BRAZOS VALLEY COMMUNITY HEALTH RESOURCE CENTERS: A CASE STUDY

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PREFACE

The Episcopal Health Foundation commissioned the Center for Community Health Development at the Texas A&M School of Public Health to prepare this Case Study and a companion Toolkit to help communities understand the value of, and process for, creating Community Health Resource Centers (CHRC) to serve their populations.

This document, the Case Study, describes the "what and why" of developing Community Health Resource Centers. The Toolkit document, also available, is the "how to" of this process. Because they were designed to be independent of each other there is some duplication between the two documents. Ideally, we imagine potential users of the Toolkit would read this Case Study in order to gain a thorough understanding of how, historically, the CHRCs were developed, as well as acquiring details to assist in the actual implementation of the same or similar process within their own community.

This report was developed by the Center for Community Health Development

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Introduction

This case study captures the development of a successful endeavor that began in 2001 and is recognized in the Brazos Valley, Texas, as the foundational processes and activities resulting in a network of Community Health Resource Centers (CHRC). Currently, six CHRCs operate in five rural central Texas counties; each community's process and outcome for the development of CHRCs was unique, but common threads are present in each. These "one-stop shops" were designed to provide access to a wide variety of health and human services – direct care, as well as those services addressing social determinants of health, for rural communities in the Brazos Valley via a shared workspace and common resources.

The Partnership Approach, a Community Health Development (CHD) based strategy, set the stage for the Community Health Resource Centers across the Brazos Valley through community assessment, community organizing, capacity building, and securing needed resources. The following provides a history of the CHRC concept, details the CHD process, discusses the pertinent dimensions of community capacity building, and the development and evolution of the Brazos Valley CHRCs.

The Community Health Resource Center Concept

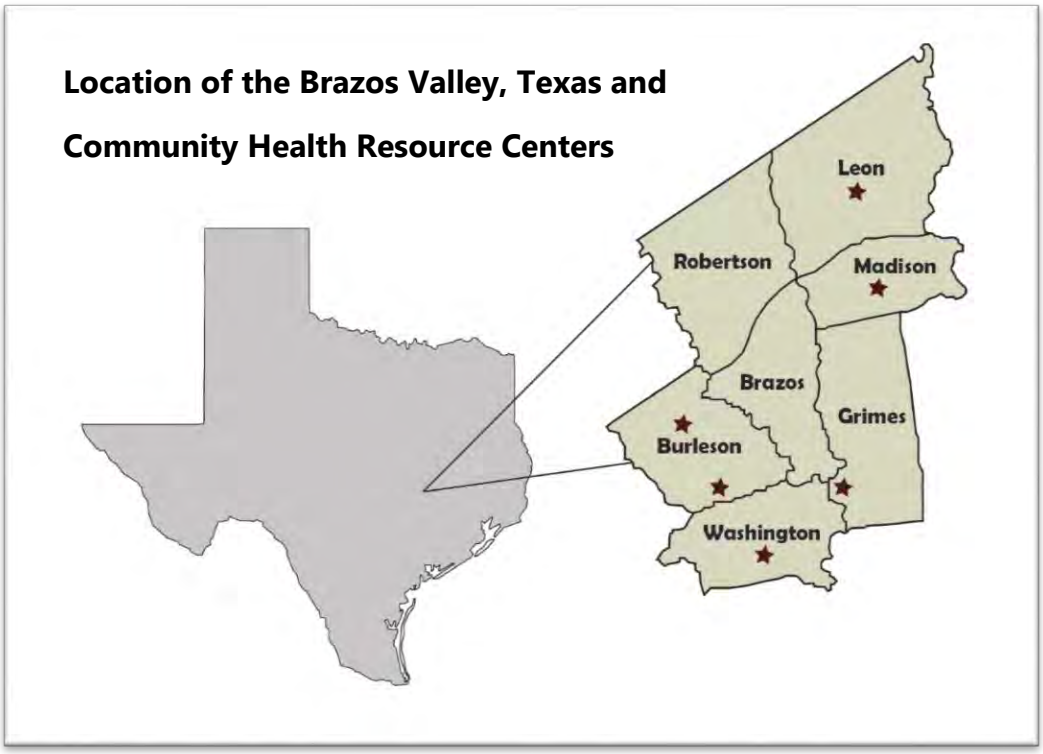
In the 1880s, East London and New York City witnessed the start of the "settlement house" movement, which focused on, and primarily served immigrant populations (Harvard University Library, n.d.). This model served as a major consideration in the development of the CHRCs as they have some of the same elements and characteristics of settlement houses – in both their approach and array of services. Settlement houses typically included educational activities and social services designed to reduce the efforts of poverty and other social determinants of health, mirroring much of

what is provided in today's Brazos Valley Community Health Resource Centers.

More than a century later in the mid-1990s, the CHRC concept was utilized in Augusta, Georgia, in the establishment of the Beulah Grove Community Resource Center. Emerging from the organization of a community health improvement partnership, which sponsored a community health status assessment, the resource center was developed as a solution to a constellation of health problems identified one of Augusta's zip code regions (Mirshak, 2014). The health partnership in Augusta was comprised of a wide variety of representatives of local government, health care organizations, human services agencies, the business community, religious organizations, law enforcement, and other community sectors. Largely funded by the local teaching hospital, which was motivated by trying to reduce costs of operations resulting from inappropriate use of the emergency department for primary care, the partnership supported conducting a community health assessment to identify the factors impacting health status. A member of the Augusta Partnership for Community Health, the pastor of a large African-American church in the affected community, was open to helping address the needs of the local neighborhood identified through the assessment. As such, the Beulah Grove Baptist Church's new Sunday school classroom building, a recently converted old bar across the street, transitioned into the Beulah Grove Community Resource Center during the week when not in use by the church. It has continually expanded to include primary care and many other services.

The original Augusta Partnership for Community Health was later incorporated as a 501(c)3 non-profit organization called the Central Savannah River Authority Partnership for Community Health. Five years after its creation and building on the success of its first project, they established a second center in collaboration with the Belle Terrace Presbyterian Church in a community with similar issues. Now, nearly 20 years after its establishment, the Belle Terrace Health and Wellness Center recently expanded into a new 18,000 square foot facility, which allows for continued growth of programs and services (Medical Associates Plus, 2016).

Today, in the Brazos Valley Region of south central Texas (see picture right), Community Health Resource Centers provide a mix of services to residents of the region (reflecting local needs and priorities identified through a series of community health status assessments). While they operate under different governance and financing models, they all reflect the similar processes and values of the original community health resource centers described above – the efforts are *community-led, community-identified, and community-driven*.



PRESENT DAY BRAZOS VALLEY COMMUNITY HEALTH RESOURCE CENTERS

Each of the Brazos Valley Community Health Resource Centers serve as a "one-stop-shop" for local residents to gain access to multiple resources simultaneously instead of having to visit multiple provider locations. Each CHRC provides different services, depending on the local needs and resources available in the community.

Burleson County Health Resource Centers

- Locations: Caldwell, TX and Somerville, TX
- Governance: Burleson County Health Resource Commission
- Support Provided by: Burleson County Hospital District, Burleson County, CHI St. Joseph Health System and Burleson St. Joseph Hospital, City of Somerville, Somerville Independent School District
- Services Provided: Comprehensive Case Management, Low-cost Medical and Dental Care, Sexual Assault Resources, Aging and Disability Services, Mental Health Services, Rent Assistance, Alcohol and Substance Abuse Counseling, Legal Assistance, Parent Education and Anger Management, Linkages to Other Services and Programs

Grimes County Health Resource Center

- Location: Navasota, TX
- Governance: Grimes Health Resource Commission
- Support Provided by: Grimes County and CHI St. Joseph Health Grimes Hospital
- Services Provided: Senior Meals, Transportation, Free Counseling, Educational Programs, Medication Assistance, Telehealth Counseling

Leon County Health Resource Center

- Location: Centerville, TX
- Governance: Leon County Health Resource Commission
- Support Provided by: Leon County
- Services Provided: Senior Services, Transportation, Women, Infants & Children (WIC) Services, Adopt a Meal, Case Management and other services through Project Unity, Telehealth Counseling

Madison County Health Resource Center

- Location: Madisonville, TX
- Governance: Madison County Health Resource Commission
- Support Provided by: Madison County, CHI St. Joseph Health – Madison Hospital, City of Madisonville
- Services Provided: Senior Meals, Transportation, Alcohol & Substance Abuse, Food Bank, Indigent Health Care, Legal Aid, Medication Assistance, Audiology, Sexual Assault Resources, Youth and Family Services, Telehealth Counseling

Washington County Health and Service Center

- Location: Brenham, TX
- Governance: Faith Mission and Help Center, Inc.
- Support Provided by: Faith Mission and Help Center, Inc.
- Services Provided: Non-emergency health services, Women, Infants & Children (WIC) Services, Medication Assistance, STD Screenings, Immunizations, County Indigent Program, Telehealth Counseling

The Community Health Development Process

As was the case in Augusta, the Brazos Valley's Community Health Resource Centers (CHRC) were established using a Community Health Development process. Community Health Development (CHD) is an approach historically rooted in the practice of public health, economic development, social work, applied anthropology, community psychology and other disciplines (Steckler, Dawson, Israel, & Eng, 1993; Wendel, Burdine, & McLeroy, 2007). It shares the goal of developing community problem-solving capacity with broader approaches such as community development and community organizing; however, it also incorporates the simultaneous goal of improving population health status along with building community capacity (Felix, Burdine, Wendel, & Alaniz, 2010). Both of these goals are pursued using various planned change strategies, recognizing the impact of the social determinants of health/health disparities, and are informed by a social-ecological perspective. Eventually, perspectives for changing communities included the importance of community context and community readiness, which may require different facilitation strategies (Chin & Benne, 1976; Amick, Levine, Tarlov, & Walsh, 1995; McLeroy, Bibeau, Steckler, & Glanz, 1988; Rothman, 1979).

In the mid 1980's McLeroy et al., building on the work of Bronfenbrenner, developed the social ecological model as a framework for guiding the development of population health improvement interventions (McLeroy, et al., 1988). That model draws attention to the interplay of different levels of social organization (individual, family, neighborhood, community, state) and suggests that multiple-simultaneous interventions are most likely to be effective in improving population health.

Community Health Development (CHD) is an approach drawn from multiple disciplines, and employed by social workers, nurses, public health educators, community psychologists, and agricultural extension workers (Burdine et al., 2007). The process includes actions that:

- engage the community;
- strengthen community involvement in the process of assessing health-related needs and establish priorities;

- assist communities in planning, implementing, and evaluating interventions; and,
- disseminate their outcomes to other communities.

Using the Partnership Approach to implement CHD, the four-step process engages the community throughout. Assessment serves as the basis for the process, much like other health program planning models. However, assessment in the Partnership Approach pushes past identifying local issues to also serve as a driving factor for identifying solutions to address the issues via available resources. Strategies for ensuring the planned initiative(s) are locally sustainable are stressed; and, from the earliest stages, consideration of how the project(s) will determine success requires an evaluation plan. Evaluation is valuable because it allows the project(s) to not only have evidence of successes in achieving outcomes with the local community, reinforce the community health development process, and encourage sustainability, but it is also tangible information to share with other communities and public health professionals.

The Community Health Development Process

Community health development, in the context of the community health resource center as the initiative, emphasizes population health status rather than economic or social progress as an outcome. Its principles are philosophically rooted in the fundamentals of democratic thinking – that collective action for a common good is optimal for problem solving (de Tocqueville, 1838). The approach focuses on building community capacity to positively impact the health of its members (Cottrell, 1976; Steckler, et al., 1993; Wendel, et al., 2007).

Community Health Development Principles

The Partnership Approach is based in the fundamental principles of community development and public health. These principles are listed below, and the information is included to communicate the core elements and values that are necessary for successful working collaborations around the improvement of community health.

- Community involvement in the health status improvement process is critical and should be incorporated in all stages. Participants should include representation from most recognized community constituency groups, and where possible, community members should be responsible for completing steps in the process.
- The community health assessment provides opportunities to not only prioritize opportunities to improve health status, but also to examine the broader determinants of health.
- A broad definition of health should be adopted as part of the process to provide a framework for analysis and intervention on both health-specific and broader determinants of health-related issues.
- The goal of all efforts should be the improvement of community health status, as opposed to only "meeting the needs" that exist in a community.
- A comprehensive involvement approach and assessment of community health take time and resources which should be obtained from as many organizations and individuals within the community as possible. No single organization has the capacity to effectively address community health problems, so no single organization within the community should be expected to support the entire community health assessment process.
- Steps in the process will need to be altered to address the unique characteristics of the community undertaking the assessment effort. However, standardized methods and measures should be a consideration in every community.
- Developing local capacity for health status improvement and the ability to sustain that capacity is critical to improving a community's health status. Attention must be placed on developing or enhancing the functions required to support health status improvement. The functions include resource development, training and technical assistance, information and resource exchange, monitoring and evaluation, and the use of multiple community demonstration sites.
- Moving from the medical model to the health status model broadens the base of social accountability for the improvement of community health status from the shoulders of health care providers only to all segments of the community.
- Developing a model for the production of health in each community should be a goal of each community health improvement effort

THE PARTNERSHIP APPROACH

The Partnership Approach is a framework for implementing CHD and has been developed and refined over the past thirty years through its application in dozens of communities. It was first implemented and evaluated in the Community Health Improvement Project of Lycoming County, Pennsylvania, between 1978 and 1984 - the original "CHIP" project (Stunkard, Felix, & Cohen, 1985). Over the following decade, this strategy was refined and applied extensively through the Henry J. Kaiser Family Foundation's National Health Promotion Program (Inglehart, 1988). The Partnership Approach continues to be an effective strategy to improve health in the United States, Canada, and Europe (Brownell, & Felix, 1987; Felix, Stunkard, Cohen, & Cooley, 1985). A major refinement of the approach has been the development of a comprehensive, population-based health status assessment as a core organizing strategy (Felix & Burdine, 1995; Burdine & Felix, 2017).

The framework serves as the strategy to plan, develop, implement, monitor, maintain, and evaluate a community's shared vision for the production of health. The Partnership Approach is a managed incremental change process that operates simultaneously at the structural/resource level of a community and at the local/grassroots level. Designed to mobilize people in a community to produce health through a process which builds or enhances relationships between community sectors (e.g., health care, human services, religion, education, local government, the private sector), the common objective is to improve the community's health status. As such, it is characterized as a ***people process*** because it nurtures these relationships and connects organizational representatives in a forum designed to be interactive and collaborative (requiring them to work together) in order to achieve change. Through the community mobilization process, community ownership of the overall process, activities, and outcomes can be established. Such actions are especially important when working in smaller communities where facilitators may be seen as "outsiders."

COMMUNITY CAPACITY

Community capacity refers to the characteristics, resources and skills that a community can apply in addressing local issues. Community capacity building is the process of enhancing these characteristics, resources, and skills to increase a community's effectiveness in problem solving. In a comprehensive examination, Wendel, Burdine, McLeroy, Alaniz, Norton, & Felix (2009) identified seven dimensions of community capacity as it relates to any health improvement strategy. These dimensions are:

- Skills, knowledge, and resources
- Social relationships
- Structures, mechanisms, and spaces for community dialogue and collective action
- Leadership and leadership development
- Civic participation
- Value systems, and
- A learning culture.

All of these dimensions may be enhanced through training, technical assistance, and facilitated experience. These categories help organize our thinking, but fall short in translation to practice, therefore Felix and colleagues (2010) developed a complimentary scheme more suited for practitioners.

Skills, Knowledge, and Resources

Every community has its own unique mix of skills, knowledge, and resources. They exist both in individuals, as well as in organizations, and need to be identified from the beginning of any community engagement. In 2001, the Robert Wood Johnson Foundation commissioned a white paper on the feasibility of a rating system of community capacity to improve population health as a potential tool to add to their funding processes (Burdine, Felix, Wendel, & Somachandran, 2003). By including a measure or measures of community capacity for population health improvement the

thought was that communities with a higher potential for success could be identified and selected for priority in funding. When a significant potential negative impact on communities with low capacity scores was identified as a potential outcome, the strategy was abandoned, but the insights into community change strategies inform other capacity building activities.

Wendel et al. (2009) described skills as consisting of: leadership, organization, facilitation, and collaboration. They defined knowledge as consisting of policies, procedures, and access to information and resources outside of the community (knowledge of those resources). Resources consist of: physical capital (i.e., machines, equipment, and productive materials), social capital (i.e., norms of reciprocity, social trust, inter-network relationships, sense of community), and human capital (i.e. ability to use the individuals at their maximum capacity based on their skills, knowledge, and resources).

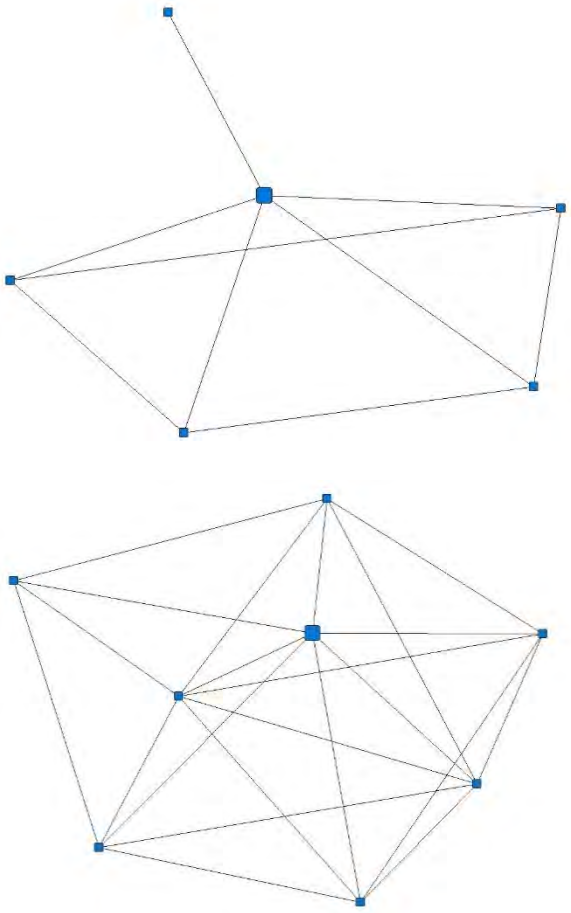
Social Relationships

As with many of the community capacity elements, they seem obvious and commonsensical, but our experience is that far too often adequate attention is not paid to some of these "obvious" factors. Social relationships within a community is one of those factors. Therefore, although it is no great insight to suggest it, the nature of social relationships within a community is a critical element to understand. "Who talks to who?" "What are the communication channels?" "What are the dividing lines and common threads that characterize social relationships in this community?" are among the questions that need to be asked from the very beginning of a community engagement. Is there community history that dictates some of the relationships – are they based on race, income, geography (e.g., "across the tracks"), culture or other factors? Are these factors assets or barriers in improving or applying a community's cohesion and collaboration? These answers are fundamental to shaping plans for population health improvement strategies and community capacity building activities.

Density, Reach, and Diversity of Social Networks

Improving or maintaining strong, positive social relationships can be both a process and outcome of a capacity building/health improvement process. One of the ways of measuring this is to monitor social networks. Social network refers to the degree which individuals are socially connected within their community. By identifying the density, reach, and diversity of social networks through a social network analysis, we can see changes in relationships between key individuals and organizations and use that information as part of the intervention process as Clark et al. (2014) pointed out.

In the diagrams to the right, results from a longitudinal network analysis illustrates the changes in the social networks of one of the Brazos Valley CHRCs as measured by the number of *formal memorandums of agreement* between network agencies and organizations. The network relationships displayed on the right shows connections approximately one year after inception. The CHRC (larger node at the center) is connected to five other organizations and serves as the "central" organization in this network. Although most of the organizations are already connected to each other, if the resource center would no longer be in the network, then one organization would be disconnected from the network. Three years later, many relationships were established with the CHRC and other local social service and health care provider organizations, resulting in a network that increased by two organizations (right). However, while only increasing in size by two organizations,



Growth in connectivity of a county health resource center from one year after inception (top) and three years later (bottom). The CHRC in each diagram is represented by the larger node (square).

the connectivity among the organizations expanded significantly from nine ties present in the initial network to 23. Via relationship building and the network center (the CHRC) serving as a central resource for many organizations to provide services, new relationships were documented by formal memorandums of agreement. In other network questions in the survey, less complex relationships such as information sharing, joint planning of events or activities, and shared resources were also examined and demonstrated similar positive network relationship development.

Structures, Mechanisms, and Spaces for Community Dialogue and Collective Action

Understanding both the history and processes through which communication, negotiation, and collective action occur within a community is another capacity we need to assess. There are two approaches in community dialogue – formal and informal. Formal refers to official or publicly recognized channels of communication, while informal refers to generally personal or unofficial channels – a city council meeting versus neighbors talking. Both can promote open dialogue and action in meetings, social events, or group activities.

Often these structures and mechanisms are reflective of the dominant culture of a community. Traditional paternalistic cultures, for example, often have limited, closed structures and mechanisms for dialogue and collective action is limited to a few leaders in key power positions. Expecting a more open and inclusive process such as community health development to be readily adopted is naïve. In that situation, the CHD process needs to be implemented such that both the "top" and "grassroots" elements of a community are engaged and have meaningful participation. In this example, building experience with collaboration and communication with groups not typically included in the conversation becomes a capacity building goal of the overall strategy.

Leadership and Leadership Development

Leadership appears twice when examining community capacity – as a skill and as its own category of community capacity. As a skill, it is a needed resource found in unique individuals who have the capacity to mobilize and empower the community, provide strong representation, and effective

communication. As a community characteristic, leadership, and particularly the development of current and new leaders enhances coordination and collaboration, structure and organization, accountability and feedback. It is important to remember that there are both formal and informal leaders when developing a CHRC.

County judges in Texas function as both a judicial figure, presiding over minor misdemeanor and civil cases, and as the county's chief executive, charged with budgetary matters and presiding over the county's administrative body, the County Commission. Thus, a county judge is defined by their role as a local community leader. They are supported well by regional bodies called the [Regional] Council of Government (COG) who supports clusters of counties with centralized and consolidated services such as planning, transportation, and human services among others that smaller counties may not be able to afford individually.

Both the county judges and the Brazos Valley Council of Governments (BVCOG) played a major role in facilitating the development of the CHRCs. The involvement of both judges and the BVCOG gave legitimacy to the community assessment process that identified the need for the CHRCs. Through the BVCOG's board, which is comprised of the county judges from the region, collective access to the central formal leader in each community was provided.

The timing and context of the introduction of the CHRC idea to each of the county judges, as well as their personalities, life experience, and political views generated an array of initial responses from highly skeptical to immediately embracing the idea. Since long-term sustainability was among the most fundamental characteristics of the CHRCs we were promoting, from the first meetings the information that CHRCs would need to be locally funded, indefinitely, was introduced. Given the relatively small budgets of the rural counties in the region, what seemed like a modest request for such a worthwhile project was challenging for many of the judges. Having other partners involved in the process helped soften that request, both in terms of political support and sharing the costs, and was critical to the overall success of the effort.

An example of this occurred in one of the Brazos Valley counties, where the county judge's initial reaction was quite skeptical, expressing concern about expanding health and human services. Counties in Texas are required to set aside eight percent of the local budget to pay for care of medically indigent residents, and the budget was already tight. However, after the local hospital offered free space and office furniture, and initial funding for the office staff was provided from a Healthy Community Access Program (HCAP) grant, he was swayed to consider the idea of the resource center. Of course, responsible oversight of county funds is a critical concern for county judges. Eventually he committed that while unsure this idea would actually work, if it did, the resource center would go in the county budget. Fortunately, that was the case and county budgets, along with other local support now fund all of the community health resource centers that are still open nearly 15 years later.

Other dimensions of community capacity were also present throughout the development of the resource centers, however were more reflective in nature –civic participation, learning culture, and value system, and are thoroughly described elsewhere. Participation from service providers in the development of the CHRC concept was critical to the success of the resource centers and is described in detail in the Toolkit companion document. The communities' willingness to learn the development process and build their own capacity was, without a doubt, one of the keys to the success of the projects. The connectedness to their community and caring nature for assisting others in the community were the core values of what drove this process towards success.

Community Health Development Process in Action in Brazos Valley, Texas

The following section presents the results of a review of archival documents from the CHRCs, the Brazos Valley Health Partnership (BVHP), and the Center for Community Health Development (CCHD), as well as interviews conducted with individuals who were key in the development of the BV CHRCs. Reviewed archival documents included meeting minutes, strategic plans, bylaws, policy and procedure manuals, published articles and book chapters, as well as other documents. Interviews were conducted with 21 individuals, including current and former executive directors of health resource centers, current and past county health commission members, hospital administrators, county judges, and past graduate assistants and staff members of the CCHD involved in the resource center facilitation process.

In 2001, the CCHD at the Texas A&M University School of Public Health (TAMU SPH) utilized Community Health Development (described previously) as a strategy to improve health in the Brazos Valley, Texas. The heart of the Brazos Valley region in Texas is located 90 miles northwest of Houston and is anchored by the centrally located Brazos County and its twin cities of Bryan-College Station where Texas A&M University is located. Brazos County accounts for 57% (215,037), of the regional population, which is largely due to the presence of the university (Center for Community Health Development [CCHD], 2016). The remainder of the Brazos Valley is comprised of the six surrounding rural counties of Burleson, Grimes, Leon, Madison, Robertson, and Washington, whose populations range from 14,222 (Madison) to 35,043 (Washington).

Over the next eight years, the Brazos Valley Health Partnership, five rural counties, and CCHD partnered to create six health resource centers. CCHD facilitated the CHD process of assessment, planning, and implementation to develop locally supported, sustainable health solutions (Felix et al.,

2010). This section describes those activities in the context of the development of the BV CHRCs through the use of the Partnership Approach as an implementation of Community Health Development. It is important to note that while the activities described below may appear to have been implemented in a chronological or linear fashion, often activities within each step occurred simultaneously.

STEP 1: ASSESSMENT

Many planning models for health improvement exist, including, but not limited to models such as the Mobilizing for Action through Planning and Partnerships (MAPP), a Planned Approach to Community Health (PATCH), and the PRECEDE/PROCEED model (National Association of County and City Health Official, 2018; U. S. Department of Health & Human Services, n.d.; Green & Kreuter, 2005). CHD and the Partnership Approach are similar to these models in that they share an assessment as the foundation of the entire process. Unique to the Partnership Approach to CHD is the inclusion of a social reconnaissance component. Social reconnaissance is an interview-driven methodology to quickly identify key community leaders, their biases, preferences, and values. That information is incorporated into an overall guiding strategy for future collaboration, based on their "enlightened self-interests."

The social reconnaissance process yields three products. First, the information to develop a formalized recruiting and organizing strategy, including the development of community themes for building a collaboration that mixes various individual and institutional interests. Second, is the identification of key participants and potential co-sponsors. The third product is identifying community readiness for,

and additional potential sponsors and participants for a collaborative community health improvement effort.

Building on the organizing strategy developed through the social reconnaissance, a formal community health status assessment is step one when considering implementing a CHD process and the associated activities of the Partnership Approach's Phase I and II. This step is the foundation for the following:

- A *process to engage the community* in the design and implementation of a community health status assessment (increasing community ownership and potential buy-in to the results);
- The *ability to collect and analyze data* resulting from that assessment, including health behavior, health status, demographics, health services utilization data and perceptions of community issues, trends and themes, opportunities, barriers, history of community collaboration and resource availability, advice for collaboration, and perceptions of the benefits of the current health system; and,
- *Collecting comparison secondary data* from other local, state, and national resources in order to provide a reference for the local community's profile, specifically around the broader determinants of health, and other social, economic and political forces, in the larger context.

The outcome of this process results in a population-based health status assessment, which includes data, a report, and a formal presentation of results to the community. The collaborative nature of the process has provided opportunity for an established, functioning partnership through which health status improvement interventions can be developed. What follows is an accounting of the assessment process in the Brazos Valley, Texas.

Assessment in the Brazos Valley

Using the Partnership Approach, CCHD organized regional stakeholders in 2001-2002 to provide the support and input required to conduct the first regional population health status assessment in the Brazos Valley. This process was the beginning of long lasting community-campus partnership to

improve local health status. Key community leaders identified through the social reconnaissance were engaged to form a "steering committee" to help plan and conduct the assessment which was jointly funded by TAMU SPH, St. Joseph Regional Health Center, College Station Medical Center, the Brazos Valley Council of Governments, and the United Way of the Greater Brazos Valley, among others.

Members of the steering committee along with a group of health care professionals and community members helped to tailor the household survey's scope of questions and in organizing community discussion groups. The Steering Committee served as a critical link to identify a variety of population groups and stakeholders. Political or work-related connections served to link the assessment process to community gatekeepers for each of the targeted communities who were approached to assist in recruiting local representatives for numerous community discussion groups.

The process took approximately one year from the initial stakeholder engagement to the presentation of assessment findings in September 2002. The assessment culminated in the two-day Brazos Valley Regional Health Summit with more than 100 attendees from essentially every community sector. Results indicated Brazos Valley rural counties had a significantly older adult population, higher rates of chronic disease, and disparities in education, socioeconomics, health status, and access to care. Furthermore, the household survey and community discussion groups indicated five primary needs for the region, including the need for information and referral services, comprehensive case management, medication assistance, transportation, and access to care (CCHD, 2002).

Disparities in access to care between the rural residents and those living in Brazos County resonated with attendees. Although nearly 40% of the region's population resided in the rural counties, nearly 90% of the services designed to care for the regional population were housed in Bryan-College Station, presenting substantial barriers to access for rural residents, especially those who are older and/or economically disadvantaged. Medical and health and human services agencies/social service providers all agreed that providing more readily available services to residents of rural counties was imperative, but also recognized that individual organizations could not afford to operate satellite offices in every rural county (many of these agencies has attempted to operate satellite offices in the rural counties but were largely unsuccessful). They also agreed that the CHRC model might create an opportunity to provide services if they did not have to fully and independently fund offices.

STEP 2: PLANNING

Planning for the implementation of health status improvement initiatives looks different in each community. In the Brazos Valley, the engagement that resulted from the CHD strategy had motivated people to act in their community's best interests. The next step in the CHD process was to plan for community health improvement based on the prioritized issues determined by the assessment. Connections and partnerships established during the assessment provided an opportunity to work together for the collective good of the community. Additionally, the assessment had examined *policies* that inhibited or enhanced local solutions to health status improvement, *practices* currently in place in the community; *processes* that need to be in place to implement health status improvements, increase access to care and insurance coverage; and *resources* required to accomplish these goals. Based on the community health status assessment, the CHRCs were initially developed to provide comprehensive case management, housing information, medication assistance, access to health

care providers, transportation to care in Bryan/College Station, education/counseling and information/referral services.

Planning began with selecting the community issue to be addressed in the community health improvement initiative and was based on the priority areas established by the community health assessment. Important to this selection process is taking into consideration the importance and changeability of the community issue; should an issue be selected that is not changeable (i.e., poverty rates), the less likely the initiative is to be successful. Community support for the selected initiative is also critical. However, if community organizing efforts were able to garner support for the assessment, then it is likely the community will be supportive of the chosen initiative. However, it is important to be sure the selected issue(s) is chosen *by* the community, not *for* the community by a facilitator. In the Brazos Valley process, skilled facilitators assisted the community focus on potential initiatives that had at least a reasonable possibility of measurable impact within a relatively short timeframe. This occurred during Day One of the Regional Health Summit.

Once the issues were selected, the planning process shifted to the formation of "task groups" on the second day of the Health Summit. Participants returning for day two had been instructed to identify their personal and/or organization priorities and to be prepared to select and participate in one or more groups being established. "Task groups" were labeled as such because their focus was to be short-term. The immediate tasks were to: (1) thoroughly investigate the determinants and factors surrounding their issue, through additional analysis of assessment data, as well as reviewing the literature, (2) identify potential solutions, from a

literature review as well as their professional networks, e.g. programs that had worked in other communities, and any key parameters for success in that environment, and (3) develop specific recommendations for how to implement their solution(s) which were presented to the full partnership. Each group was given 90 days to complete this task and were supported by faculty, staff and students from CCHD and the TAMU SPH. The task groups were encouraged to use tools such as logic modeling to validate their approach. Finally, the task groups were asked to consider how they would evaluate success in their communities for any given problem (as very useful application of the logic model approach), and to plan for sustainability of any initiative(s).

STEP 3: IMPLEMENTATION

It is overly simplistic to suggest that after assessment and planning you "just do it" and call that implementation. Implementation is the translation of concepts and plans to reality and action. Every element of a plan requires the adaptation to application, which may vary widely depending on each community's context. Another element that impacts the implementation is time. An implementation plan should be considerate of available resources – from budgets to staffing – and how those may be impacted by a variable such as time. Is there enough money to implement a "grand plan?" Can we find the right person with the desired qualifications in a few weeks or is it going to take months? These and similar factors require both broad oversight and leadership, as well as detailed management.

An effective collaboration between community leaders (responsible for oversight) and project or agency staff (tasked with details management) is essential. From acquiring additional resources as needed, to continuing the development of support for local structures to improve health, to the institutionalization of the intervention, planning and implementation are intertwined, as is the relationship between leadership and staff. Carrying out the activities of the intervention is at the core of the implementation process, but monitoring intervention progress through process and outcome evaluation, identifying needed training(s), providing technical assistance, communication, and planning for sustainability are also critical during implementation.

Implementation of the Brazos Valley Community Health Resource Centers was further fueled by a three-year, $2.1 million grant from the Health Resource Services Administration (HRSA) Healthy Community Access Program. Obtained in 2003 by CCHD on behalf of the Brazos Valley Health Partnership, a year after the task groups began their work and the need for health resource centers was identified, the funding was used as "seed funding" to start the CHRCs, as well as provide the technical assistance and facilitation led by CCHD, resulting in the first center opening in Madison County in 2003. Burleson, Grimes, and Leon counties soon followed, with their CHRCs opening in 2004 and 2005. In 2006, Burleson County opened a second center in the southern part of the county (Somerville) based on the success of their initial center in the county seat (Caldwell). BV CHRC development was overseen by the Brazos Valley Health Partnership which consisted of key community leaders and collaborating organizations including the College Station Medical Center, St. Joseph Regional Health Center, the Brazos Valley Council of Governments, Brazos Valley Community Action Agency, Brazos Valley Council on Alcohol and Substance Abuse, several county judges, and patient/consumer advocates. Key activities in carrying out the implementation of the CHRC development included:

- Gathering community support
- Acquisition of local resources, including, but not limited to a facility, utilities, phone, internet, furniture, etc.
- Securing commitments from organizations to offer services in the CHRC
- Developing a budget
- Hiring a CHRC office manager and/or Executive Director
- Creating a yearly strategic plan
- Developing a tracking system for evaluation/reporting purposes
- Ensuring commitments for sustainability
- Marketing of the CHRC
- Development of policies and procedures and an operations manual
- Establishing local oversight/governance (eventually the County Health Resource Commissions)

After completion of the HRSA grant, a CHRC was also established in Washington County, with technical assistance provided by CCHD. Community leaders in Washington County decided to incorporate their CHRC in an existing organization, Faith Mission, in 2008. Although the creation of this CHRC was different from the other counties, the Washington County Health and Service Center also acts as a 'one-stop-shop" for its residents, providing similar services.

Fifteen years later in 2018, all six Brazos Valley Health Resource Centers are locally sustained by their respective community and are still in operation. Each center is unique in the services and resources it offers, but at the core belief of each is the need to provide local access to health and social services to improve the health of their county's residents.

STEP 4: EVALUATION

Evaluation has many functions including affirming the worth and value of something, examining opportunities and methods for improvement, and providing a basis for accountability. It involves setting and defining standards and determining the degree to which the object being evaluated compares to those standards and passing judgment about the worth of the object being evaluated (House, 1980). Under the Kennedy administration, the federal government brought new emphasis to evaluation of social programs. The key questions asked included if the program did what it was supposed to do and what were the effects of the program? The interest in outcomes allowed program administrators to not only look at the success of the program, but also determine if the program could be effective elsewhere.

Unfortunately, the task of evaluation can be difficult for evaluators when the evaluators, stakeholders, and audiences for the evaluation may all have different assumptions, perspectives, and preferences

related to the evaluation's purpose (improvement, judgement, program development, etc.), context (political ideologies, community, stakeholder values, etc.), and criteria or counterfactuals (standards of success, expectations, etc.). Taking all of these into consideration, developing an evaluation of the initiative(s) is important; although, evaluation is an often-neglected portion of any project's process.

Evaluation of the CHD process is best centered around the dimensions of community capacity given the connection between building capacity as a product of the CHD process. The dimensions of community capacity include skills, knowledge and resources; social relationships; structures, mechanisms, and spaces for community dialogue and collective action; quality of leadership and leadership development; and civic participation which are discussed earlier in Partnership Approach section of this document. Not all dimensions of community capacity were evaluated during the development of the BV CHRCs as the primary focus of the HRSA funded project was opening the CHRCs. Evaluation measures were primarily process oriented examining the *process* that accompanied the resource center development.

Some documentation of the HRC development process allowed for a combination of the community capacity dimensions to be evaluated, such as meeting minutes from the numerous meetings taking place during the initial development of the regional partnership as well as the county health resource centers. Minutes documented the progress and actions of the community and service provider participants along with the facilitators and included a list of attendees, which eventually led to partnership rosters. Minutes and attendance rosters served as archival data from which a variety of topics could be evaluated – participation, new or existing partnership members, leadership, conflict/conflict resolution, etc. Over time, growth in partnership members' skills related to leadership and meeting facilitation could be seen during an archival review of meeting minutes and planning documents.

Moreover, in the early stages of the partnerships development, leaders and participants were asked to critically reflect on their participation in meetings via a survey instrument. The instrument encouraged

meeting attendees to reflect on their role(s) and engagement during the meeting, as well as reviewing the meeting leader(s) and how different situations were received or handled, including what they would have liked to have seen happen in the meeting. Such critical reflection provided an opportunity to review member growth with respect to skills, knowledge, and participation/leadership.

Participation of individuals and organizations presents an additional opportunity to evaluate the diversity of the partnership and inventory skills and resources present (and absent) of partnership members. With the development of the overall Brazos Valley Health Partnership and the community health resource centers, attendance at meetings was documented via sign in sheets allowing for the creation of tracking documents to review who was or was not participating.

Central to capacity building efforts is building upon existing and/or developing new relationships among partnership members, particularly to generate trust and confidence between collaborating entities/individuals (Clark, 2014). "By building the capacity of relevant community organizations to work together, communities may be able to address health and social issues more efficiently" (Goodman et al., 1998, p. 268), yet existence of relationships does not necessarily indicate capacity. Relationship existence *may* indicate a degree of trust between organizations. Throughout the development of the resource centers, the project expected to see a growth in not only the number of interorganizational relationships present with each HRC, but the depth of the connection as well. Thus, a key evaluation component was documenting the changes of these relationships overtime using an interorganizational network survey.

An interorganizational network survey was conducted beginning in 2004 to document the development of the regional partnership – the Brazos Valley Health Partnership. Additional administrations of the survey occurred in 2006, 2009, and 2012. The survey examined four types of relationships between community organizations – sharing information, jointly planning events or activities, sharing of tangible resources, and formal memorandums of understanding or agreements – in a relational matrix format where each participant answered the questions about each of the other

organizations listed in the roster of the survey. For instance, in 2004 each organization surveyed answered each of the four questions regarding their relationship with the other 32 organizations listed in the survey. A definition of each of the organizational relationships measured can be found below. The first two questions asked about frequency of interactions between the responding organization and a listed organization and allowed for responses of 0=*never*, 1=*once or twice,* 2=*every few months*, 3=*monthly or almost monthly*, 4=*weekly or almost weekly*, and *5=daily/almost daily*.

Interorganizational Network Survey Terminology	
Sharing Information	Refers to receiving or providing data, updates on health-related programs or services, educational materials, newsletters and/or other types of information related specifically to health issues or problems facing low-income residents of the Brazos Valley.
Jointly plan, coordinate or conduct an activity, training, event or program	Examples include coordinating referrals or follow-up health services for the underserved populations, planning a health education workshop, developing a program to reach at-risk groups within the community for various diseases (e.g. diabetes), writing a collaborative grant, co-sponsoring a community meeting or health fair.
Sharing tangible resources	Refers to sharing or exchanging resources such as staff, space, equipment, or funds. This may or may not involve formal working arrangements between organizations, like contracts, subcontracts, resolutions or memoranda of agreement.
Formal working agreements	Existence of a formal memorandum of understanding or contract.

Each administration reflected a different number of organizations included in the survey as organizations may have closed or left the partnership if the development no longer coincided with an organization's mission or organizations (such as health resource centers) were new and added to the surveys. Survey results from the 2006, 2009, and 2012 surveys allowed the evaluation to conduct an egocentric analysis on each of the health resource centers – in other words, only the health resource center relationships were shown in the evaluation. Consistent growth and complexity of relationships was shown in each of the resource centers.

Other direct evaluation of the health resource centers included process and outcome measures. Process measures used in the evaluation of the health resource centers included documenting improved efficiency in the delivery of health and social services in rural communities via data collected within each health resource center including encounter logs as reported by service providers (i.e. client visits by service), number of service providers offering services in the resource center, and satisfaction surveys conducted by the health resource centers. An analysis of the return on community investment (ROCI) was provided to local community funders (county, city, organizations included in the CHRC funding) which compared the cost of operating the resource center, including volunteer time, to the number of residents served. In most cases, the average cost per CHRC client was between $1.50 and $2.50.

Outcome measures which would be documented by future community health assessments, key leader surveys, health resource center client surveys, included:

- Improved quality of care – Improved quality of care changes could be documented by seeing an increase of self-reported health status and a decrease in prevalence of chronic disease and mortality rates.
- Effectiveness, coordination, and cost savings – Improved coordination and effectiveness would be evident if there were a decrease in numbers of residents who delayed health care due to costs or extended travel time and a decrease in the reported distance traveled for care.
- Perceptions of local leaders regarding access to health care for low-income families.

Evaluation plans are best comprised from the beginning of any project initiative as part of the overall planning process and should reflect the needs of the different stakeholders. As such, many other opportunities for evaluation could be utilized in CHRCs. Yet a critical perspective requires the evaluation plan to be feasible and one that will not overburden the community.

Factors that Fostered Success in the Brazos Valley Health Resource Centers

Reflecting back on 15 years of community health resource centers in the Brazos Valley, much can be learned from what went well. At the same time, perhaps the most important lessons come from things that could have occurred differently. Given the Brazos Valley Health Resource Centers are still in operation and being sustained independently, it is hard to say that anything was specifically a failure, but much of what happened was unprecedented so perhaps its more useful to think of it in terms of trial and error. Something that worked well in one community may not have worked well in another, and vice versa. Sometimes a specific event did not go as planned and required us to regroup and try a different method or person. However, it happened, we can certainly agree that everything was a learning opportunity. This section presents the results of a thematic analysis from community partner interviews and archival document review.

COMMUNITY READINESS ✓

Analogous to individual readiness in the Stages of Change model, community readiness is the "degree to which a community is willing and prepared to take action on an issue" (Plested, Edwards, & Jumper-Thurman, 2006). Community readiness includes nine stages, which range from no awareness of an issue to community ownership. Stages in between represent a linear progression based largely on increasing awareness of the issues with planning and implementation of an initiative(s) to address it with the stages ending on a note of ownership of the issue. Ownership is represented by having extensive knowledge about the issue and its determinants, local efforts to address the issue, with support and commitment from the community to long term, ongoing efforts.

The development of the BV CHRCs began midway through this model of community readiness as critical community leaders and local organizations were all too familiar with the issue of lack of access to care by Brazos Valley rural residents. This knowledge of the issue, while known anecdotally, was

brought into the spotlight via the first regional assessment. Yet despite this knowledge and awareness, the mechanism to address the issue had yet to come to fruition.

While there was no specific community readiness assessment used in the local communities, i.e., the Triethnic Center's Community Readiness Tool, community readiness for the CHRC project was evident through social reconnaissance and in the response of community organizations following the first Health Summit. Organizations cooperated to combine a variety of resources to address the issue of access to health care, including office space and furniture, to personnel and funding, in order to get the first health resource center open.

Crucial political support was also present. Those closely involved in the development of the resource centers had knowledge of and/or political connections and served as important liaisons to local politicians to assist in securing support for the resource centers. Over time, these political connections remain critical to the success of resource centers being locally sustained.

COMMUNITY COMMITMENT ✓

Measured by engagement of key community leaders, community commitment at the beginning of this process varied widely from "fully committed" to "highly skeptical, but willing to participate." The emphasis on sustainability established from the very beginning of the project encouraged community leaders to keep focus on how this was going to continue without grants or other external support. Many local organizations committed to offering services in the CHRCs as well without compensation. Years later, even if skeptical at first, many of the same organizations/services are still available in the CHRCs providing access to valuable services for rural communities. During one interview in particular, the interviewee was adamant regarding financial support from the community, "that [money] is staying in the budget! I will fight to make sure it stays in there. The services are too important!"

FINANCIAL SUPPORT ✓

As has been described, TAMU SPH was the initial sponsor, making the capacities of CCHD available to the initial co-sponsors of the process. Funding for the community health status assessment was obtained from many members of the Brazos Valley Health Partnership, the initial "steering committee" and body growing out of the CHD process. Additional support was obtained in 2003 through the Healthy Community Access Program (HCAP) grant. Commitments from BVHP members for different aspects of the CHRCs were obtained as each new site was developed.

Eventually, the financial support was turned over to the county and various models now exist as to how each HRC is supported financially. Some are supported fully by the county budget. Others are funded by their city and county, while others also offer programmatic services such as senior meals in order to supplement the HRC budget.

SUSTAINABILITY PLAN AND INSITUTIONALIZATION ✓

As discussed previously, from the beginning of the project, planning for sustainability was in the forefront. "We're not going to ask you for money now, but in three years you will have to locally sustained them." was a phrase widely reported as being heard by community leaders and organizations from CCHD staff. The initial funding provided by the HRSA grant was used to develop and strengthen infrastructure and capacity in a way the project would be self-sustaining in the end.

Many activities in the initial establishment of the CHRCs targeted not only increasing access to health care for rural residents, but also intended to lower the costs of providing services to rural residents for service organizations. By lowering costs to providing care, the CHRCs would become a sustainable resource for residents and organizations. This sustainability plan co-located services at the CHRC and used case management and service coordination to assist organizations to collectively expand services to the rural counties of the Brazos Valley. Further, enrollment of resource center clients into public insurance and other assistance programs, such as the Medication Assistance Program, helped

increase the volume of providers able to bill for reimbursed care in order to redirect funds other places. Telehealth technology also reduced costs for organizations to provide services in the rural counties. Finally, the volunteer transportation service located in the CHRCs not only eliminated the barrier of transportation for residents but could help decrease the number of residents who postpone care only to end up with more complicated and expensive health care needs.

Since the inception of the HRC model, community ownership of the resource centers has been a goal. More than a decade later, the resource centers are self-sustaining and have become a county and/or city, local institution. Institutionalization is the last step of most intervention adoption models. We can assuredly report that the county health resource centers have become a standard of practice in each of their communities.

ACADEMIC PARTNERSHIP ✓

Brazos Valley communities have seen research projects from the local university for decades. Unfortunately, many communities were hesitant to engage in an academic partnership as the result of bad experiences. Previous attempts left communities no better off as programs were reported to "come and go" as funding came and went. Important to the success of this project, the academic partnership (TAMU SPH) had to show commitment to the long-term project and provide assurances the efforts would not be abandoned. The CHD model's emphasis on capacity building was manifested through both verbal commitments as well as specific activities designed to benefit the community (e.g., workshops for community leaders/members on grant writing, communication, project management, etc.)

During this time, CCHD provided technical assistance throughout the development process which included: 1) crafting operational policies and procedures, 2) training health resource center staff, 3) developing services such as a volunteer-driver transportation program, 4) securing long-term local and external financial support for the centers, 5) establishing the local advisory boards (county health resource commissions) and their governance structure, and 6) facilitating the commissions' annual

strategic planning. Although over time the degrees of connectedness between the CHRCs and CCHD has lessened, in general (and varies by CHRC) that too is an indicator of the degree to which community capacity has been built.

SELECTED INITIATIVE(S) ✓

As CHRCs opened their doors, numerous programs and initiatives were eventually offered or planned. Selecting an initiative for implementation at the community level is important. First, ensuring community support for the health resource center is one thing, but securing similar support for each of the initiatives is as well if one is going to succeed. As in most planning models, initiatives should be based on the prioritized needs identified by the community during an assessment process. Maybe even more importantly, in addition to being an important need, the need should also be something that is feasible, thus giving the project and project partners a chance to celebrate success. As successes are noted and celebrated, community partners and the community itself can continue hearing about the resource center and the availability of new programs or events.

One example of a priority issue that was selected in the first health resource center, Madison Health Resource Center (MHRC), was the enrollment of residents in the Medication Assistance Program (MAP), a program that provides prescription assistance to low income individuals. The program is a common program throughout the U.S. in organizations assisting low-income individuals and may go by other names. No matter the name, the goal of the program is to assist individuals in applying for prescription assistance for free or discounted medications from pharmaceutical companies.

These prescription assistance programs (PAP) have varying requirements for application and/or eligibility and require an enrollee to renew their applications. The confusion surrounding applications, the need for cooperation of prescribing providers with the PAPs, and the transition to online applications in the early 2000s, realized a need to have a knowledgeable staff person available to assist low-income individuals with the application processes. Initially coordinated by a staff person from a program providing services within the MHRC, demand required the hiring of a person

dedicated to the MAP program alone. Offering this assistance service through the MHRC allowed low-income Madison County residents to access needed medications at more affordable rates.

Another more complicated issue that was successfully addressed was the need for a transportation system for rural residents. The transportation program was modeled after the local Retired Senior and Volunteer Program's (RSVP) volunteer transportation program. First, the program targeted adults of all ages to volunteer to assist in providing transportation in the county. Vans were initially purchased as part of the HRSA funding, and finally transferred over to the counties who are currently responsible for vans' operation, maintenance, and insurance. Following volunteer recruitment and training, the service was marketed to the local community, and the volunteer transportation program was off the ground with a goal of providing 500 rides in the first project year. Since the inception of the transportation program in the BV CHRCs, over 50,000 rides have been provided.

No matter the type of initiative chose, planning is a critical step to success. It is highly recommended that as initiatives are considered, the planning committee should research similar evidence-based, effective programs. This step is another area where the inclusion of an academic partner with a public health and/or health education and promotion background could be key.

Challenges and Limitations

There are significant limitations to the generalizability and replicability of CHRCs, based on this case study, that should be taken into account. Each community has its own personality, so to speak, with respect to needs, resources, culture, and communication style (among other characteristics). This should remind those working towards implementation of a CHRC that no two communities are exactly the same. As a result, each community requires its own strategy for successful implementation of an intervention such as a CHRC.

Throughout the development of this case study, results from the interviews and archival document review provided several challenges (and associated limitations) that any community or potential sponsor of a CHRC activity should consider. These are discussed below.

"THE CHALLENGES WERE UNIQUE TO EACH PLACE, BUT EACH CHRC BUILT OUR RESILIENCE FOR THE NEXT LOCATION. WHEN WE COULD ANTICIPATE CHALLENGES AND ISSUES AT THE NEXT LOCATION, IT WAS NOT AS MUCH OF A CRISIS."

UNDERSTANDING COMMUNITY HEALTH DEVELOPMENT AND CAPACITY-BUILDING APPROACHES

The most fundamental error one could make, even with the best of intentions, is to discount the competency of the community with whom/in which you intend to work. Of course, having a skilled facilitator and staff to assist with this process is important, but they are secondary to the expertise of the community itself. This paradox of needing experienced professionals to facilitate a process in which their expertise has to be subordinated to that of the community is challenging for many – both the professionals and community leaders. The principals and methods of community health development provide the framework and rationale for valuing cooperation among community leaders, other participants, and facilitators in a shared power relationship. In this paradigm all involved have their area of expertise - whether it is knowledge of community history, leadership skills, or social relationships in the community – which when brought together as a collective increase the community's capacity.

In this case study we discuss the elements of community health development and community-capacity building approaches as a distinct method for pursuing two simultaneous goals – improving population health status while increasing a community's capacity to solve its own problems. Although often discussed in graduate training programs (e.g., public health, community organization, political science, social work), few are actually trained in these methods. This represents a significant limitation to the broad dissemination of CHRCs as a population health improvement intervention.

Therefore, *finding the right facilitator* is a major challenge. This challenge can be amplified into a larger problem if mutual respect between the community leaders and facilitator is unable to be achieved.

UNDERSTANDING COMMUNITY CONTEXT

Each community has a history and set of characteristics - beyond demographic differences (which is another subset to consider) - that make it unique. Learning about these factors takes time but is essential in helping a community design its own version of what and how any given intervention should be modified and implemented. CHRC's are no exception. As this case study documents, even though there were many common elements – the same grant funding, facilitators and driving regional factors - the implementation within each community was, and needed to be, different. Even the two CHRCs in Burleson County – only 17 miles apart, needed different approaches to be successful.

The Social Reconnaissance approach described in this case study focuses on identifying these unique community context factors and helps formulate a strategy for that situation. *Time and patience* are the associated limitations in this challenge. Most professionals and community leaders are looking for quick solutions. While that is admirable in many circumstances, that expectation requires skilled management in most communities, something often lacking in small, rural communities. By no means is this statement meant as a disrespect towards small, rural communities! But, finding communities that have a high capacity - where communication, experience with local collaboration, extensive knowledge of community history, and a host of other factors – is often a challenge.

Both of the challenges discussed thus far were frequently mentioned in case study interviews as needing to have "community buy-in" to the CHRC concept. In many cases, this requires changing mindsets at the individual, organizational, and community levels. Again, community health development activities help identify enlightened self-interests of those involved. By incorporating

"WHEN YOU START WITH NOTHING; FIRST, YOU HAVE TO SELL THE CONCEPT."

them into an overall community health development strategy to engage political leaders, health and human service providers, and the broader community, the project will be more likely to succeed.

COMMUNICATION

The third challenge seems to be a component of every model to address human behavior – that is "communication." Formal and informal communication between key leaders, as well as among key organizations, as well as who is included and excluded through various communication channels, are all important elements of community capacity building projects. Effective communication can be a tremendous asset in terms of a community's current capacity. However, it can also be a target of change. In many past CHRC projects, the CCHD monitored interorganizational networks. By doing so, the connections between organizations, and how they changed as the resource center developed relationships over time, served as an indicator of communication and interactions between various network members. Network members were able to be identified as those critical to the network for survival, those important for spreading information throughout the network, as well as those missing from the network. The results were used in planning and communication-related community capacity building activities.

Another important communication-related strategy is building awareness and familiarity with the community about the CHRC. Establishing a clear identity for the CHRC is important. The process of "getting the word out" is also never ending. There are always new groups and changes in leadership that require developing or renewing relationships. Allocating staff time for this communication and outreach should be a priority for the CHRC.

LEADERSHIP, ORGANIZATION, AND MANAGEMENT STRATEGY

Every community has people occupying positions of leadership. It is not news that the degree, style, and goals of the leadership exhibited by those individuals can vary dramatically. But, in the Community Health Development process, the goal is to understand how that leadership "works" – are

organizations "led" into collaborative or defensive postures? Do they anticipate every new event or interaction as potentially a threat or an opportunity? Are organizations optimized for responsiveness or to minimize the impact of change? The answers to these and other similar questions can give the facilitator a frame of reference within which to cast the overall community capacity building strategy. The limitation associated with the challenge is that *changing leaders is a dramatic and sometimes traumatic event for communities*. For example, having to tell the board of an organization that the reason they cannot accomplish the goal they have set is that the CEO is not supportive of that action, is a difficult process to facilitate.

Within the organization, the need for skilled/dedicated staff at the CHRC was also pointed out through the case study. Workers with "passion and vision" for the audience served by the CHRCs is obviously linked closely with the success of each of the CHRCs we examined. Having a staff that is eager to help others in the community, but to also understand the limitations of the CHRCs ("can't solve all the problems everybody brings to us") requires careful selection and ongoing training. CHRC office managers often juggle many different roles that range from answering phones and checking in clients to assisting with case management to attending health fairs. Budgetary restrictions (covered in the next challenge) and the need for multiple staff persons is often a balance that is hard to achieve.

FINANCES AND RESOURCES

One of the attractive characteristics of CHRCs is that it has a very low threshold for implementation compared with many other population health improvement initiatives. However, even the relatively low cost can be challenging for small, rural counties, such as those included in this case study. The amount of discretionary spending allowed in most local government is quite small and getting the buy-in of a county judge, the county commissioners, or mayor, city council, city manager, forces them to select among other alternatives. In other words, they have to decide what not to fund in order to fund a CHRC. Often, as a consequence, there is another program, service unit, or political player who "loses" as a result of this funding decision. Anticipating and planning how to manage that outcome is part of the overall community capacity building process.

Given the long-term goal of sustainability, CHRCs must look to find funding from a variety of sources beyond just local government. This may come in the form of grants or contracts for programs and services, or through relationships with other providers to share revenue streams, or other mechanisms. The limitation of course is that those other entities also face *budgetary constraints* and have to find your value proposition more attractive than maintaining their own infrastructure. Many of those we interviewed pointed out the impact of the physical space, both in terms of the limitations imposed by lack of space (e.g., the slow adoption of the telehealth program because of the space requirements) but also the value to the community of a space they saw as dedicated to "them."

"SPACE DONATED FOR THE CHRC WAS VERY IMPORTANT!"

Another finance/resource-related limitation was that many providers did not plan beyond initial CHRC funding. The *need to plan for sustainability* was communicated repeatedly from the outset of the process. However, when the grant funds began to run out, some providers struggled to maintain services – others dropped but were replaced by more robust service providers.

TRANSPORTATION

Among the biggest problems reported in rural communities is transportation – particularly people getting to medical care. This was certainly the case in the Brazos Valley Health Status Assessments and as a primary driver in the development of the CHRCs. Transportation then, is the next challenge. The authors' experience in many rural communities attempting to provide a transportation solution has followed a similar pattern. The problem is identified or acknowledged. The obvious solution of "we need to buy or borrow a van to transport people to medical care" is proposed ["How about all those church vans that sit idle 6 days a week?"]. Then the "but how will we pay for insurance?" question is raised and all too

"A CHALLENGE WAS THAT PEOPLE THOUGHT THEY COULD BE TAKEN ANYWHERE FOR ANYTHING AT ANY TIME OF THE DAY."

often the initiative grinds to a halt. In the Brazos Valley case study, the initial vans were purchased through a grant and donated to the counties, which agreed to include them in their "fleet insurance" – a very low incremental cost to the county. Initially all the van drivers were volunteers. Some of the CHRCs have moved to paid, part-time drivers to provide for consistency, but some have been successful with an all-volunteer model. Finally, other funding streams have been identified to supplement the costs of the transportation activities. Additional challenges created by the transportation programs is that members of the public thought they could be driven anywhere they needed to go for any purpose. While most of the CHRCs have in fact broadened the range of acceptable destinations to include grocery stores and pharmacies, there is still an ongoing tension between where members of the public desire to be taken and the resources for transportation available through the CHRCs.

The final challenge to call to your attention is that of the value of a regional health status assessment. Throughout the case study interviews respondents commented on the benefit of the assessment in two ways. First, as a remarkable tool for gathering and organizing information about all the factors impacting the health of their communities. Second, was as a tool for organizing their population health improvement intervention activities – specifically the CHRCs.

A comprehensive health status assessment, such as those conducted every 3-4 years in the Brazos Valley, is costly in terms of dollars and political capital. As discussed previously, to be able to meaningfully discuss the drivers of population health status at appropriate population group levels (e.g., age, sex, race, education, and income – at a minimum), requires both large samples of quantitative data and appropriate qualitative data. While this cost can and should be shared by numerous health and human service providers, it still represents a large commitment from numerous organizations. The challenge of acquiring these resources, particularly early on in this kind of project can be monumental. However, the benefits to not just CHRC planning and implementation, but also to other community health initiatives (not to mention strategic, program planning and regulatory/reporting requirements of various partners) collectively is a huge benefit to a community.

Communicating these benefits of a community health assessment to the key players in an environment is paramount among the tasks the facilitator, stakeholders and staff have in their roles and responsibilities.

Conclusion

The current status of the development of CHRCs is very exciting. Two counties in/adjacent to the Brazos Valley have expressed interest in developing CHRCs and through another Health Science Center in North Texas, two additional communities have been engaged in that conversation. We believe this model has applicability to many communities, not just those in Rural Central Texas and not just rural communities in general. While that is where our experience is based, the Augusta examples are certainly evidence that in urban neighborhoods the same problems (access to care) exist and similar solutions ("one-stop-shop" CHRCs can work").

This Case Study of the development of the Community Health Resource Centers in the Brazos Valley was commissioned by the Episcopal Health Foundation to document the process and identify key elements for consideration of replicating this approach to increasing community capacity to address local health issues, improve access to care and population health status. A companion Toolkit document provides further explanation and example materials, protocols and additional resources for use in those replication activities. The foundation for the activities described in this Case Study and the Toolkit are the principles of Community Health Development in the following table.

We hope the reader has found this material interesting and that health professionals, community leaders and others will be inspired by the experiences we have attempted to describe as an approach to helping their community better meet the needs of its residents.

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