



Lessons and Stories from the Social Innovation Fund: Building Partnerships to Support Health Solutions for Rural Communities

“And we won’t just be looking at the usual suspects in the usual places. We won’t just be seeking the programs that everybody already knows about, but we also want to find those hidden gems that haven’t yet gotten the attention they deserve. And we’ll be looking in all sorts of communities — rural, urban, and suburban — in every region of this country, because we know that great ideas and outstanding programs are everywhere — and it’s up to us to find them.”
— President Barack Obama announcing the creation of the Social Innovation Fund, June 30, 2009

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About the Social Innovation Fund

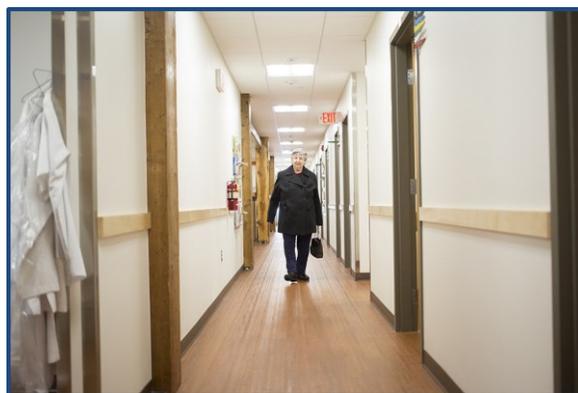
The Social Innovation Fund (SIF) is a program of the Corporation for National and Community Service that awards grants to identify, validate, and grow promising approaches to challenges facing local communities. SIF works with and through existing grantmaking institutions, or “intermediaries,” to direct resources to innovative, community-based nonprofit organizations, or “subgrantees” focused on youth development, economic opportunity, and healthy futures. SIF requires both intermediaries and subgrantees to match the federal funds with non-federal cash on a dollar-for-dollar basis.

Introduction

TANA WOLFE moved to Casper, Wyoming in August 2014 to take a job as a special education teacher in the local middle school. Leaving her parents and her sister (“she’s my best friend,” Tana said) back home in Colorado was difficult. Add to that the stress caused by a tough divorce and the rigors of being a first-year teacher, and Tana was feeling anxious and depressed.

Tana’s mother, who has suffered from depression for much her life, encouraged Tana to get help. At her mother’s urging, Tana went to the Community Health Center of Central Wyoming to see what its doctors could do for her.

“I had never gone to the doctor for something like this,” Tana said. “In fact, I didn’t know that depression was something you went to a regular doctor for.”



Fortunately for Tana, the Community Health Center of Central Wyoming is part of a project supported by the federal Social Innovation Fund to bring a new model of depression treatment to underserved rural communities like Casper. The focus of the model: supporting clinics to provide effective depression treatment through a team-based approach that includes the primary provider, a depression “care manager” and a consulting psychiatrist.

Tana started seeing her care manager once a week for counseling and therapy, and the care manager helped her develop strategies for dealing with anxiety and stress. Before long, Tana started scoring better on a nine-question depression test administered at the center. Most importantly, she was able to develop more confidence at work and an ability to deal with day-to-day frustrations without spiraling into depression.

In April 2015, Tana signed a contract to stay at the school where she is working for another year. “I feel like special education is a field where I can really make a difference, and I am feeling much more comfortable now about staying here and getting a strong start in my career,” she said.

Reaching Out to Rural Areas

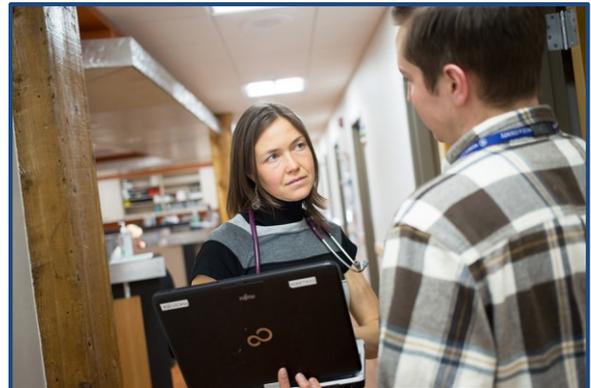
Since it was established in 2010, the federal government’s Social Innovation Fund has made awards to grantees totaling over \$240 million¹ to support “innovative, community-based solutions that have compelling evidence of improving the lives of people in low-income communities throughout the United States.”² These awards, in turn, have leveraged more than \$397 million in committed non-federal funds from private philanthropy and other sources.

¹ As of March 2015

² <http://www.nationalservice.gov/programs/social-innovation-fund/about-sif>

Creating and sustaining public-private partnerships to support social innovation can be a challenge in any community. But in rural areas, the challenge can be even greater for a number of reasons. These include: a relative lack of private philanthropic resources; the scarcity of “home-grown” expertise and technical assistance in areas from evaluation and fundraising to program management; and smaller populations that can make it hard to evaluate programs and demonstrate impact at a scale commensurate with the level of public and private investment.

While most of the SIF’s grantees — known as “intermediaries” — to date have focused their work in urban and suburban areas, a few have specifically targeted rural communities with their investments. Two of these initiatives focusing on rural areas were launched under the banner of SIF’s “Healthy Futures” focus area, which targets innovations to promote healthy lifestyles and reduce risk factors that can lead to illness.³ The two SIF intermediaries concentrating their “Healthy Futures” work in rural communities are:



1. **The Foundation for a Healthy Kentucky** launched the four-year Kentucky Healthy Futures Initiative (KHFI) to bring evidence-based healthcare solutions to rural communities across the state. Organizations supported by the initiative have included nurse-managed clinics, telemedicine, mobile health services, care navigation and a community activities center.
2. **The John A. Hartford Foundation** is supporting implementation of an evidence-based depression treatment model at eight rural health clinics in the Mountain West, a region with high rates of depression and suicide relative to other parts of the United States. Developed by the University of Washington, the Project IMPACT (Improving Mood – Promoting Access to Collaborative Treatment) model has been adopted successfully at hundreds of other sites nationally and around the world.

About This Report

Through these two initiatives, SIF and its grantees have learned important lessons about the challenges and opportunities involved in forging public-private partnerships in rural communities, as well as what works to bring evidence-based public health solutions to these areas. In this article, we share the stories of the SIF’s work with these initiatives, and share lessons from the work for public and private funders. Those lessons include:

- The lack of philanthropic resources in rural communities requires proactive, flexible approaches to funding evidence-based innovation.
- Intermediaries should balance their zest for seeing early results with the need for planning, convening, and other preliminary work.
- Intermediaries need to provide technical assistance in the areas of implementation and evaluation to address capacity gaps in rural communities.
- Sustainability of SIF funded programs requires working closely with rural communities to change systems and identify ongoing resources for evidence-based solutions.

³ The three SIF priorities are: Healthy Futures, Economic Opportunity, and Youth Development.

“Rural communities face many unique challenges when it comes to supporting and scaling innovative approaches to meeting people’s needs,” said Lois Nembhard, Deputy Director of the Social Innovation Fund. “Through SIF’s work, we hope to contribute to building a shared understanding of what works to create successful public-private partnerships in these communities.”

ONE. Project IMPACT: Bringing Evidence-Based Depression Treatment to Rural Communities in the Mountain West

The John A. Hartford Foundation was established in 1929 by the family owners of the A&P grocery chain. For much of its early history, the New York City-based grantmaker supported pioneering biomedical research. After the A&P Company’s 2010 bankruptcy filing, the foundation’s focus narrowed with the decline of its assets, which had been heavily invested in company stock.

Today, the Hartford Foundation focuses less on supporting basic research and more on strengthening healthcare delivery and practice — in part, by supporting the development and dissemination of new, cost-effective models of care that show promise for improving health outcomes for older Americans.

Among the health care solutions developed with support from the Hartford Foundation is the IMPACT method of depression treatment. IMPACT (which stands for Improving Mood – Promoting Access to Collaborative Treatment) was created by Jürgen Unützer, an internationally recognized psychiatrist and researcher at the University of Washington. Also referred to as Collaborative Care, the model is based on close coordination between a patient’s primary care physician, an on-site depression “care manager” and a consulting psychiatrist.



“A lot of programs say they offer integrated behavioral health care, but that often means you go to the primary provider and then you are referred separately to a mental health counselor. They treat you in parallel but they don’t really work together,” explained Wally Patawaran, a Hartford Foundation program officer. Patawaran continued, “What’s different in this approach is there is a high degree of synchronization across the team.”

Patawaran said IMPACT works because it builds on the relationship that patients already have with their primary health care provider. However, instead of relying on the primary provider to take on the responsibilities of overseeing a patient’s behavioral care treatment, the model places those responsibilities on the care manager, who is charged with following up on patients, checking in to see how they are doing, and making sure the patient is progressing and doesn’t fall through the cracks. To make sure patients are getting appropriate and effective care, the entire process is informed and guided by the expertise of the consulting psychiatrist.

A Proven Approach

As reported in the *Journal of the American Medical Association (JAMA)* in 2002, the IMPACT model more than doubled the effectiveness of depression treatment for older adults in primary care settings. At 12 months, about half of patients receiving Collaborative Care reported at least a 50-percent reduction in depressive symptoms, compared to only 19 percent of those in traditional care settings. A subsequent analysis showed that the benefits of the intervention persisted after a year. In all, patients enrolled in IMPACT care experienced more than 100 additional depression-free days over a two-year period compared to those not enrolled in IMPACT care.

The Hartford Foundation has supported Unützer and his colleagues at the University of Washington's AIMS Center for more than a decade. Together with the California HealthCare Foundation, Hartford funded the \$10 million randomized clinical trial that resulted in the JAMA article, and the two foundations have joined with other funders to bring the model to more than 1,000 health clinics in the United States and around the world.

For the most part, however, providers adopting the IMPACT approach have been located in areas with high-density urban and suburban populations. The reason: More people means more patients and more impact. When the Hartford Foundation learned that the federal government was interested in using the Social Innovation Fund to “find and grow” evidence-based solutions so they could reach higher numbers of low-income people, the foundation's staff saw an opportunity to take the model to a new phase of development by implementing it in more rural communities across the United States.



“The IMPACT model was backed up by a wealth of evidence and some adoption, but it hadn't been disseminated to low-income, rural settings, so we thought it was a natural candidate for the SIF,” said Patawaran.

In 2012, the John A. Hartford Foundation was awarded a two-year, \$2 million federal grant, thus commencing its participation in the five-year SIF program. The focus of the grant: supporting the implementation of the IMPACT model in eight community health clinics in the states of Washington, Wyoming, Alaska and Montana.

The Hartford Foundation matched the SIF grant by contributing \$2 million of its own funds to meet the SIF match requirement and to cover the costs of technical assistance and training from the AIMS Center. The SIF also requires each clinic “subgrantee” to match its award on a dollar-for-dollar basis, which means the Project IMPACT work has received \$6 million in funding overall from the three sources.

Why Rural Communities?

Low-density rural areas are a natural target for better models of depression treatment for a variety of reasons, including high rates of depression, lack of accessible care, and the tendency of many rural residents to avoid getting help because of the stigma associated with behavioral health challenges.

High rates of depression. Depression is one of the leading causes of disability worldwide and the number two cause of disability in the United States after heart disease.⁴ Its damaging effects include reduced productivity, lower incomes and overall poor health. Rural areas in the United States are especially susceptible to high rates of depression, primarily because of higher rates of social isolation, poverty and economic distress. The states of Wyoming, Alaska and Montana — three of the target states for the Hartford Foundation's Project IMPACT work — regularly compete for the highest rates of depression in the country, as well as the most suicides based on population.⁵

⁴ See Depression Fact Sheet, World Health Organization, <http://www.who.int/mediacentre/factsheets/fs369/en/>. Accessed July 13, 2015.

⁵ See, for example, “Solving the Riddle of the U.S. Suicide Belt,” Robert Wood Johnson Foundation. <http://www.rwjf.org/en/library/articles-and-news/2013/06/solving-the-riddle-of-the-u-s--suicide-belt.html>. Accessed July 13, 2015.

Lack of accessible behavioral health care. Individuals in rural communities face a variety of barriers to finding quality behavioral health care. According to Diane Powers, associate director of the AIMS Center at the University of Washington, long travel times to health clinics are a “huge issue” in the mountain West. “Not only do these states have a shortage of behavioral health providers on a per capita basis, but providers also tend to be located in urban areas,” she said.

Even with lower gas prices, the long travel times create a huge disincentive to accessing behavioral health care. As a result, patients either don’t seek care at all, or else they get it from already stretched primary care providers, who are likely to prescribe anti-depressant medications with no therapy and minimal follow-up, an approach that research shows is largely ineffective in fighting depression.

IMPACT solves the access issue in rural areas by supporting clinic-based primary healthcare providers and care managers to provide high-quality behavioral care on site, with support from a psychiatrist who consults with the team via phone and/or telemedicine technologies. “The more isolated the community and the bigger the workforce challenge in the area when it comes to the availability of expert behavioral care, the better this model works,” said Powers.



Stigma and rugged individualism. For many people, a key benefit of living in a rural community is that everyone knows who you are. But this can create problems for individuals with behavioral health issues, who may be reluctant to seek the care they need out of fear that their neighbors and friends will find out.

“The lack of anonymity in rural communities can make them great places to live, but not necessarily if you are wanting to get help and support for depression,” said Patawaran.

Add to the lack of anonymity a “pull yourself up by the bootstraps” culture in many rural areas, and it’s easy to see why rural

communities have higher rates of depression and suicide; many people simply don’t seek treatment even if it’s available.

According to Powers, the IMPACT approach is uniquely beneficial in rural areas because it reduces the stigma associated with getting treatment for depression. Not only does it build on the relationship that many people already have with their primary care physician, but the approach relieves patients of having to park in a separate parking lot or go to a separate medical office for depression treatment.

“In this approach, you are just going to the doctor’s office and no one has to know why,” she said. “Everything is normalized, so it’s like you are getting help with any other health issue.”

Bringing IMPACT to Casper

The Community Health Center of Central Wyoming is a nonprofit health care provider serving two of the largest counties in the state at three clinic locations. Working under the slogan, “Complete Care Under One Roof,” the organization’s health care staff sees approximately 15,000 patients a year and provides a full range of services in areas from pediatrics and women’s health to pulmonary health, oral health and more.

Before it became a SIF subgrantee, the center served patients with depression in the same manner as many other rural clinics across the country. If a doctor had reason to think a patient might be suffering from the disease, the doctor prescribed medication with minimal follow-up.

Staff at the center have known for some time that they wanted to be able to do more for depression patients, based on the problems they were seeing in the community. The center serves one county (Fremont) that in 2012 ranked highest in the

nation for suicides on a per capita basis.⁶ Center staff knew that many patients in their largely rural service area were not seeking (or receiving) urgently needed behavioral care.

Today, thanks to its participation in Project IMPACT, the Community Health Center of Central Wyoming has a fulltime, Project IMPACT-funded depression care manager on staff and two care managers who work part-time for the project, together with a psychiatric nurse practitioner who is on call to consult with the primary care team on a case-by-case basis.

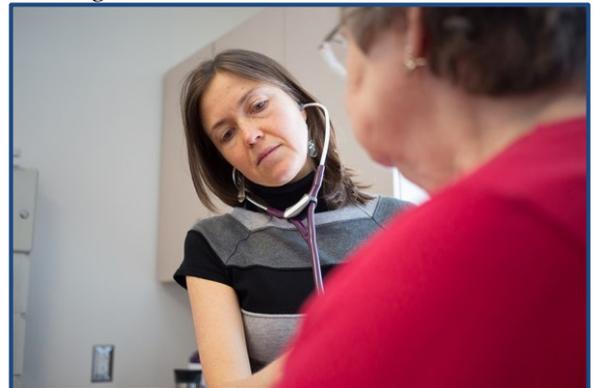
A patient still accesses depression treatment via the primary care provider, but that provider now has support to ensure that patients get the care (including medication and/or therapy, as appropriate) and the follow-up they need. Alicja Iznerowicz, the project manager with the center, said: "The message from the primary provider is, 'I will continue to be your doctor, but we have a team that will stay with you until we get through this.'"

In addition to implementing the new Collaborative Care approach, the center also is much more intentional and proactive about identifying patients who can benefit from depression treatment. The waiting room in the center's Casper location has posters on the wall telling patients, "You are stronger than depression." On one of the posters, the staff crossed out the "You" and changed it to, "Together, we are stronger than depression."

"When people walk in, we hope that sends a message to the fiercely independent population we serve that there is nothing wrong in seeking help, and that seeking help is in fact a sign of strength," said Iznerowicz.

Following the Project IMPACT guidelines, the center's staff now asks questions of patients while taking their vitals to identify those who might be candidates for depression treatment. Based on a patient's answers to those questions, the primary care provider talks to patients about the center's approach to treating depression.

"We never say we have a new program, because people are always suspicious when they hear that. We say this is how we treat depression and it is a team-based effort and you will access everything through your primary care physician," said Iznerowicz.



Results

After two years, the IMPACT approach has garnered positive results for the center and its patients. In February 2014, the center had just 18 active patients in depression treatment. As of April 2015, the total was 135 active patients, and nearly 400 patients had received depression treatment in some form. This exceeded the center's original goal of supporting 350 patients to access such treatment by June 2015.

Not only is the center treating more patients for depression, but it is getting good results for them. Like other Project IMPACT sites, the center measures patient outcomes using a popular and validated nine-item depression scale called the PHQ-9. The latest results: a majority of patients who had been treated at the center (56 percent) improved their PHQ-9 scores by 50 percent or more.

The Community Health Center of Central Wyoming is not alone in delivering good results for depression patients. According to Powers at the AIMS Center, it is just one among the seven rural sites that are the focus of the SIF initiative achieving excellent results through adoption of the IMPACT model.

"Overall it is working really well," Powers said, noting that the AIMS Center's early evaluation efforts show that all but one of the eight sites are hitting targets for the number of patients served, as well as meeting benchmarks for quality of care.

As of June 2015, the subgrantee sites have enrolled 2,389 patients into the IMPACT model of care.

⁶ <http://wyomingpublicmedia.org/post/2012-was-record-year-suicides-fremont-county>

“Practitioners at these sites tell us again and again that introducing this kind of model has been critical in these communities,” said Patawaran.

Project IMPACT Sites

Funders joined the Social Innovation Fund and the John A. Hartford Foundation to support better depression care at a total of eight community health clinics in the Mountain West. The subgrantees are located in rural areas that are either medically underserved, or that face a shortage of healthcare professionals.

Subgrantees	City, State	Initial SIF Subgrantee Award	Match Funder(s)
Community Health Center of Central Wyoming	Casper, Wyoming	\$314,000; 2013-2015	Kinskey Family Foundation and Margaret A. Cargill Foundation
Mat-Su Health Services	Wasilla, Alaska	\$465,000; 2013-2015	Rasmuson Foundation
Partnership Health Center (PHC)	Missoula, Montana	\$488,000; 2013-2015	Margaret A. Cargill Foundation
Peninsula Community Health Services	Bremerton, Washington	\$320,000; 2013-2015	Margaret A. Cargill Foundation
Valley View Health Center (VVHC)	Chehalis, Washington	\$350,000; 2013-2015	Board of County Commissioners in Lewis County, Washington
Bighorn Valley Health Center	Hardin, Montana	\$230,000; 2014-2016	Helmsley Charitable Trust
Butte Community Health Center	Butte, Montana	\$200,000; 2014-2016	Helmsley Charitable Trust
Kodiak Area Native Association (KANA)	Kodiak, Alaska	\$384,000; 2014-2016	Alaska Native Tribal Consortium

For more information: jhartfound.org/grants-strategy/current-strategies/models-of-care/social-innovation-fund/

TWO. Kentucky Healthy Futures Initiative: Improving Access to Quality Health Services in Rural Communities Across Kentucky

The Foundation for a Healthy Kentucky was established in 2001 with assets from the 1993 merger of Anthem Inc. and Kentucky Blue Cross Blue Shield. The foundation's grantmaking focuses broadly on promoting policies that respond to the health care needs of the state's residents, improving children's health, and supporting communities to adopt innovative strategies for serving low-income populations. Since 2001, the foundation has made more than \$25 million in grants.

The Kentucky grantmaker was one of only 11 organizations in the country to receive funding in the first round of Social Innovation Fund grants in 2010. It matched the \$2.5 million in federal funds with \$2.5 million of its own to launch the Kentucky Healthy Futures Initiative (KHFI). Through the initiative, grants were awarded to nine Kentucky nonprofit organizations working in low-income and mostly rural communities to improve access to health services, reduce health risks and disparities, and promote health equity. Each of the nine nonprofits, in turn, matched the grants it received from the foundation, bringing the total of public and private resources for the work to \$9.4 million.

Surveys show an urgent need to improve access to health care in rural Kentucky. In the latest Kentucky Health Issues Poll conducted by the Foundation for a Healthy Kentucky, 4 out of 10 adults over age 45 (39 percent) said they were in "fair or poor" health, compared to just one-third (33 percent) who said their health was "excellent or very good" and 28 percent who said their health was "good."⁷ Kentuckians with lower incomes were significantly more likely to report lower levels of health.

Like other rural areas across the country, rural Kentucky communities show relatively high rates of obesity, diabetes, cardiovascular disease and stroke. Surveys have shown that these problems are in part due to higher-than-average rates of tobacco use, poor diets, lack of exercise and other factors. Kentucky, for example, has the highest rate of adult smokers in the nation, and it ranks fifth in adult obesity.⁸

The Kentucky Healthy Futures Initiative was a four-year initiative aimed at addressing these health challenges by improving access to affordable, high-quality health services in rural communities in the state. In 2014, the Foundation for a Healthy Kentucky made its final grants to its SIF subgrantees, which included nurse-managed healthcare clinics, telemedicine projects, mobile health services and other innovations. The common thread linking the subgrantees was their focus on improving access to needed health services, reducing health risks and disparities, and promoting health equity in low-income communities in Kentucky.

In a February 2015 press release from the foundation marking the last year of the initiative, the foundation's president and CEO, Susan Zepeda, said it had "harnessed more than \$9 million in resources to develop the evidence base for effective approaches to prevention and provision of health services in the Commonwealth." Zepeda continued, "These health innovations were successfully launched here in Kentucky because a lot of people came together with their hearts, good ideas, and pocket books. This was a case where everybody had to put some money in the project and work together." (For more on the impact and reach of the initiative, see below.)

7 <http://www.healthy-ky.org/presentations-reports/reports/kentucky-health-issues-poll>

8 http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2012/states/kentucky/index.htm; and <http://stateofobesity.org/adult-obesity/>

Diverse Projects, Diverse Needs

The Kentucky Healthy Futures Initiative supported a diverse range of projects. In Meade County, for example, a semi-rural community on the outskirts of Louisville, the Meade Activities Center combined grants from the SIF and the Foundation for a Healthy Kentucky with other monies to launch new exercise, nutrition and afterschool programs that have served more than 1,000 children and adults to date.

The Meade Activity Center's executive director, Aaron Greenwell, pointed out that local families with financial resources have the ability to take their children to Louisville for camps, enrichment programs and sports, but lower-income families do not. Through its participation in the SIF-supported initiative, the center has been able to offer an accessible array of camps, sports and other health-related programs for all residents on a free or a sliding-scale fee basis.

Among the new programs the center launched as part of the Kentucky Healthy Futures Initiative is CATCH, a free, twice-a-week afterschool program. CATCH, which stands for Coordinated Approach to Child Health, is an evidence-based program operating in 10,000 schools and communities nationwide to teach children how to be healthy for life. With activities focused on wellness and nutrition, the Meade Activity Center is serving 300 children at four elementary schools through the program.

"Working with the Foundation for a Healthy Kentucky and the Social Innovation Fund has been a springboard for us to become a credible and well-justified organization providing vital services to the people in this area," said Greenwell. Thanks to the momentum and the added attention provided by its participation in the Kentucky Healthy Futures Initiative, the center raised enough capital and recently broke ground on a new health and wellness facility for the community.

Another Kentucky Healthy Futures Initiative subgrantee was the Montgomery County Health Department, which used its grants to develop a health outreach program to serve low-income residents in three Appalachian counties: Montgomery, Bath and Menifee. The program relies on three full-time "health navigators" who link patients with the healthcare services they need.

"One of the overarching goals of the program is to identify those who have chronic illnesses and to help them understand their illness and how they have to manage it, while making sure they can find the resources they need," explained Jan Chamness, public health director with the Montgomery County Health Department.

Montgomery County already had an impressive track record with its El Puente patient navigation program targeting Hispanic residents. The SIF project was designed to build on that effort by reaching beyond the Hispanic population to other cultural and ethnic groups.

20,000 Served

According to the Foundation for a Healthy Kentucky, KHFI projects like these have improved the quality of life for more than 20,000 Kentuckians, provided training for more than 250 health care providers, and reached underserved populations in more than 90 of the state's 120 counties.⁹ The final report on the initiative listed a range of positive outcomes resulting from the work of the subgrantees. These included: reduced use of hospital emergency rooms by patients receiving improved primary care; increases in physical activity among program participants; and a trend toward fewer hospital readmissions for participants in a telepsychiatry program.¹⁰

⁹ <http://www.healthy-ky.org/our-focus/healthy-futures-initiative>

¹⁰ http://www.healthy-ky.org/sites/default/files/KHFI_Eval_Report_2014_FINAL%2003-31-15.pdf

Despite these successes, the KHFI has not been without its challenges. The Montgomery County Health Department, in fact, had to drop out of the initiative after two years because it could no longer meet its part of the match. According to Chamness, the department, like other county health departments across the state, faced a “financial storm” in 2011 and 2012 as Kentucky shifted to a managed-care system for Medicaid. A 2013 report from the state auditor for Kentucky found that the shift had created financial hardship for local health departments across the state.¹¹

In addition to the fiscal challenges, Chamness said Montgomery County struggled to meet the evaluation requirements associated with the SIF grant (see page 16 for more on these challenges, and on how SIF and its intermediaries support rural organizations with evaluation).

Montgomery County’s struggles with participating in the Kentucky Healthy Futures Initiative are illustrative of some of the unique challenges of carrying out public-private partnerships in rural communities. One of the biggest challenges: finding local philanthropic resources to support the work.

According to Zepeda at the Foundation for a Healthy Kentucky, the KHFI was designed to build on another multiyear foundation initiative called Local Data for Local Action, which supported communities to develop homegrown solutions to the most urgent health care needs they faced.

“They say that if the problem is in the community, it’s likely the solutions are there too,” Zepeda said in an interview for this report. “So our focus was on engaging scrappy, community-based organizations and coalitions to take control of what was making people sick and supporting them to turn things around.”

But as the grantmaker set out to implement the new SIF-supported initiative, it found that the “scrappy, community-based organizations” it wanted to work with faced an array of challenges meeting the strictures of the federal program. As the Montgomery County example illustrates, these challenges include: identifying and cultivating funders in philanthropically underserved areas; and developing the systems and the capacity to meet the evaluation and administrative requirements associated with participating in a large federal initiative.

“Worth the Effort”

Even with these struggles, however, participants generally say that the Kentucky Healthy Futures Initiative has been worth the effort. According to a 2012 evaluation of the first two years of the initiative, “While participating in SIF has been a challenge for both the Foundation and its subgrantees, it has brought valuable resources into the Commonwealth. ... Subgrantees also report that participating in KHFI has benefited their organizations and that the programs have broad community support.”¹²

The evaluation found that a majority of Kentucky subgrantees (80 percent) indicated that they were satisfied or very satisfied with their participation in the KHFI. In addition, all of the respondents (100 percent) were satisfied or very satisfied with the extent to which KHFI enabled them to address an important health issue in their community. The following is a typical subgrantee comment from the evaluation:

“Overall, it’s been a very challenging experience, but I wouldn’t have traded it for the world. We wouldn’t have been able to give this tremendous asset to the community without the Foundation’s support and we really appreciate their partnership. It hasn’t been easy, but it’s been worth it.”

Chamness at the Montgomery County Health Department expressed similar feelings about the KHFI, praising the attention and the resources it brought to rural health care issues while also noting the challenges associated with the work. Despite the loss of the SIF funding, she said Montgomery County’s participation in the SIF project has opened

11 http://apps.auditor.ky.gov/Public/Audit_Reports/Archive/2013MedicaidManagedCarereport.pdf

12 http://www.healthy-ky.org/sites/default/files/KHFI%20Eval%20Report%202010-2012_FINAL%204-8-13.pdf

doors to other funding opportunities. For example, the county was successful in obtaining other federal grants to continue and grow its community health worker program. The county also received support to create a federally qualified health center (FQHC), a designation that makes clinics in underserved areas eligible for enhanced reimbursement from Medicare and Medicaid, plus other benefits.

“Participating in the Kentucky Healthy Futures Initiative helped us develop the evaluation tools and the data we needed to obtain other federal funds to continue and expand our work,” Chamness said.

Kentucky Healthy Futures Initiative Sites

The Kentucky Healthy Futures Initiative has supported nine sites across the state to increase the scale of community-based health care solutions with evidence of real impact:

Subgrantee (Kentucky Site)	Evidence-based program	Initial SIF Subgrantee Award	Match Funder(s)
St. Joseph Health Systems/ Kentucky Health One (Lexington)	Establish nurse-managed, primary care clinics, with telemedicine options, in two low-income rural communities: Powell and Wolfe Counties	\$250,000; 2012	St. Joseph Health Community Partnership Fund
Montgomery County Health Department (Mt. Sterling)	A health education/navigation program to serve a low-income population in three Appalachian counties: Montgomery, Bath and Menifee	\$100,000; 2012	Montgomery County and State funds appropriated to the Montgomery County Health Department
Cumberland Family Medical Center, Inc. (Burkesville)	Nurse-managed clinic in McCreary County	\$250,000; 2012	Patient revenues (non-federal funds)
Home of the Innocents (Louisville)	Pediatric dental clinic for children with special health care needs across KY	\$250,000; 2012	Kosair Charities, Metro United Way, Crusade for Children, various corporate and private funders
Meade Activity Center (Brandenburg)	Active lifestyles in community and schools in Meade County	\$250,000; 2011	Individual/community donations; service fees
Oldham County Health Department (LaGrange)	Establish a free/low-cost nurse-managed clinic for the uninsured to serve Carroll, Henry, Oldham and Trimble counties	\$100,000; 2011	Oldham County Ministerial Association; individual and church donations
King’s Daughter’s Medical Center (Ashland)	Mobile health unit for cardiac screening/ healthy hearts in Elliot, Floyd, Johnson, Lewis, Magoffin, Martin Morgan, and Rowan Counties	\$124,548; 2011	King’s Daughters Health Foundation

Subgrantee (Kentucky Site)	Evidence-based program	Initial SIF Subgrantee Award	Match Funder(s)
St. Elizabeth Medical Center (Edgewood)	Emergency room telepsychiatry	\$100,000; 2011	St. Elizabeth Foundation
Norton Healthcare Centers for Prevention and Wellness, in collaboration with the Norton Healthcare Foundation (Louisville)	A health education/navigation program to increase access to timely health care for low-income and uninsured residents	\$100,000; 2011	Norton Healthcare Foundation

More information: healthy-ky.org/our-focus/healthy-futures-initiative

THREE. Lessons from the SIF’s Work in Rural Communities

While working in partnership with the John A. Hartford Foundation and the Foundation for a Healthy Kentucky on the initiatives profiled in this article, the Social Innovation Fund has identified four key lessons about what it takes to build successful public-private partnerships that bring evidence-based solutions to underserved rural communities.

Lesson #1: The lack of philanthropic resources in rural communities requires proactive, flexible approaches to funding evidence-based innovation.

Perhaps the biggest challenge facing rural communities when it comes to adopting new and better approaches to improving health services, whether behavioral or physical care, is a lack of financial resources. As a result, people in rural communities tend to lack access to affordable, quality health services that might be available to their counterparts in urban and suburban areas. In addition, rural hospitals and clinics are notoriously understaffed, as practitioners migrate toward better-paying jobs in urban and suburban areas. Often, these institutions also lack the technology and infrastructure to support new healthcare delivery models.

While federal and state governments provide a variety of funding streams to support rural health clinics,¹³ government support rarely is enough to keep the doors open. A report from the North Carolina Rural Health Research Program found that 43 rural hospitals across the country closed between 2010 and 2014. A key factor in the closures: low Medicaid and Medicare reimbursements, which is how most patients in rural areas pay for their healthcare.¹⁴

In addition, unlike clinics and other healthcare institutions serving low-income populations in many urban and suburban communities, rural clinics lack access to private sources of funding, including corporate and foundation support.

“Rural communities like those where the SIF is investing are philanthropically underserved, which makes it important to explore creative ways to find new streams of private funding for this work,” said Nembhard of the SIF.

It didn’t take long for the John A. Hartford Foundation to encounter the challenges associated with working in

¹³ For example, many rural areas across the country are served by federally qualified health centers (FQHCs), which qualify for enhanced reimbursement from Medicare and Medicaid, among other benefits. More info: <http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html>

¹⁴ <http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>

philanthropically underserved rural areas. Despite wanting to work with eight or more clinics, the foundation's first request for applicants only attracted seven prospects, of which five eventually were funded. "The match funding requirement scared people off," said Diana Powers of the AIMS Center.

As the foundation began to work with the initial cohort of five clinics, word got out that it was proactively supporting them to find the resources to meet their match commitments under the SIF grant, often by bringing in other funders from outside the targeted communities. This drew added interest in the initiative as the foundation issued a second request for applicants. Ultimately, four more clinics applied and three were approved, bringing the total number to eight.

"Interest grew because people started to see how serious we were about supporting clinics to meet the match," said Patawaran. "We work nationally so we could locate funders with an interest in spreading this work in rural parts of the country."

In some cases, clinic subgrantees had local match funders in place. For example, the Lewis County Board of County Commissioners is providing the match to implement the IMPACT model of depression treatment at the Valley View Health Center in Chehalis, Washington; and Casper, Wyoming's Kinskey Family Foundation is supporting a portion of the match for the Community Health Center of Central Wyoming.

But for the majority of the eight sites, the John A. Hartford Foundation identified national funders to support the subgrantee side of the match. For example, the New York-based Helmsley Charitable Trust is providing support for two of the clinics; the Margaret A. Cargill Foundation in Minnesota is contributing toward the match for three sites; and the Rasmuson Foundation in Anchorage, Alaska, is supporting the match for the Kodiak Area Native Association clinic in Kodiak.

"Thanks to the notoriety that the SIF provides and the availability of federal dollars to support this work, we were able to help these clinics find the startup capital to implement this model," said Patawaran of the Hartford Foundation's fundraising efforts. To ensure that all grant funding goes directly to the targeted communities, the Hartford Foundation has taken the added step of running Project IMPACT "at cost," using its own funds to cover staffing and administrative costs associated with the project.

"We wanted every dollar to count for the treatment of the people in these communities," Patawaran said.

The Foundation for a Healthy Kentucky responded to the relative lack of philanthropic resources in the rural communities it was targeting by teaming up with local and regional hospital systems to support the match requirements for many subgrantees.

"We wound up dancing with behemoths because we had to reach out and find those entities for whom a \$250,000 grant was not a big deal," said Zepeda, the foundation's president and CEO. While the non-local funding was critical in allowing the rural communities to participate in the SIF-supported initiative, there were also downsides. Because many of the projects were not funded by community entities, Zepeda said some of the local projects lacked the "home-grown community support" that might contribute to more sustainable solutions over time.

Those Kentucky subgrantees that raised their own matching funds locally for this work reported mixed results. The Meade Activity Center matched its annual \$250,000 from the Foundation for a Healthy Kentucky primarily with income from program fees. In addition to its recreational programs and camps, the center operates a nine-hole golf course and a swimming pool that provide fee income. Said the center's Aaron Greenwell: "The community support for what we are doing has been phenomenal."

But the Montgomery County Health Department encountered huge struggles with the match, particularly after facing a fiscal crisis in 2011 and 2012. The health department's Jan Chamness commented that nonprofit organizations and government agencies serving rural populations in areas like Montgomery County cannot be expected to meet the same match requirements as similar entities in wealthier communities.

SIF's Nembhard, however, noted that the SIF match requirement is intended to triple the federal investment, augment working capital and spark new collaborations, helping subgrantees more effectively transform lives beyond the initial grant period. "Securing match funding, whether locally or from outside a community, is crucial to ensure that it is sustainable," Nembhard said. "Our intermediaries provide training and technical support to their subgrantees to raise their part of the match." In addition, under Section 198k(i)(3) of the National and Community Service Act of 1990, as amended, the SIF may reduce the matching funds for an intermediary serving a community that the eligible entity demonstrates is "significantly philanthropically underserved." In 2014, the SIF issued its first match waiver to a grantee that met the definition of philanthropically underserved and reduced the match requirement by 50 percent. To be eligible, grantees must have been a SIF award recipient for at least one year.

Takeaways for other public-private partnerships targeting rural communities:

- Support local entities to identify and secure philanthropic resources inside and outside their communities.
- Broker relationships with non-local funders that might support the work.

Lesson #2: Intermediaries should balance their zest for seeing early results with the need for planning, convening, and other preliminary work.

The vision of the Social Innovation Fund is to bring transformative change to more people and more communities across the country. This can be hard to do in the scope of a five-year grant period. As with any large-scale initiative aimed at supporting community-based solutions to pressing social problems, intermediaries must balance the need for local organizations and communities to do the spadework required to prepare for and implement solutions with the pressure to get results as soon as possible.

The difficulty of successfully achieving this balance was evident in the work of the Foundation for a Healthy Kentucky. Based on the foundation's experience with a previous statewide initiative, it initially incorporated a planning year into its proposal to the Social Innovation Fund.

"What worked in that [earlier] initiative was building in a 12- to 18-month planning period, with time for convening and data-gathering and other activities, so communities could develop a bankable business plan identifying their funding needs during startup along with a plan for sustainability," said Zepeda.

But after awarding the grant to the Foundation for a Healthy Kentucky, the Social Innovation Fund asked the grantmaker to eliminate the proposed planning period and to provide subgrantees with implementation grants at the outset. This was in keeping with the SIF approach to supporting innovation, described in the 2015 SIF Notice of Funding Availability:

"Although the practice of social innovation is commonly understood to be the invention and testing of new ideas, the Social Innovation Fund seeks to support innovations that have advanced beyond the beginning stages, are showing signs of effectiveness, and have the potential for greater scale."¹⁵

"Part of the problem was that we didn't grasp that when the SIF used the term 'innovation,' they wanted to support evidence-based methodologies that could be scaled ASAP," Zepeda said. "In the SIF's view, the only thing these initiatives lacked were the resources to get up and running."

The move to rapid implementation caused challenges for many of the Kentucky subgrantees as they struggled to build community support, develop evaluation plans, and expand staffing and systems to do the work. In the 2012 evaluation of the Kentucky Healthy Futures Initiative, subgrantees reported that challenges in areas from hiring to technology to building new systems and infrastructure significantly delayed their progress. Among the results: three subgrantees requested no-cost extensions during the first two years of funding. Zepeda suggested that a planning period might have

¹⁵ <http://www.nationalservice.gov/programs/social-innovation-fund/our-model>

forestalled these kinds of problems and contributed to better outcomes.

Kirsten Breckinridge, a former program officer at the SIF, oversaw the grant with the Foundation for a Healthy Kentucky in 2011. “For rural communities there is relationship building that needs to happen to get everyone bought in and educated about what’s being asked of them,” she said. “And sometimes the timelines for federal funding truncated that initial relationship-building and trust-building.”

Of course, the Kentucky organizations weren’t alone among SIF subgrantees in encountering challenges as they began their work. Even implementing an evidence-based model that is fairly prescriptive in terms of how to go about achieving change — as subgrantees in the Hartford Foundation initiative were asked to do — can be a challenge in rural and non-rural communities alike.

Adopting the IMPACT model and ramping up services and support for a growing number of depression patients was not an easy road for the Community Health Center of Central Wyoming. At the outset, the center made the mistake of approaching the work “like any other grant,” admitted COO Ryan Bair. The center hired a full-time care manager to oversee the program, but Bair said staff did a “cursory” job when it came to boning up on how to implement the model and make it successful. After launching the model in October 2013, the center had just 18 patients in depression treatment by February.

Bair said part of the problem was that the center was in the middle of a leadership transition at the time. In fact, things started to look up after the center hired a new CEO, Daniel Meyers, with a background in therapy. Meyers rapidly became a strong champion of Project IMPACT, and the center took steps to integrate the model as a core service area. To increase uptake, the center stopped charging patients for the service, instead using its grants from the Hartford Foundation and its partner funders to cover the costs of the program. It also launched a determined effort to engage the entire staff in the success of the program, and to start measuring and tracking patient outcomes.

The big change came when the center hired a new family medical practitioner in February 2014. In the new doctor’s initial days on staff, Meyers and Bair sat down with him to explain the importance of the model and the benefits it offers not just to patients but to the entire medical team. Before long, all family providers were reworking how their teams screened patients, and the effort began to deliver results.

The implementation delays at the Community Health Center of Central Wyoming were not unique among clinics adopting the IMPACT model. “I tell clinics from the start that everyone has challenges getting this model up and running,” said Diane Powers of the AIMS Center. “It is a team-based model and you have to change how you work as a team. People haven’t done this before and a lot of the time we have to get a ways down the road before they realize how much they need to change their approach.”

Wally Patawaran at the Hartford Foundation echoed Powers’ comments. “There is not a surefire recipe for how to implement this model. It is different in every clinical setting. The biggest thing to note is everyone should approach this work with eyes wide open and a willingness to respond to challenges as they surface.”

Takeaways for other public-private partnerships targeting rural communities:

- Ensure continuous learning and convening are part of the planning and relationship building process so scaling activities are prioritized and can be realized.
- Weigh the challenges connected with implementing evidence-based practices at the heart of the partnership. Are these activities truly of the “plug-and-play” variety? What types of technical assistance and planning support would help rural grantees implement them?
- Adjust expectations so that subgrantees can hit the ground running even with prescriptive models for change.
- Support subgrantees to fine-tune and adapt to implementation challenges as they arise.

Lesson #3: Intermediaries need to provide implementation and evaluation support to address capacity gaps in rural communities.

The lack of public and private funding to support health care services in rural areas means that clinics and other community-based organizations often lack the organizational and staff capacity to implement new initiatives and models of care. And, to the extent that public-private partnerships rely on rigorous evaluation of results, organizations in these communities often need technical assistance, training and other support to ramp up their ability to gather good data and evaluate their work.

As noted above, subgrantees participating in the Kentucky Healthy Futures Initiative reported a variety of challenges associated with their SIF-funded work. According to the 2012 evaluation, “Complying with grant requirements was overwhelmingly the most frequently cited challenge to participating in KHFI.”

Meeting the stringent evaluation requirements associated with the SIF was a particular challenge for the Kentucky organizations. From the start, SIF made clear to intermediaries and subgrantees that evaluation was a core component of the work. As the SIF website explains:

“All programs funded by SIF must be able to demonstrate a preliminary level of effectiveness and then take part in a rigorous evaluation to strengthen their base of evidence and to document and assess whether their approach works more effectively, costs less, or leads to better results for our country’s communities.”¹⁶

The SIF’s emphasis on evaluation is founded on its goal to identify and validate promising approach to challenges facing communities. But Jan Chamness at the Montgomery County Health Department said the SIF evaluation requirements were “too much of a burden” for her thinly staffed agency.

In the 2012 evaluation of the KHFI, all grantees talked about the difficulties associated with developing evaluation plans that would pass muster with the SIF. Six of the nine subgrantees also identified challenges with implementing the evaluation design that was approved. These included: setting up data systems; training staff on the importance of the evaluation and how to use the data systems; and concerns about lost data due to the length of time it took to get approval for the evaluation plan.

That said, the Montgomery County Health Department ended up using the evaluation model it eventually developed for the SIF grant to craft a logic model and evaluation plan for a subsequent federal grant application that was approved. “As painful as it was at the time, it turned out that it was to our advantage to go through that experience,” Chamness said.

Like other SIF intermediaries, the Foundation for a Healthy Kentucky provided grantees with technical support and training to build their capacity to deal with evaluation and other issues. These training opportunities included retreats, webinars, and one-on-one evaluation technical assistance provided by the Center for Community Health and Evaluation, a Seattle-based firm that is the foundation’s evaluation partner for the initiative. A significant majority of subgrantees responding to the 2012 evaluation rated the support they received as “somewhat useful” or better, with the technical assistance on federal grant compliance and reporting and evaluation getting the highest marks.

Zepeda noted that the diversity of organizations in the KHFI portfolio created challenges when it came to providing technical assistance. With organizations working on a range of projects that included everything from community health navigators to afterschool programs, they faced an equally wide-ranging set of challenges and capacity needs.

¹⁶ <http://www.nationalservice.gov/programs/social-innovation-fund/our-model>

In contrast to the Kentucky experience, the John A. Hartford Foundation's Project IMPACT was focused on supporting eight sites to implement the same model of care, so assisting them to do so was a more straightforward, if still challenging, task.

Technical assistance and training for the Project IMPACT sites was built into the initiative from the start. The AIMS Center at the University of Washington, based on its experience supporting the implementation of the IMPACT model of depression treatment at hundreds of other sites, provides training and technical assistance to each of the clinics participating in the program. The John A. Hartford Foundation negotiated a contract with the AIMS Center on behalf of the eight clinics.

According to the foundation's Wally Patawaran, working with the AIMS Center helps the grantmaker ensure that clinics are getting high-quality support, while also creating economies of scale and relieving clinics of the administrative burden of managing their own contracts with AIMS or other consultants and service providers. Yet another benefit: With one team tracking successes and challenges on a continuing basis, that information can more readily be used to improve program design.

Ryan Bair, COO with the Community Health Center of Central Wyoming, described monthly meetings with an AIMS Center consultant to go over the latest numbers on patient care and to surface challenges or problems where the health center might need additional guidance or support. "The AIMS Center really has this down to a science and their support has been invaluable," Bair said.

Patawaran noted that participating in the SIF places a heavy burden on the local clinics, and the Hartford Foundation set out from the start to try and reduce that burden as much as possible. "The bottom line is you have to meet these sites where they are in terms of their capacity to do this work, and so this is as much about administrative capacity building as it is about clinical capacity building. It is about helping to alleviate the burdens in some areas so these sites can focus more on what really matters for the people in these communities."

Even with the support his clinic received, Bair said participating in the SIF project has been tough at times. "We weren't in any way prepared for the requirements, the scale, the amount of reporting and the amount of overall clinic change that were required," he said. But he said the process was made much easier because of the support the clinic received to implement the model.

In addition to the technical assistance and training provided by Social Innovation Fund intermediaries, the SIF itself has expanded the capacity-building support it provides since the first round of grants in 2010. For example, the SIF has worked with JBS International to provide evaluation training and technical assistance to intermediaries, including a detailed "Social Innovation Fund Evaluation Plan Guidance"¹⁷ that lays out a step-by-step approach to designing a rigorous evaluation. The SIF also provides intermediaries and subgrantees with technical assistance on evaluation and other topics via webinars and a variety of online resources and other materials.

"Our mission is to build local capacity for doing this work, and so we are always looking for opportunities to support intermediaries and their subgrantees to build their capacity in critical areas," said SIF Deputy Director Lois Nembhard.

Takeaways for other public-private partnerships targeting rural communities:

- Provide support to rural subgrantees so they can build capacity within their organizations and communities to implement and scale evidence-based solutions.
- Budget and plan for training and technical assistance in critical capacity areas while connecting subgrantees to expert assistance.
- Assess grantees' capacity for rigorous evaluation of their work, and provide financial and technical support as

¹⁷ <http://www.nationalservice.gov/sites/default/files/documents/SIF%20Evaluation%20guidance%208%205%202014.pdf>

needed.

Lesson #4: Sustainability of SIF funded programs requires working closely with rural communities to change systems and identify ongoing resources for evidence-based solutions.

The Social Innovation Fund was created to spur lasting change. The idea is to bring together public and private resources to support and grow solutions that don't leave a community at the end of a grant period, but that ultimately become rooted there and continue to make a difference for people long after the initial funding concludes.

The structure of the Social Innovation Fund is designed to encourage sustainable solutions because of the match requirement. With intermediaries and subgrantees together contributing a significant portion of the funds for these initiatives, the SIF brings other parties to the table that can hopefully sustain the work over time. The reason: through their participation and funding, they have a vested interest in the continuing success of the innovation.

But how can public and private funders encourage and support sustainability in philanthropically underserved rural communities where it can be hard to find local resources to fund these solutions on a continuing basis? As explored above, the two foundations profiled in this article answered this question in part by supporting subgrantees to find the matching funds they needed, even if that meant seeking funding sources outside of the targeted communities.

"I'm not sure what we would have done if the Hartford Foundation hadn't gone over and above the requirements of the grant and opened the door to a huge portion of the matching funds for this work," said Ryan Bair at the Community Health Center of Central Wyoming. He added, "Finding some of those big donors and raising that money would have been a heavy lift."

Even more important than providing help with an initial match, sustainability means supporting local organizations to tap into other sources of (hopefully) long-term funding to support their work. As part of the training and technical support it provides to the rural subgrantees implementing the Project IMPACT model of depression treatment, the AIMS Center at the University of Washington devotes considerable attention to supporting them to find self-sustaining funding. A special focus of the AIMS Center consultants in their work with the sites is maximizing their ability to collect revenues from Medicaid, Medicare and third-party insurers to support the implementation of the IMPACT model.

"The challenge when it comes to funding this work is that we are in a fee-for-service system, and some of these behavioral health services do not have a medical billing code that allows for reimbursement," said the Hartford Foundation's Wally Patawaran.

Patawaran added that in the long run, policy changes would help support broader adoption of innovations such as the IMPACT model. One such policy change he suggested: moving from a fee-for-service model to a "global capitated" system where clinics and other healthcare providers are paid a set amount based on the population served. But for now, the success and reach of the IMPACT model depends on ensuring that clinics are able to capture reimbursement dollars for the services they provide.

Another focus for the AIMS Center consultants when it comes to sustainability is culture and systems change within the clinics. The consultants work closely with the clinics to help them implement the model as efficiently as possible through better scheduling and use of staff and technology. The focus is on supporting clinics to make this work an integral part of how they serve patients. To the extent that IMPACT becomes ingrained in these organizations, the chances increase that new behaviors and work processes will not disappear at the end of the grant period.

"It's not really a question of whether clinics can carry on this work, but will they?" said Diane Powers at the AIMS Center. Citing the fact that hundreds of clinics are implementing the IMPACT model without the grant funds available to those participating in the SIF-supported project, she said, "I am completely confident these clinics can integrate this approach into who they are if they understand that this can't be a sidebar or something to graft onto their existing systems. What it

takes is a commitment to transform how they serve patients. And once people get a taste of the benefits of this approach for patients and clinics alike, it's hard to turn back." The Community Health Center of Central Wyoming provides an example of how this change process happens. "This is ingrained in our culture now," said COO Ryan Bair. "We are absolutely confident we can sustain this because we now have champions throughout the organization for the approach." What's more, the center now is exploring similar, team-based approaches to treating diabetes, hypertension and other health issues it sees in the population it serves.

Among the Kentucky Healthy Futures Initiative subgrantees, the 2012 evaluation showed that most said identifying and securing additional financial support was the key to sustainability. The most common strategies for raising additional revenue among the Kentucky subgrantees were: seeking additional grant funding (71 percent); obtaining reimbursement or user fees for services provided (57 percent); and "other fundraising" (43 percent).

The two KHFI grantees we spoke with for this article show two approaches to sustainability. As noted above, the Montgomery County Health Department was able to secure new federal funding after exiting the Kentucky Healthy Futures Initiative. Today, the Health Resources and Services Administration of the U.S. Department of Health and Human Services is supporting the county health department's outreach and enrollment activities targeting underserved populations.

The Meade Activity Center, for its part, has been able to increase both fee funding and donations for vital programs since participating in the SIF. "Being part of a high-profile initiative like that has been hugely beneficial for us," said Center Director Greenwell. To date, the center has raised \$1.25 million toward the construction of its new health and wellness facility, thanks to an active fundraising program that includes an annual gala event. "All funds for the new building are coming from the community, and the bulk of it is in smaller donations," Greenwell said.

Takeaways for other public-private partnerships targeting rural communities:

- Identify opportunities for subgrantees to gain financial independence from grant-based funding and sustain evidence-based programs and solutions through fee revenue and other sources.
- Engage in dialogue to explore possible policy changes that would support subgrantee capacity to sustain the work, including new reimbursement models.
- Support systems change and culture change within subgrantee organizations so that evidence-based programming becomes embedded in their operations.

Conclusion

Depression survivor Tana Wolfe of Casper, Wyoming, is living proof of the benefits that come with bringing healthcare innovations to low-income Americans in rural communities. So are hundreds of other patients at the eight rural health clinics in the Mountain West that have adopted the IMPACT model of depression treatment. And, so are the thousands of Kentucky residents who have been touched — and their lives improved — by the work of the nine organizations participating in the Kentucky Healthy Futures Initiative.

The Social Innovation Fund, the John A. Hartford Foundation, the Foundation for a Healthy Kentucky and their subgrantees knew from the start of their work together that increasing the impact of promising health care solutions in rural communities would not be an easy road. As a result, the two SIF intermediaries undertook a number of activities to increase the chances that their public-private partnerships would yield favorable results for all involved. These included:

- Proactively supporting rural subgrantees to find the resources they needed to implement the work and meet their match requirements;

- Supporting rural subgrantees to build and grow their capacity to adopt new ways of working and to conduct rigorous evaluation of their results; and
- Supporting subgrantees to identify and pursue avenues for sustaining the work over the long haul.

It is thanks to these and other activities that the SIF and its partners have delivered results for the rural communities they are targeting. The money alone was never enough to spur lasting change; equally important have been the capacity building and technical assistance these communities received to try and make the work stick. Also crucial to the subgrantees' success: the credibility and the heightened attention that comes from working with high-profile public and private funders, as well as the encouragement to adopt proven models for addressing long-term community problems.

As the SIF's experience with these two initiatives shows, the challenge for public and private funders is to support rural communities to make the most of the resources they have, financial and non-financial, while enabling local organizations to develop the skills and the knowledge to make proven solutions work.

"Rural communities are at a distinct disadvantage when it comes to having the financial resources and the capacity needed to strengthen health care delivery and improve health outcomes," said Damian Thorman, Director of the Social Innovation Fund. "But our experience shows that solutions are possible when public and private funders join together to support local organizations to make evidence-based programs work."

"What I like about this clinic is that we have multiple sources of support. We have the [Foundation for a Healthy Kentucky], the Social Innovation Fund, Baptist Northeast [Hospital], community churches and private donors. I think it's an excellent model for our nation because it's not just one quick fix, it's a lot of people coming together."

Diane Riff, Advanced Practice Nurse Practitioner, Hope Health Clinic, Oldham County, Kentucky