiment has been replaced with more reciprocal and collaborative relationships. Our rural partners now invite the foundation to consider investing in innovations they are working on and welcome us as a "thought partner." In the process of empowering our rural partners to take control of their own future by becoming more highly capacitated and collaborative, the REACH Healthcare Foundation has found new partners, new opportunities for investment beyond the Rural Health Initiative, and new ways of working with and supporting our rural partners.

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