



Kate B. Reynolds
Charitable Trust
Investing in Impact

Healthy Places NC: 10 Years That Changed the Way We Work



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A Note from Trust President Laura Gerald, MD, MPH

The Kate B. Reynolds Charitable Trust launched an ambitious place-based program in 2012 to improve health in rural communities around our home state of North Carolina. Over the last decade, the Trust worked with residents to develop community-driven strategies to improve health outcomes in 10 rural counties, providing more than \$100 million in grants and support to these communities.

This report looks back at this work and offers key findings about what the Trust and Healthy Places NC counties accomplished. It identifies challenges and provides lessons for other funders interested in rural place-based work. We hope this 10-year evaluation serves as a resource to others investing in long-term community-led change.



Resourcing Rural North Carolina

Approximately 14 percent of the population lives in rural areas, according to the U.S. Department of Agriculture, but only about seven percent of grantmaking goes to rural areas.¹ Many of these communities have faced long-term disinvestment yet are critical to the overall health of our state and country.

I am from one of these rural counties. I know the opportunity and power that exists there. Growing up, I was surrounded by hard-working, committed people who gave their talent and time to our community, and to me. As president of the Trust, it has been an honor to spend time in these communities, to learn from the people living and working there, and to amplify their voices.

I want to thank our community partners, technical assistance providers, and Trust staff—current and former—who poured their hearts and souls into Healthy Places NC. I want to acknowledge our colleagues in the philanthropy community whose pioneering work in place-based funding shaped this work. Finally, I want to thank the evaluation team, led by Trust Director of Learning & Impact Kristen Burwell Naney, PhD, for leading this retrospective.

While historic inequities continue, there is hope and persistence for a more equitable future. And that hope and persistence are at the heart of Healthy Places NC.

Healthy Places NC and the Trust

The launch of Healthy Places NC marked a radical shift in how the Trust operates to make a long-term impact. Program officers left their offices, spending time in communities, so they could really listen. We focused our grantmaking on amplifying the power of grassroots organizations and people of color to lead the changes they wanted to see in their communities. Along the way, we deepened our commitment to racial equity and partnered with amazing individuals and organizations committed to systemic change. Together we accomplished a great deal, but there is so much more we can do together.

Mrs. Reynolds asked us to improve the health and quality of life of people with low incomes across North Carolina when she established the foundation in 1947. Today we know that the largest disparities in health, education, and economic outcomes exist by race and place, so our commitment to rural North Carolina and communities of color remains steadfast.

Looking Back

Our vision for thriving, equitable communities is one of the reasons we decided to reflect on what we have learned from 10 years of Healthy Places NC. It is our greatest example of evolving from a charitable funder supporting good work, to a community-driven funder focused on changing systems. As we spent time in communities, we heard that the past is still present, and healing has not occurred.

That is one of the reasons that, during our [75th anniversary](#) in 2022, we acknowledged where our foundation has caused harm. We were transparent about the fact that the money we invest in North Carolina today came from tobacco profits and inherited funds originally earned from the sale and labor of enslaved Black people. We are now divested from tobacco and have committed more than \$100 million to community-led businesses that benefit North Carolinians. Our decision to be transparent and to change our investments, together with our trustee, Wells Fargo, signals our commitment to the people we serve and our acknowledgment that to truly make a long-term impact, we must start with ourselves. In 2023, we released an [Equity Framework](#) to explain how we got here, where we're going, and why there is no credible route to systems change that does not go through racial equity.

Working Forward

Moving forward, we are regionalizing this rural work and investing in Healthy Places NC communities poised to change policies locally and at the state level. We believe that centering racial equity and investing in systems change efforts—partnering with community members, grantees, and committed colleagues—is the only way to decrease persistent disparities. We know we cannot do this work alone.

We encourage other funders to amplify the power of communities that have been historically, and often intentionally, marginalized. Systems change is a team sport, and we hope others will commit to this vital, long-term work.

Join us in creating a just, equitable society where everyone in North Carolina thrives.

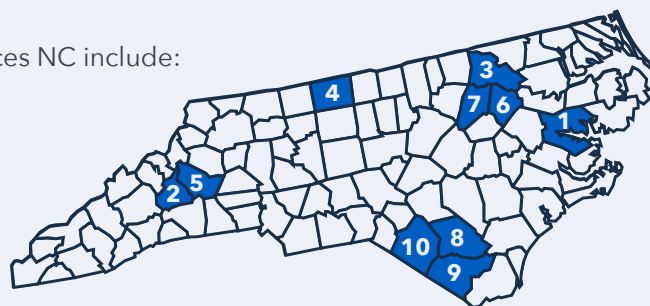


Executive Summary

The Trust launched Healthy Places NC in 2012 to improve the health of residents in our state's rural and vibrant, yet under-resourced communities. Investments helped build residents' power and capacity to address health issues impacting the communities and advocate for change at the local, regional, and state levels. This 10-year evaluation report details the initiative and what the Trust learned from this deep, long-term work.

The 10 counties involved in Healthy Places NC include:

- | | |
|---------------|--------------|
| 1. Beaufort | 6. Edgecombe |
| 2. McDowell | 7. Nash |
| 3. Halifax | 8. Bladen |
| 4. Rockingham | 9. Columbus |
| 5. Burke | 10. Robeson |



The Trust used a cultivation model to activate and support local stakeholders to take concrete steps to improve community health and health equity. Before providing grants, the Trust's program officers spent time in communities, listening to—and learning from—residents about opportunities and challenges facing rural areas.

The Trust provided support for leadership development, facilitation, and strategic planning, as well as projects that helped participating organizations build trust locally.

Substance misuse, adverse childhood experiences, equitable food systems, and access to recreation were the primary focus, with grassroots organizations and leaders of color later leading the charge to activate community change.

About the Trust

The Kate B. Reynolds Charitable Trust works for equitable access to quality health care, education, and economic opportunity for every resident of Forsyth County and across North Carolina. We work in partnership with communities for racial equity and systems change, as data show that too many people are marginalized by race and place.

More than 75 years ago, Kate B. Reynolds founded the Trust to improve the quality of life and health for residents with low incomes. Today, we're examining the root causes of the issues Mrs. Reynolds cared about and addressing them through a contemporary lens. We are amplifying power and capacity of residents to make the change they want to see in their communities and state.

Healthy Places NC: Stages of Development

The 10 years of work can be divided into two evolutionary stages. A process evaluation was performed to document how the initiative was implemented and the impact that was achieved within Healthy Places NC communities.

STAGE 1: 2012 - 2015

LAUNCHED SEVEN COUNTIES: Beaufort, Halifax, McDowell, Rockingham, Burke, Edgecombe and Nash

PRIMARY FINDINGS:

Community capacity to address health issues increased.

Surveys conducted by an evaluation team from Duke University's Division of Community Health found that, on average, local stakeholders in the earliest four Healthy Places NC communities reported increases in leadership skills, ability to collaborate with diverse groups, understanding the community's health issues, and ability to use resources to develop new solutions.

Networks expanded to include individuals from outside the health sector.

Through grants and counsel from regional support organizations (RSOs), a variety of interagency coalitions and networks working on local health issues became more functional and strategic. New networks formed and existing ones expanded membership and participation. This often involved bringing individuals and organizations outside the traditional health sector.

Trust grants enabled organizations to do deeper, more effective work.

Grants from the Trust allowed nonprofit organizations—many of which had been overlooked in the past—to develop more effective programming, reach more people, raise visibility, and connect with other organizations with shared interests.

2016: Shifting our focus

As a result of both learning and changes in staffing at the Trust, Healthy Places NC sharpened its focus on racial equity, systems change, and building the power of grassroots groups beginning in 2016. This led to shifts in how local stakeholders were supported, as well as the *types of groups* that were supported.

STAGE 2: 2019 - 2022

LAUNCHED THREE ADDITIONAL COUNTIES: Bladen, Columbus, and Robeson

PRIMARY FINDINGS:

Focusing on grassroots groups broadened the work.

An explicit focus on engaging grassroots organizations allowed a broader range of organizations to be supported and strengthened by Healthy Places NC. The emphasis on grassroots community empowerment and shifting systems required a change in technical assistance partners, but also led to stronger connections between local and state-level health improvement efforts.

Amplifying power on the ground became central to the long-term initiative.

To advance health equity, some of the groups supported by the Trust and Rural Forward NC began paying more attention to power dynamics in their communities. In a limited number of instances, these groups were able to influence how policy, programming, and resource allocation decisions were made. Some grassroots leaders advocating for equity stepped forward to run for elected office.

Some systems began to shift at the local level.

While Healthy Places NC prompted only the beginning stages of large-scale systems change, most communities saw some improvement in more specific systems involving recreation, food, and public health.

2022 Reaching our \$100 million commitment

Healthy Places NC has expanded regionally, with a special focus on Eastern North Carolina, as data show that the largest health disparities exist by race and place in the eastern part of our state. The design of Healthy Places NC evolved over the course of the 10 years to address challenges that arose in the early years and to incorporate the perspective and wisdom of people who joined the initiative. Much was learned about using place-based philanthropy to advance equity in rural communities. This report presents detailed descriptions of challenges that arose and key lessons for funders.



Introduction



Healthy Places NC was a 10-year place-based initiative designed to improve health outcomes in economically disadvantaged rural communities (Tier 1 counties) across North Carolina. It brought the full range of the Trust’s resources to stimulate lasting community-wide health improvements in rural Tier 1 counties—places that, while often rich in resources and human capital, have some of the poorest health in North Carolina. Many of these counties had traditionally been ignored by philanthropic foundations.

The underlying theory for Healthy Places NC was that the health problems facing Tier 1 counties (e.g., diabetes, heart disease, poor nutrition, lack of physical activity, untreated mental illness, substance abuse) had immediate causes, but also stemmed in large part from underlying factors that related

to the local history, economy, culture, and political structures. As such, the Trust believed that progress required more than grant funding for disease-specific programming.

The Trust designed Healthy Places NC with the intent of activating local stakeholders to take greater initiative, think more strategically, move to action, work together in a manner that challenged convention, and learn from their experience in ways that deepen and broaden the work. Long-term, the Trust expected Healthy Places NC to increase local stakeholders’ capacity to identify and solve health problems and to design and implement programs and policies that advance community health. Healthy Places NC also aspired to set in motion new thinking and behaviors that could translate into a strong community culture that promotes health.

Goals:**Activate community members****Promote new and stronger relationships****Increase community members' capacity to identify and solve health problems****Set new thinking and behaviors in motion****Shift the community culture**

The Trust knew that these new efforts would need to grow and develop at a local level, rather than have an outside authority prescribe an approach they deemed appropriate and/or evidence-based. The work would need to be authentically “local.”

Unlike typical place-based initiatives, Healthy Places NC did not begin by convening local stakeholders to conduct a planning process. Evaluations of initiatives where the foundation convened and supported a centralized planning group found that these initiatives often introduced artificial structures that undermined long-term relationships.^{2,3,4} Instead, Healthy Places NC relied on the Trust’s program officers and a range of partner organizations to cultivate new work with the potential to achieve community-level improvements in health. In this cultivator role, the program officers reached out to a wide range of organizations and residents, encouraged them to develop ideas, and worked with them to move their ideas into actionable strategies.⁵ The program officers also cultivated new relationships by connecting local individuals or groups with complementary interests (especially those who didn’t know or trust each other).

The Trust designed its exploration and cultivation approach with the following goals:

- **Activate community members** to take greater initiative, think more strategically, move to action, work together in ways that go against convention, and learn from their experience in a manner that deepens and broadens the work.
- **Promote new and stronger relationships** (especially across sectors) that stimulate new ideas and bigger, broader “projects.”
- **Increase community members’ capacity to identify and solve health problems**, and to design and implement programs and policies that advance community health.
- **Set new thinking and behaviors in motion**, leading to more sizable and strategic health-improvement work across the community.
- **Shift the community culture** to better promote health (e.g., more proactive).

The Trust believed that these shorter-term outcomes would eventually translate into **improved population health and reduced health disparities**.

Initially Healthy Places NC intended to stimulate and support community-based programs and projects that would address community-identified health issues. The Trust subsequently added an explicit goal around increasing health equity within and between counties, which now informs both its grantmaking and the focus of the program officers’ cultivation work.

Healthy Places NC: By the Numbers

The Trust selected 10 rural counties to participate in the Healthy Places NC initiative at varying amounts of investment, funding periods, levels of grassroots involvement, and demographic composition.

The tables below indicate each county's involvement in Healthy Places NC over the 10 years, as well as characteristics of the local population.

When exploring these data, there are a few important considerations to note:

1. Any focus area or support type category labeled with an “*” was added during Stage 2, when the Trust’s strategies and goals for the initiative became more formalized;
2. Race and ethnicity categories are only represented when the population percentage equals at least one percent or higher;⁶
3. “Other counties” reflects areas across the state where Healthy Places NC work was initiated but never progressed; and
4. The term “grassroots” refers to organizations created outside of traditional agencies and institutions to fill critical gaps in community. These groups often retain informal organizational structures with local funding.



Beaufort

Investment Highlights	
Total # of Grants Awarded	63
Total Investment	\$11,394,056
Funding Time Period	2012 – Present
Total # Grassroots Grants Awarded	10
# of Grassroots Organizations Funded	5
Grassroots Investment Total	\$2,791,767

County Race and Ethnicity ⁶ (N=44,898)	
White	65%
Black or African American	24%
Hispanic, Latino/a/x, or Latin American	8%
Two or More races	2%



Halifax

Investment Highlights	
Total # of Grants Awarded	91
Total Investment	\$12,624,637
Funding Time Period	2012 – Present
Total # Grassroots Grants Awarded	10
# of Grassroots Organizations Funded	8
Grassroots Investment Total	\$1,331,252

County Race and Ethnicity ⁶ (N=42,291)	
Black or African American	52%
White	38%
American Indian, Alaska Native, or Indigenous	3%
Hispanic, Latino/a/x, or Latin American	3%
Two or More Races	3%
Asian or Asian American	1%



McDowell

Investment Highlights	
Total # of Grants Awarded	83
Total Investment	\$15,096,426
Funding Time Period	2012 – Present
Total # Grassroots Grants Awarded	13
# of Grassroots Organizations Funded	8
Grassroots Investment Total	\$4,535,827

County Race and Ethnicity ⁶ (N=44,527)	
White	87%
Hispanic, Latino/a/x, or Latin American	6%
Black or African American	3%
Two or More Races	2%
Asian or Asian American	1%

Rockingham

Investment Highlights	
Total # of Grants Awarded	62
Total Investment	\$11,077,226
Funding Time Period	2012 - Present
Total # Grassroots Grants Awarded	7
# of Grassroots Organizations Funded	4
Grassroots Investment Total	\$1,728,304

County Race and Ethnicity ⁶ (N=91,266)	
White	72%
Black or African American	18%
Hispanic, Latino/a/x, or Latin American	6%
Two or More Races	3%
Asian or Asian American	1%

Burke

Investment Highlights	
Total # of Grants Awarded	41
Total Investment	\$5,345,983
Funding Time Period	2014 - Present
Total # Grassroots Grants Awarded	2
# of Grassroots Organizations Funded	1
Grassroots Investment Total	\$359,129

County Race and Ethnicity ⁶ (N=87,611)	
White	81%
Hispanic, Latino/a/x, or Latin American	7%
Black or African American	6%
Asian or Asian American	4%
Two or More Races	2%
Other	1%

Edgecombe

Investment Highlights	
Total # of Grants Awarded	80
Total Investment	\$8,134,852
Funding Time Period	2014 - Present
Total # Grassroots Grants Awarded	14
# of Grassroots Organizations Funded	11
Grassroots Investment Total	\$1,568,590

County Race and Ethnicity ⁶ (N=49,609)	
Black or African American	57%
White	35%
Hispanic, Latino/a/x, or Latin American	5%
Two or More Races	2%





Nash

Investment Highlights

Total # of Grants Awarded	65
Total Investment	\$5,087,183
Funding Time Period	2014 - Present
Total # Grassroots Grants Awarded	13
# of Grassroots Organizations Funded	11
Grassroots Investment Total	\$890,237

County Race and Ethnicity⁶ (N=95,176)

White	46%
Black or African American	41%
Hispanic, Latino/a/x, or Latin American	8%
Two or More Races	2%
Other	2%
Asian or Asian American	1%

Bladen

Investment Highlights

Total # of Grants Awarded	25
Total Investment	\$2,942,576
Funding Time Period	2018 - Present
Total # Grassroots Grants Awarded	7
# of Grassroots Organizations Funded	4
Grassroots Investment Total	\$659,823

County Race and Ethnicity⁶ (N=30,105)

White	54%
Black or African American	34%
Hispanic, Latino/a/x, or Latin American	8%
American Indian, Alaska Native, or Indigenous	3%
Two or More Races	1%

Columbus

Investment Highlights

Total # of Grants Awarded	24
Total Investment	\$3,483,329
Funding Time Period	2018 - Present
Total # Grassroots Grants Awarded	8
# of Grassroots Organizations Funded	4
Grassroots Investment Total	\$927,651

County Race and Ethnicity⁶ (N=51,474)

White	59%
Black or African American	29%
Hispanic, Latino/a/x, or Latin American	6%
American Indian, Alaska Native, or Indigenous	4%
Two or More Races	2%
Asian or Asian American	1%

Robeson

Investment Highlights

Total # of Grants Awarded	31
Total Investment	\$6,325,923
Funding Time Period	2018 - Present
Total # Grassroots Grants Awarded	7
# of Grassroots Organizations Funded	5
Grassroots Investment Total	\$1,814,091

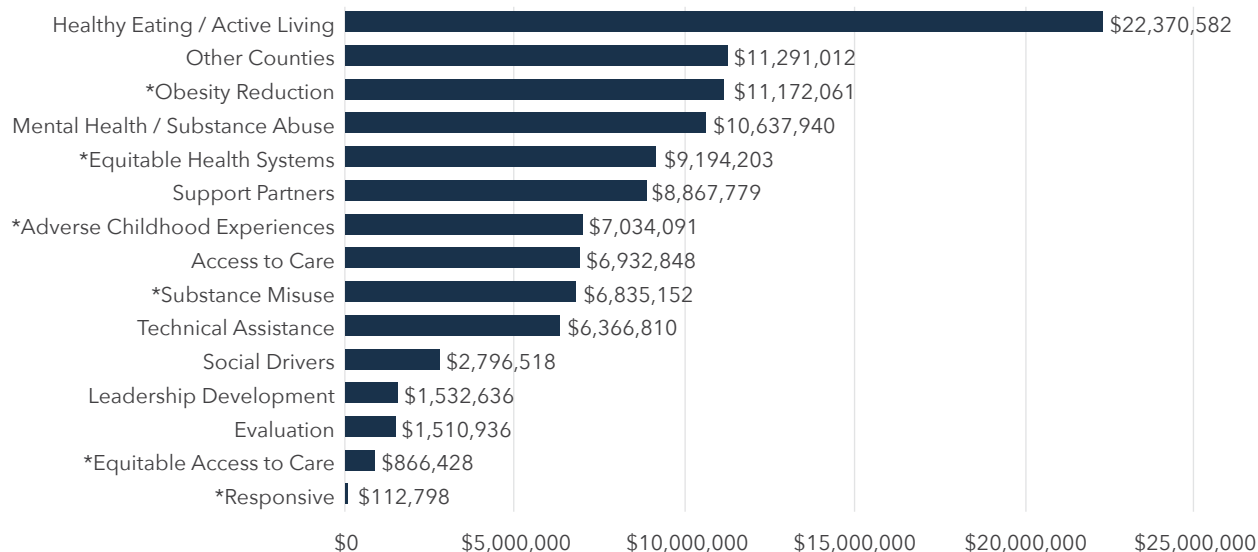
County Race and Ethnicity⁶ (N=116,328)

American Indian, Alaska Native, or Indigenous	41%
White	24%
Black or African American	23%
Hispanic, Latino/a/x, or Latin American	9%
Two or More Races	2%
Asian or Asian American	1%

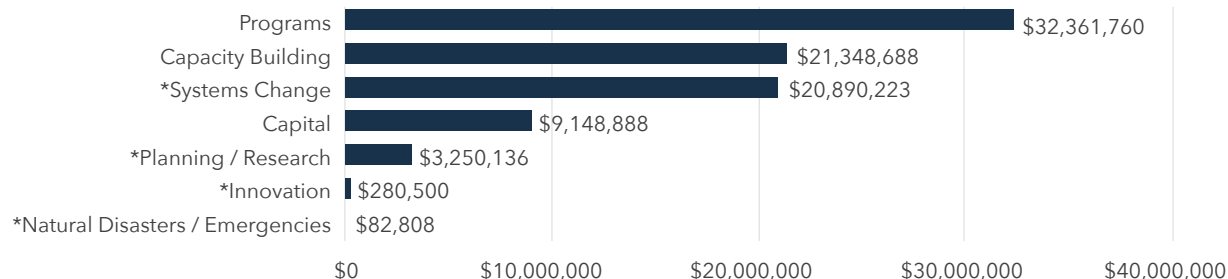


Total Investment Highlights		County Race and Ethnicity ⁶ (N=10,551,162)	
Total # of Grants Awarded	576	White	61%
Total Investment	\$107,521,794	Black or African American	20%
Funding Time Period	2012 - Present	Hispanic, Latino/a/x, or Latin American	10%
Total # Grassroots Grants Awarded	91	Two or More Races	5%
# of Grassroots Organizations Funded	61	Asian or Asian American	3%
Grassroots Investment Total	\$16,606,671	American Indian, Alaska Native, or Indigenous	1%

Focus Area



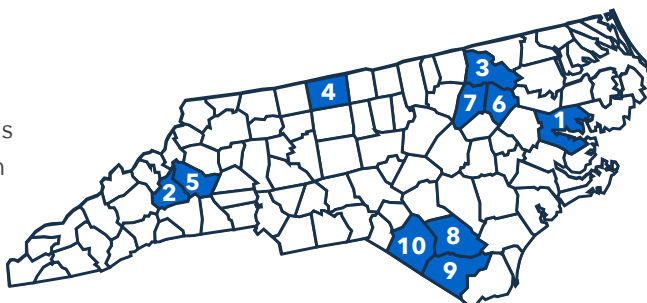
Support Type



\$100 Million Goal Exceeded: \$107,521,794

Priority Counties:

- | | | |
|---------------|--------------|-------------|
| 1. Beaufort | 5. Burke | 9. Columbus |
| 2. McDowell | 6. Edgecombe | 10. Robeson |
| 3. Halifax | 7. Nash | |
| 4. Rockingham | 8. Bladen | |



Findings: The Stages of Healthy Places NC



The Healthy Places NC initiative can retrospectively be divided into two stages. Stage 1 was exploratory and emergent, during which the Trust funded many of its typical bodies of work, but also took a broader approach to fund projects that encouraged community momentum. Stage 1 was further marked by the Trust's engagement with a host of technical assistance partners and two regional support organizations (RSOs) providing capacity building and supporting complementary work at the state level. The Trust encouraged a community engagement model to reach marginalized communities but had not directly invested in grassroots groups to strengthen the approach.

Stage 2 was characterized by the Trust prioritizing direct funding to leaders of color and systemically marginalized organizations. Furthermore, the Trust worked with communities to map systems change strategies and measure progress on identified goals. The final three counties in the Healthy Places NC initiative were launched during the second stage. The intentional emphasis on grassroots community empowerment and specific outcomes required a shift in technical assistance partners. It also led to much stronger connections between local and state-level health improvement efforts.

Stage 1 Overview

A key feature of Healthy Places NC was the decentralized nature of community strategizing. Rather than the traditional place-based approach of supporting a single entity within each county, the Trust sought a range of nonprofit organizations and government agencies to do new or larger work to improve community health. At the outset of Healthy Places NC, the Trust was agnostic about the specific health issues it supported. Program officers immersed themselves in communities to identify organizational leaders with ambitious ideas in line with the Trust's interest in access to primary care, diabetes, mental health and substance abuse, and community-centered prevention (physical activity, built environment, and food access).

Program officers operated according to a "cultivation" model, which was quite different from how they had been expected to work prior to Healthy Places NC.⁷ Rather than soliciting well-formulated proposals from organizations with a strong track record, program officers now reached out to a wider range of local stakeholders to encourage new action. At the outset of their engagement, program officers spent two to eight

days a month in their Healthy Places NC county, meeting with people from different organizations and networks to learn about their prior work and ideas for the future, while also gaining a deeper understanding of the county's issues, history, people, and culture. Program officers also cultivated new relationships by connecting local stakeholders with complementary interests, especially among those who didn't previously know each other. To serve as effective cultivators, program officers were expected to develop and make use of a core set of "essential functions," including: active listening; building and managing relationships; communication; power analysis; brokering connections; facilitating networks; strategic analysis and problem-solving; grantmaking, management and monitoring; questioning and advising; and critical thinking.

To identify and gain access to a broader set of local stakeholders, each program officer identified a "program officer extender," who lived or worked in their respective Healthy Places NC county. The Trust hired this person to provide the program officer with background information, make contacts with a





range of local stakeholders, and engage in follow-up conversations to support the development of new partnerships and fundable project ideas.

Program officers did not introduce potential projects during their conversations, but instead encouraged local stakeholders to pursue their own ideas. To stimulate new thinking and networks, Trust leaders looked for state and national implementation partner organizations that offered training or consultation. Four such implementation partners were identified in the second half of 2012:

- **County Health Rankings and Roadmaps** (CHRR), a group at the University of Wisconsin Population Health Institute that issues an annual county-level report on a broad range of health indicators and offers technical assistance on community health planning and programming;
- **KaBOOM!**, a national organization based in Washington, DC, that organizes one-day playground builds relying on local volunteers;
- **Center for Creative Leadership (CCL)**, based in Greensboro NC, which offers a variety of leadership-development programs to corporate and non-profit clients; and
- **North Carolina Division of Public Health** (NCDPH) Physical Activity and Nutrition Branch, which had a Community Catalyst model to stimulate new work in healthy eating and active living.

The Trust contracted with these four groups to deliver county-specific programming for all Healthy Places NC counties.

- CHRR staff (including the executive director) visited each of the first three Healthy Places NC counties for two days of presentations and community meetings on the county's health rankings, providing audiences with insights on how issues are interconnected and where leveraging opportunities exist.
- KaBOOM! was commissioned to conduct two playground builds in each Healthy Places NC county, including a Design Day and a Build Day.
- CCL offered a two-part, four-day training on "boundary-spanning" leadership for up to 30 local leaders delivered at a site within each county; and
- NCDPH hired a full-time "Catalyst" in each Healthy Places NC county to consult with local organizations on programming related to healthy eating and active living.

By mid-2013, all three of the first-round Healthy Places NC counties (Beaufort, Halifax and McDowell) received support from these four groups.

Four additional counties (Burke, Edgecombe, Nash, and Rockingham) were added to Healthy Places NC between 2013 and 2015, and also received support from the state and national implementation partners.

In 2014, the model required additional capacity as counties were added. The Trust hired two RSOs: Rural Forward NC, which served the five Healthy

Places NC counties in eastern and central NC, and Rural Support Partners, which served Burke and McDowell Counties in western NC.

The Trust team believed that having an intermediary organization would help navigate needs, provide important assistance on the ground in each county, and reduce the power dynamic of having a funder participate in support roles that are necessary for community-driven change. Each RSO extended and expanded the cultivating, connecting, and advising that program officers provided to local stakeholders

during the first 18-24 months of a county's involvement in Healthy Places NC. The RSOs provided a broad range of services that helped local stakeholders maintain their momentum and deepen their work as the program officer reduced their time in the county. These services included: assisting in the design and implementation of new projects, facilitating strategic planning processes, building organizational capacity, and building and strengthening networks.



Stage 1 Evaluation

Evaluation during Stage 1 was conducted by a research team at Duke University's Division of Community Health. The primary methods used for the evaluation were:

1. Two waves of key participant interviews (KPIs), approximately two years apart, in the initial four of 10 Healthy Places NC counties (Beaufort, Halifax, McDowell, and Rockingham).
2. Two waves of KPIs (approximately two years apart) with personnel from the Trust involved with the initiative, program officer extenders, personnel from RSOs, and personnel from partner agencies.
3. Two waves of surveys (approximately two years apart) in the four early counties.
4. One wave of KPIs and surveys in Burke and Edgecombe/Nash counties.
5. Health improvements and related work were analyzed in Halifax, McDowell, and Rockingham counties, and case studies were developed on the progression of efforts around specific health issues in the four early counties.^{8,9}

Launch and Communications

Data from initial KPIs indicated that Healthy Places NC was successful in communicating this new philanthropic approach to the communities (particularly the importance of partnership, relationship-building, long-term commitment, listening to the community, and trust) and generating enthusiasm for this approach. Program officers, RSOs, and Trust communications staff were essential to this success. Respondents recognized that multi-pronged Healthy Places NC-led communications strategies (e.g., launch events, website content, newsletters) were critical in raising awareness of this new initiative and its unique characteristics, building momentum around the work, and engaging community members. Communications continued to be valuable, with some observers indicating that as more counties were brought into the initiative. Trust

staff said their own appreciation of the importance of a specialized communication function grew through their experience with Healthy Places NC.

"I think it is awesome that it is not an 'in and out' type of grant opportunity. They are trying to build some infrastructure, communications—they are investing in all of it. They are staying within the community and are flexible. They are able to help make Beaufort a healthier place."

*— County Leader**

Leadership and Network Development

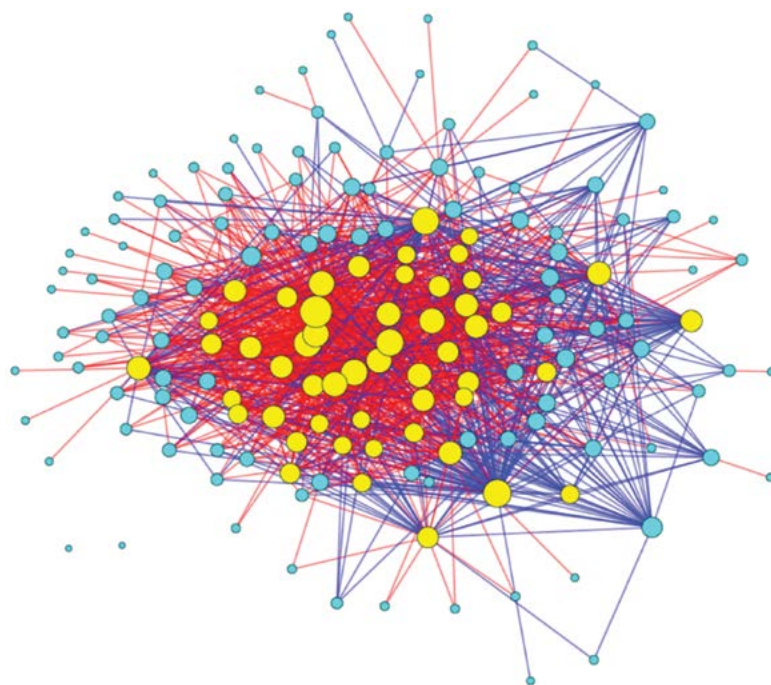
Data from the interviews and successive community surveys indicated an increase in both leadership and network development. Partner organizations (the four mentioned above, as well as others added), Trust staff, and RSOs played important roles in this progress. Survey data indicated growth in leaders' self-rated attitudes towards collaboration, capacity to recruit others into the work, and ability to use resources in new ways to meet community needs. Growth was also noted in awareness of health issues, belief among respondents that they could make change, and self-perceived ability to connect diverse groups and individuals.

"Now people are really thinking and really collaborating and scratching their heads."

*— County Leader**

Networks of people working to improve community health and well-being grew significantly, due to new involvement of stakeholders from outside the traditional health sectors (e.g., people working in education or the faith community). This growth is reflected in the large number of new or strengthened linkages (shown in red) in the social network map shown in Figure 1. This map shows the relationships among individuals working on community health and well-being in Halifax County as of a 2016-2017 survey. Individuals are represented as dots and the connecting lines reflect instances where two individuals communicate, coordinate, or collaborate to improve health and well-being in their community. Red lines (vs. indigo) indicate that connections were initiated or strengthened by Healthy Places NC.

Figure 1: Network of individuals working to improve health and well-being in Halifax County at time of second survey (2016-2017).



Dots: Individuals (Size of dot indicates number of connections to others in the network).

Yellow Dots: Stakeholders most central to the network.

Lines: Relationships of communication, coordination, or collaboration among the stakeholders.

Red Lines: Relationships that were either initiated or strengthened because of Healthy Places NC.

While Halifax was one of the first counties in Healthy Places NC and an early standout in network development, network growth was significant across all counties involved during Stage 1. Moreover, in some counties where African Americans had previously been disproportionately on the peripheries of these networks, they moved into more central positions.

“Now people are starting to talk more, having conversations and bringing people together. I know that people had these ideas but did not know how to start the conversation. Healthy Places NC has helped start making those changes and start conversations.”

– County Leader*

Expanded leadership and networks provided stronger community capacity for addressing a broad range of issues. Response to Hurricane Matthew was an example of an outgrowth of capacities and networks that were built through Healthy Places NC.

New Projects

One of the most immediate outcomes associated with the grant funding and other support from Healthy Places NC was the development of new projects. This occurred in all Stage 1 counties, although there was county-level variation in the extent to which this work reflected new directions. One of the more innovative projects to occur in Stage 1 was the community paramedicine project in McDowell County, which engaged stakeholders from a broad mix of health and non-health domains.

“The community paramedicine program demonstrated cross-sector collaboration. The program is a social care check-in program that gives EMS the ability to show up in a non-ambulatory vehicle to check things out where someone lives before a situation escalates to a hospital visit. We brought people together from three different counties who were all working on community paramedicine, who had different ideas, and were supporting each other’s work.”

– Current Trust Staff

“Outside of the money, which is great, the most valuable asset that our organization has gotten from the Trust has been connecting us with individuals who are world-class thinkers.”

– County Leader

Impact of Healthy Places NC on the Trust

Implementing Healthy Places NC resulted in changes not only within the participating communities, but also within the Trust. Indeed, a majority of implementation team members during this stage believed that the most **significant impact of Healthy Places NC’s earliest years was, in fact, on the Trust’s mental model, practices, and knowledge that undergirds how it interacts with communities.** The Healthy Places NC model represented a significant break not just from the Trust’s way of working, but from prevailing norms in philanthropy writ large where, historically, grantmaking decisions were made from a distance by a panel of topical experts unfamiliar with the unique and dynamic context for the proposed program or strategy.

By developing a grounded understanding of a community’s key stakeholders and institutions, leadership (both positional/formal and informal), infrastructure, norms, and culture, Trust staff felt better able to discern where an infusion of capital

might have a meaningful impact than they could using the traditional philanthropic model. This set the stage for a significant evolution of Healthy Places NC for the second half of the decade.

“Healthy Places NC changed the pattern at the Trust. It got them out in the community, making authentic relationships before doing any grant making. Find out who’s who. Do asset mapping. Find out what issues are most important. Who are the community sparkplugs? Who are the leaders we want to focus on? Healthy Places NC is not implementing a model; it’s supporting those local leaders to implement their plans to make their community better—just amplifying it. That really is the goal of Healthy Places.”

– Implementation Partner

“I think Healthy Places was designed in a brilliant way to change how we do philanthropy because it was designed by people who know philanthropy. It was not great in terms of community change because it was not designed by people who know how to change communities.”

– Current Trust Staff



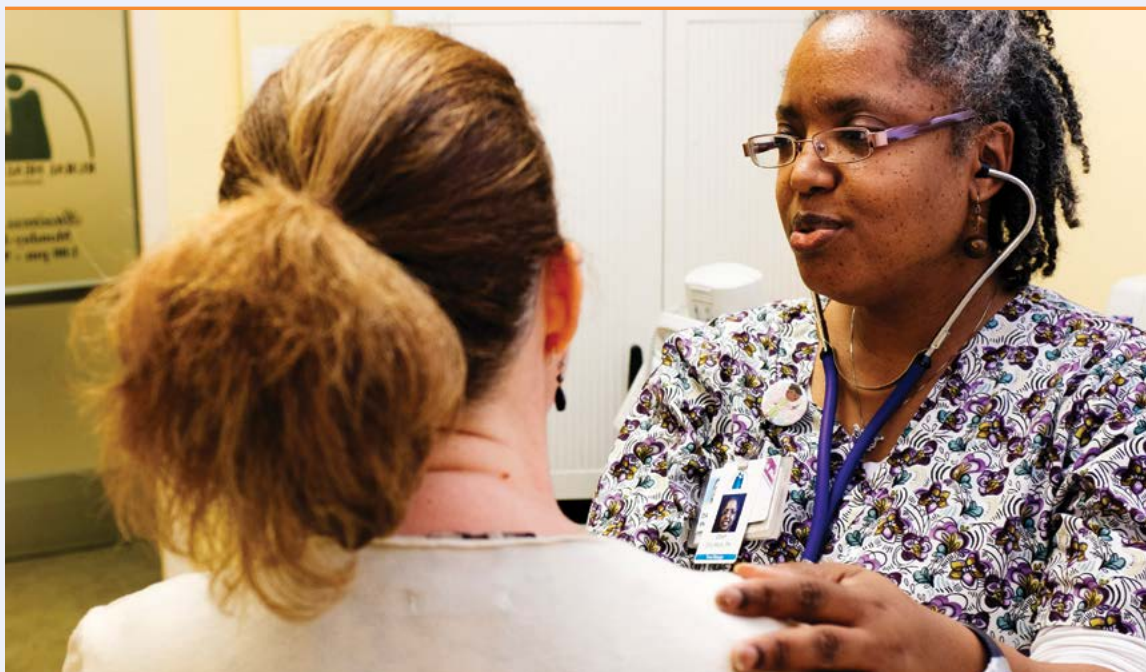
STAGE 1 COMMUNITY STORY

Embedding a Federally Qualified Health Center in a Hospital

Institutional Systems Change at the Local Level

At a community conversation in Halifax County, North Carolina in 2018, Brian Harris, then CEO of the Federally Qualified Health Center (FQHC)—Rural Health Group (RHG)—and his team learned that 225 of their patients visited the local hospital's emergency department (ED) a combined 3,200 times with the majority of visits taking place between the hours of 5:00-9:00 p.m. Rather than struggling to figure out how to make the clinic more accessible, RHG worked with Halifax Regional Medical Center—now ECU Health North Hospital—to establish the state's first FQHC within a hospital ED.

The team quickly recognized that this was harder than it sounded, due to regulatory concerns. A major barrier was the Emergency Medical Treatment and Labor Act (EMTALA), which requires hospitals with EDs to provide a medical screening examination to any individual who visits and prohibits hospitals with EDs from refusing to examine or treat patients. Once in the door, the ED must serve patients and cannot divert the visit to the primary care clinic. Despite these regulatory concerns, the





clinic experienced success in reaching their patients. Eventually, RHG moved out of the ED and established a freestanding clinic operated by the FQHC, but remained co-located on the hospital's campus.

While there were concerns about the move interfering with their ability to see patients, the clinic experienced the opposite—an influx of patients. Rather than going through the ED, a separate building provides patients with a more direct route to RHG in a convenient and familiar location.

As RHG now serves more than 34,000 patients per year, Yvonne Long-Gee, current CEO, stresses that this effort is about more than location. They continue to focus their efforts on recruitment, provider and staff retention, workforce development, providing transitions in care, behavioral health, case managers, community health workers, and high-quality medical services. All assist patients in receiving access to care, such as scheduled primary care appointments prior to hospital discharge, along with evaluating social needs that impact health outcomes and inappropriate hospital readmissions.

CEO Long-Gee notes they could not do this work alone. “Our relationship with our community partners, the local health department, pharmacies, EMS, and ECU Health North hospital results in improved health outcomes and timely access to appropriate levels of both primary and acute care,” says Yvonne.

While reflecting on the successful transition of moving the FQHC out of the ED, RHG continues to emphasize the collaborative spirit of the stakeholders involved, and the importance of improving care coordination and navigation within health systems to address the diverse health needs of their community.

Transition from Stage 1 to 2

While the transition period was not a distinct stage, there is important context to consider as the impetus for Stage 2. Evaluation results from Stage 1 identified unmet expectations and challenges. While grantmaking was critical in supporting work and signaling the kind of work the Trust wanted to fund, some community stakeholders became more focused on grants as they grew in volume. They lost sight of the fact that grants were only one piece of Healthy Places NC, along with community mobilization, network, capacity-building, and identifying resources beyond the Trust.

Despite the clear evidence of growth in local stakeholder leadership, data indicated ongoing support was needed for more challenging aspects of leadership, such as identifying and addressing potential barriers to progress. Moreover, while network involvement from outside the health sector was growing, those in the health sector generally continued to play more of the important leadership roles. In addition, the Latinx population was underrepresented in county networks during this stage; and there was a sustained pattern of stronger leadership attributes and greater network centrality for those serving the county, region, or bigger cities and towns than for those serving smaller communities. Organizational development was not a major focus of Healthy Places NC during this stage; some community members felt more progress in this area would help build capacity for work resulting in sustained improvement in community health and health equity.

“The leadership training was a powerful experience for many of our early leaders who had not gone through something like that. It offered a sense of prestige that built confidence, and they’re now part of a special fellowship. But I felt like we could’ve made that part stronger and there was a little bit of a missed opportunity to capitalize on that for future change efforts.”

— Implementation Partner

During Stage 1, the Trust did not directly invest in small grassroots organizations. A few general operating grants were awarded previously; however, they mostly went to larger statewide associations. The implications of this funding decision allowed institutions and traditional stakeholders to engage the community, but the community activists and leaders couldn’t always participate full-time. While this fragmented yet opportunistic approach led to some complex systems changes, the Trust knew that investments in grassroots organizations were necessary to amplify systems change efforts. Stage 2 was the result of an emergent learning process that altered the initiative’s trajectory.



Stage 2 Overview

Stage 2 Implementation

Healthy Places NC consistently evolved, with a significant shift after the first four years. The Trust began to consider how to use the work from Stage 1 to become more focused, create a sense of momentum, clarify roles, and build a cadre of grassroots groups from marginalized communities to shape and lead the work.

In addition, the Trust experienced several staffing transitions between 2014-2017 which resulted in shifts and clarifications to the Healthy Places NC strategy. Foremost among these was the departure of Karen McNeil-Miller, EdD, as the Trust's CEO in 2014 and the selection of Laura Gerald, MD, MPH, in 2016. Building on Dr. McNeil-Miller's work, Dr. Gerald increased emphasis on both systems change and racial equity, which she infused directly into the Trust's approach to working with Healthy Places NC communities. Dr. Gerald also directed Trust staff to bring additional structure and definition to the Healthy Places NC approach, while still encouraging community-specific solutions and

strategies. This meant that the Trust developed more clearly defined goals, and strategies for meeting them, that optimized cohesion and coherence of the work.

Systems Change

Throughout the report we refer to systems change, which began to play a central role in the Healthy Places NC initiative. The Trust does not view systems change as a static set of relationships that produce a particular outcome. Rather, they see systems as constantly changing and evolving in ways that maintain existing power dynamics and often reinforce status quo outcomes. The Trust didn't seek systems change as an end in itself. It worked to promote more equitable outcomes. This meant learning local dynamics, understanding power relationships, and strategically intervening to center the voices of marginalized communities.

By amplifying the power of residents on the ground and investing more resources in grassroots and community organizations, the Trust was building the capacity of local actors and organizations

Prioritized focus areas:

Adverse Childhood Experiences

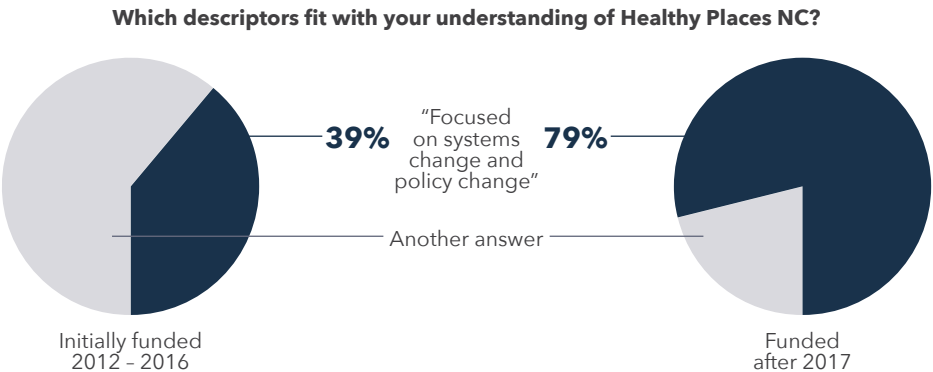
Equitable Access to Recreation

Equitable Food Systems

Substance Misuse

Figure 2: Systems Change as a Core Element of Healthy Places NC

2023 survey of 47 Healthy Places NC grantees: Those initially funded during Stage 2 were more likely to see systems change as a core element of Healthy Places NC than those who were initially funded in Stage 1.



to intervene in the systems that had historically marginalized people by race and place.

At the outset of Healthy Places NC, the Trust supported naturally emerging networks pursuing their own approach to changing health and human service systems they prioritized. Over time, the Trust and its consultants built expertise in supporting specific tools that are critical to systems change. These tools included research, communications and advocacy, convening and capacity building. During Stage 2, the Trust made these approaches available to local groups. The Trust also clarified its community-identified focus areas in 2017-2018, which influenced some of the work that would be supported within Healthy Places NC counties.

The increased emphasis on systems change also affected the Trust's approach to grantmaking, with more funding toward initiatives that took a systems approach, rather than simply funding discrete projects. This included grants for efforts like systems mapping, communications, data collection and dissemination, and advocacy. When proposals were not systems-oriented in a direct and immediate way, the Trust considered whether and how the work could set the stage for systems change. This might occur, for example, by building the credibility of a new organization with its constituency, opening new lines of relationships for collaboration, or generating a sense of possibility. Program staff were encouraged to consider and articulate how these benefits could, in turn, drive further action outside of the confines of a particular grant-funded project.

Equity and Engaging Grassroots Groups

As the Trust became more intentional in focusing on specific outcomes, they adopted a new approach to engaging local stakeholders by bringing more grassroots organizations into the fold (supported by grants). As such, the Trust not only maintained its commitment to being community-driven, but also expanded and diversified the "community" it supported. The intent here was to broaden the groups that have power in local decision-making, which fits directly with the Trust's understanding of equity.

Narrowing Implementation Partners

Another major shift in strategy during Stage 2 involved transitioning away from many of the groups that the Trust initially hired to provide support to local stakeholders, including Center for Creative Leadership County Health Rankings & Roadmaps, KaBOOM! and NCDPH's Catalyst. As these implementation partners exited the initiative, nearly all the engagement with local stakeholders occurred through the program officers and one of the original two RSOs, Rural Forward NC. This decision was driven primarily by the Trust's interest in tailoring support to the specific needs of local groups, as opposed to offering standardized forms of technical assistance. This tailored support became an important part of the grantmaking strategy, where the Trust began investing in data collection and research, advocacy and education, network building, capacity building, and convening to help grantees achieve their outcomes.

Stage 2 Evaluation

The evaluation process performed during Stage 2 was launched in 2022 by a team of external evaluators (Tanya Beer, MPA, Doug Easterling, PhD, and Mina Silberberg, PhD) under the leadership of Dr. Kristen Naney. The primary methods used for the evaluation were:

1. A mixed-methods approach was used to document the implementation of the initiative and determine how impact was achieved.
2. Semi-structured interviews were used to collect data from 40 grantees representing diverse organizations and Healthy Places NC counties. Interviews were also performed with 16 Trust staff and affiliates, and additional data was collected and analyzed from representatives of 45 grantee organizations.
3. The results informed lessons for funders invested in shifting power dynamics and systems that perpetuate health inequities, particularly in rural communities. The information in this section reflects topics that were covered in the evaluation.

Community Accomplishments

Respondents to the 2023 Grantee Survey reported improved capacity because of their involvement in Healthy Places NC. This included leadership development, building new partnerships, developing more effective programming, reaching an expanded group of clients, and raising the visibility of the organization and its programming. In addition, some organizations began to view themselves as playing a larger role within their community.

"I was able to bring more money, not only from the Trust, but different foundations. Thanks to their funding, we have been able to grow and meet the community's needs by understanding the barriers they are facing. We've created various programs curated to meet those needs—we went from having one program to 15. Every program is designed to break a systemic barrier that the Latino community, or anybody living in McDowell County, may face."

— Grantee

Network Development and Systems Change

Respondents to the 2023 grantee survey most frequently pointed to expanded networks and partnerships as the most important outcomes experienced because of Healthy Places NC. Through expanded relationships with other nonprofit and governmental organizations, grantees expanded their programming, collectively strategized around shared goals, and built stronger connections to the community members they serve.

As with Stage 1, the most frequently cited "exciting signal of Healthy Places NC impact" among implementation team members was new or more productive relationships between community stakeholders who would not normally align, collaborate, or even consult with one another when prioritizing problems or developing solutions.

The Trust's emphasis on improving systems produced long-lasting improvements in grant recipients' beliefs about the importance of systems change work and knowledge of how to go about it. In the 2023 grantee survey, 70 percent agreed that

their organization gained a better understanding of systems change through healthy Place NC, including 37 percent who "strongly agreed."

Many of these grantees are now well-positioned to engage in state-level work. For example, Healthy Places NC communities are using a community-driven approach to shape the distribution of the state's \$750 million opioid settlement funds. In 2022, the state launched Healthy Opportunities Pilots regions to use \$650 million in Medicaid dollars to pay community-based organizations to provide services, such as housing and food, to address social determinants of health. Seven of the 10 Healthy Places NC counties are a part of this work moving forward.

"I have never been at the table because we're considered an afterschool program. Nobody would think that the Boys and Girls Club would have much to say in the way of health status. Because we have direct access and we're on the ground, we're frontline with the kids, particularly as COVID-19 was happening. We were able to bring a different voice to the table. To change the health status of people in your community, you involve health care professionals. While that does make a whole lot of sense, bringing in other groups with different perspectives allows us to approach things in a different way. I'm still active in these groups now."

— Grantee



The Trust and Rural Forward NC helped to shift power dynamics by:

1. Signaling the legitimacy and expertise of “informal” community leaders, organizations, and groups to traditional power holders by giving them money and visibility
2. Resourcing the efforts and vision of these leaders and groups directly; and
3. Supporting the organizing of community members into a force that can shape policy and systems decisions (especially true in the most recent years of the initiative).

New Equity Work

With the more intentional focus on racial equity in Stage 2 that further shaped how the Trust worked, grassroots grantees felt more empowered to drive change in their communities.

“I can tell you, the first meeting I went to—‘what is your vision for your community?’ was the question, and I was like, ‘Well, I didn’t know you had a choice.’ It inspired me. I said, ‘Hey, people. You hear what they’re saying? We can have a vision. We can have what we want in our community. We got to do this.’ We found out people didn’t know they had a voice, and so we showed them how to use it and walked alongside them as they

used their voice at the county commissioners and city council meetings. Then the next year we got another grant from the Trust, and we expanded our work to the homeless shelters to provide transportation to residents for free. The shelter was in another part of the county. The county commissioners were deciding between a local or regional system to address the lack of transportation, so we got a petition with more than 500 signatures saying we need a local system, and so that’s what we got. One of our residents from the West Marion Community Forum was the first director for that system, and he was also the first Black director for any county department.”

— Grantee



Effects of Local Power Dynamics

Many Healthy Places NC interviewees believe that one of the most promising changes that resulted during the 10 years is an increase in the power and capacity of traditionally excluded communities to influence, design, and advance solutions they prioritize.

In some cases, this power was mobilized to achieve policy, programming, or local changes that observers believe are likely to influence health and health disparities over the long term. In other cases, community members ran for local public office as another way to shift power dynamics.

“One of the greatest things this program has done is helped those in leadership positions understand the importance of having somebody with lived experience at the table when you’re talking about policy or programming. Having that voice at the table is huge. That’s how we make change, and that was something that was lacking before this program.”

– Grantee

According to interviewees, some communities demonstrated a shift in norms to collaborate or consult more with community groups that have historically been excluded from shaping local health priorities and programs. Most hypothesize that this was a result of Healthy Places NC’s efforts to bridge incumbent power holders and grassroots groups with underlying shared interests; its focus on supporting internal champions and adaptive leaders within established institutions to foment changes in mindset and practice from the inside; and its ability to leverage grant dollars as an incentive to collaborate with more equitable partnership and group governance structures. This shift allowed one community to publish a toolkit on how to mobilize local stakeholders and agency partners to address inequities in rural communities,¹⁰ *Shift Happens in Community: A Toolkit to Build Power & Ignite Community Change*.

Interviewees observed wide variation between communities in the degree to which power and norms shifted. Some communities became involved in Healthy Places NC only within the last two to three years and arguably have not yet had sufficient time nor support to shift the kinds of systems-level dynamics that drive health disparities. Interviewees speculated that the variation between communities that participated for similar amounts of time was caused by a few possible factors:

- Differences in implementation team members’ beliefs in the importance of shifting power relationships and in their capacity to help negotiate tensions between groups to create true collaborative action.
- Insufficient acknowledgment of, and planning for, how “sticky” systems are, and how skilled beneficiaries of the current system’s power dynamics can keep underlying power arrangements the same, even while using all the right language and engaging in more superficial diversification of participants to appease funders.
- The tight nature of traditional power-holding networks (particularly in communities that have experienced less in/out migration), making them less receptive to influence from an outside stakeholder like the Trust, as well as to any changes to long-held norms.
- Turnover among Healthy Places NC and Trust staff who held relationships, knowledge of community dynamics, and a particular philosophy about community change that was lost during transition.

Several interviewees believe that the communities that had the most success were those where there was a cohesive strategy that the Trust program officer and the RSO advanced together in true partnership and with a strong power analysis. In communities where they did not act collaboratively as co-strategists or spend time explicitly thinking about power, the work was less likely to challenge conventional power arrangements.

STAGE 2 COMMUNITY STORY

Responding Locally to a Global Pandemic

Building a community infrastructure for collaboration

New Equity Work and Network Development

When a group of six community leaders began meeting in Addie's Chapel in West Marion, an often-overlooked and under-resourced part of McDowell County, to discuss ways to help their community, they had no way of knowing their work would grow to become an integral part of a community-led response to a global pandemic.



The meeting in Addie's Chapel grew into the West Marion Community Forum, Inc. (West Marion, Inc.) which, with support and funding from Healthy Places NC, became a nonprofit organization in 2018. West Marion Inc. engages structurally excluded communities in developing locally driven solutions and partnerships for racial and health equity. The purpose of their Black-led nonprofit is to create brave spaces for community members to share their stories, speak brutal truths, voice ideas, and build collective power to advance real and lasting changes for all.

"The most important thing for us was that Healthy Places really listened to the community and cared about what we had to say," said Paula Swepson, West Marion, Inc.'s executive director. "Rather than telling us, 'This is what you need to do,' they asked us, 'What do you need?'"

Early successes, such as a back-to-school book bag drive and a large Thanksgiving dinner attended by residents from all over McDowell County and City Council's decision to host official meetings in West Marion, encouraged community buy-in and resulted in excited and engaged community members.

The Forum continued to grow and played a critical role in launching free public transportation service in West Marion for their residents in need with a partnership with the local Department of Social Services. They even influenced county-wide policy changes related to transportation by coordinating petitions to establish a local transportation system. This resulted in new financial resources, new jobs, and the county hiring one of their community leaders as the director of the McDowell Transit System.

The community forum model expanded to other structurally excluded neighborhoods, including East Marion and Old Fort, where they facilitated more than 150 community forums that mobilized new leaders, centered the voices of those who are most impacted by inequities, and catalyzed people power for grassroots-led change. They also co-authored a book called,

“Shift Happens in Community: A Toolkit to Build Power and Ignite Change,” which shares their tools, stories, and lessons learned with movement leaders locally, nationally, and internationally.

The rise of West Marion Inc. and its grassroots leadership in McDowell County allowed for collaboration with other community-led organizations like Foothills Food Hub and Centro Unido. The Food Hub is a program of the McDowell Local Food Advisory Council, and its mission is to improve food systems in the region. Centro Unido was founded in 2011 and is a Latinx-led organization that offers more than a dozen programs with six focus areas in mind; health, workforce, advocacy, leadership, education, and art and culture. These programs are designed in a community-based method that allows Centro Unido to establish programs that target the community’s needs. Working together through Healthy Places NC on health improvement, grassroots organizations representing all parts of the county have collaborated to build trust and put equity, diversity, and inclusion at the center of their collective work.



“In McDowell County we look beyond the traditional community power structure to identify individuals and organizations to develop community-led solutions,” said Margarita Ramirez, CULA Executive Director. “Now when you work with one organization in McDowell you get an entire tapestry of community groups and leaders ready to facilitate change.”

This ecosystem of changemakers was urgently called upon during the COVID-19 pandemic, where together they helped lead a community-driven response to the lockdown and public health emergency.

“When COVID-19 hit, we didn’t have to figure out who to call. We all have each other on speed dial,” said Heather Edwards, Foothills Food Hub project developer. “Our community was facing an unprecedented crisis, and we knew that the community had to be central to driving the response.”

Together grassroots organizations worked with the health department and county agencies to support drive-thru pop-up events for COVID-19 testing, food distribution, and resources; partner with Emergency Medical Services to support mobile vaccine clinics; and participate in weekly county round table meetings with emergency management and county officials, to name just a few of the efforts.

“It was a scary time for all of us as we saw COVID-19 sweep through our county, but I am proud of what we were able to accomplish together,” said Swepson. “We lost too many people, and our community is still feeling the lingering effects of the pandemic; but I know that things would have been much worse if we had not already built the trust, relations and human infrastructure we have in McDowell County.”

LATE STAGE 2 COMMUNITY STORY

Sparking Community Collaboration on Substance Misuse

Preparing for an unprecedented opportunity

Network Development and Systems Change

When Healthy Places NC launched in Southeast North Carolina in 2019 (Bladen, Columbus and Robeson Counties), addressing the opioid epidemic quickly rose to the top of community-identified priorities. Much like rural communities across the country, the Southeast region of the state is plagued by the opioid epidemic but runs very short on substance misuse treatment options.



In Robeson County, community organizers used a three-year, \$950,000 Healthy Places NC grant to form the Southeastern Prevention and Addiction Recovery Resource Center, or SPARC. Housed at UNC Pembroke, SPARC serves as a hub to coordinate local substance misuse efforts by supporting and expanding the existing RCORP Consortium. The consortium includes nearly 40 organizations ranging from small nonprofits to the local health system.

Dr. Jackie Davis, SPARC project director, attributes the initiative's success to a spirit of collaboration. "Our original goal for year one was to expand membership (15 active) by 23 new members. Over a two-year period, we currently have more than 60 organizations" she said. "They saw a greater need to create partnerships, rather than working in silos, to tackle challenges related to addiction and identify opportunities for community education."



In neighboring Bladen and Columbus counties, community members recognized the lack of access to resources and health care providers. They worked with Healthy Places to engage a team at Addiction Consulting and Training Associates (ACT). Together they formed community-based coalitions to identify gaps hindering effective recovery and develop solutions. A needs assessment found that illicit use of prescriptions, alcohol, opioids and other abused substances were among Bladen County's most pressing issues and this information was used to forge a strategic plan.

Substance misuse collaboratives in all three counties leveraged their efforts to increase funding and create new projects, but their hard work

received a turbo charge of opportunity. In July 2021, North Carolina Attorney General Josh Stein announced a settlement agreement, holding pharmaceutical distributors and manufacturers accountable for their role in catalyzing the opioid epidemic.

North Carolina will receive a \$1.5 billion share of national opioid settlements that will support treatment, recovery, harm reduction, and other lifesaving services in communities throughout the state.



“Things look very different with the opioid settlement fund,” said Syd Wiford of ACT. “Bladen and Columbus can increase services for the next 18 years—something no county with individuals facing substance use disorder has ever experienced.”

Decisions regarding distribution of the settlement funds will be made at the state and county levels. With established coalitions and completed community needs assessments, Bladen, Columbus and Robeson counties are well-positioned to take advantage of settlement funding coming to each community. For example, Bladen and Columbus counties will use a portion of the funds to secure beds for residents at a drug-treatment center in Wilmington. Robeson County has recommended using a portion of the money to increase funding for drug courts aimed at helping drug users accused of crimes.

“We will never get an opportunity like this again, so we want to utilize these dollars for things that can’t be funded elsewhere,” said Davis. “Without SPARC, I think there is a good chance we would have seen a lot of competing proposals and duplication of efforts. Now as a community we are in lockstep about what we need and how we can get it.”





Discussion: Core Challenges in Healthy Places NC Implementation



Place-based philanthropy is often replete with challenges and Healthy Places NC has been no exception. The design of Healthy Places NC evolved over 10 years in response to challenges and perspectives gained from new people throughout the initiative.

Challenge 1

Difficulty clarifying and communicating the nature and purpose of the work

Healthy Places NC began as an effort to do something different from other place-based initiatives. In the early years, the Trust and Healthy Places NC team were much better at articulating what the initiative was not rather than defining what it was. The initiative launched before the Trust could

clarify what it was hoping to accomplish and its beliefs about how community change happens.

The benefit of this more emergent, exploratory approach allowed the team to circumvent gatekeepers, stay flexible, and avoid the “analysis paralysis” that sometimes plagues collective impact or other centralized systems change efforts. However, this lack of clarity in the early years of the initiative meant that the people in community—and program officers themselves—often didn’t understand goals and strategies. Institutional players who were accustomed to interacting with philanthropy in conventional ways defaulted to business as usual, while leaders and community groups unfamiliar with philanthropy could not fully see what the opportunity was. It also made it difficult to define roles and outcomes for technical

assistance partners. Furthermore, it drove the initiative toward producing disconnected small wins without building a sense of collective movement.

Challenge 2

Confusion from too many external partners with too little alignment

Early on, the Trust brought multiple 'support' organizations to Healthy Places NC counties in addition to the program officer. These included the CHRR, CCL, KaBOOM!, NCDPH's Catalyst program, Prevention Partners, program officer extenders and the two RSOs.

The intent was to present multiple opportunities and resources that would appeal to a variety of local stakeholders, while also signaling the Trust's commitment to the community and expectation that bold, new work would take root. However, community stakeholders often did not have a clear sense of why these external partners appeared and how they could be helpful. Likewise, the external partners were often unclear about where they should focus their work in the community or how they should intersect with each other.

As a result, communities took advantage of these resources in only a piecemeal fashion, rather than consolidating in a way that would "add up" to bigger community-level change.

Challenge 3

Building capacity to implement a complex model in complex communities

Healthy Places NC represented a substantial change in conventional practices for both foundation program staff and implementation partners. The cultivation model was adapted from the approach that the Mary Reynolds Babcock Foundation used to activate, organize, and support statewide and regional networks. The Trust initially underestimated the complexity of the model and how it would need to be adapted when implementing in different community contexts.

While the initiative had a logic model and a general sense of how communities would build their capacity, initiate new work, and shift their culture, there were no specific recipes for how change might occur in a community. As a result, program staff and implementation partners had a difficult time knowing exactly what to do and what it meant to be successful. Some program officers' and implementing partners' practices were more akin to community organizing focused more on grassroots groups, while others used a more centralized approach focused on existing institutions.

To address this, the Trust engaged the National Implementation Research Network to develop a practice profile describing the role and provide individualized and group coaching to the program officers. A separate process was used to develop a practice profile for the RSOs.

The practice profiles brought some clarity to program officer and RSO roles, but many of the functions specified in the practice profile were vague and/or challenging to execute. The coaching helped bring clarity and skills development, but



only to a limited extent. Eventually it became clear that success in carrying out the cultivation model stems from innate competencies more than trainable skills.

The Trust changed its hiring criteria and selection process to prioritize individuals with established competency in critical analysis, strategic thinking, facilitation, and give-and-take relationship building. It also reviewed and realigned its internal infrastructure to better support what was a very challenging model to understand, implement, and communicate.

Over time, this produced stability in the Trust's program staff as well as Rural Forward NC, but there was considerable interim turnover, which contributed to discontinuities in messaging and strategy within Healthy Places NC communities.

Challenge 4

Too many disparate efforts supported in each Healthy Places NC county

The initial cultivation model, combined with the large number of external partners operating in different domains within Healthy Places NC communities, promoted a profusion of discrete efforts involving different parties aimed at different issues.

Without a core overarching frame of expectations from the Trust or a centralized planning group within each Healthy Places NC community, the work supported by the Trust splayed in different directions without much potential for the large-scale impacts reflected in the theory of change.

The Trust responded in two ways after Dr. Gerald was hired. First, the Trust defined outcomes around issues the community had chosen to focus on (e.g., substance use, healthy eating, recreation and active living, food systems). These were determined based on the work that was already underway, but focused the initiative and allowed communities to gain a clearer sense of the Trust's objectives. Second, the purpose and orientation of monthly Healthy Places NC meetings involving Trust staff, the RSO, and other external partners shifted. Rather

than discussing various topics of interest, these meetings were recast as "hub meetings" and focused on bringing together what each person was doing in their community to advance projects aligned with the strategic goals. This led to better-coordinated strategies, with grantmaking and technical assistance more clearly linked to expected outcomes.

Challenge 5

Underestimating how sticky existing power structures can be

Once Healthy Places NC pivoted to larger-scale systems change as a goal, it became much harder to predict how existing systems and power holders would react. The Trust discovered that when an outside entity comes in, sometimes the most powerful institutions coalesced around existing structures or became gatekeepers as to which efforts would be supported, making it harder to make deeper systemic change. In other cases, long-standing community leaders were critical resources for community change.

Understanding these idiosyncrasies of power structures—and then finding the unique ways a foundation can partner with others in the community to shift or challenge those power structures—can be a long process requiring patience. At the same time, the Trust became more intentional around intervening on these power structures, especially the intransigent ones. The key strategy involved shifting focus and resources to supporting grassroots and marginalized groups.

Challenge 6

Linking local and state-level efforts

Outside of Healthy Places NC, the Trust was funding other state-level change efforts that could affect participating communities. For example, the Trust included resources for Affordable Care Act navigation in participating communities while it was advocating for expansion of Medicaid. However, there were only partial links between local systems change in Healthy Places NC and statewide systems change.

The community needs and priorities identified were not being used to shape how the foundation was investing in state-level work. In response, the Trust developed a pathway for supporting the work identified by communities as critical and delved more deeply into partnering with grassroots groups and supporting channels for those groups to influence state-level action.

Challenge 7

Evaluating emergent, uncertain, long-term work

At the outset of Healthy Places NC, the Trust was committed to allowing priority outcomes to emerge organically from within communities. This meant that in the first several years there were no easily identifiable health outcomes on which to anchor a more conventional evaluation. Instead, the team had a sense of how they hoped communities would respond to the first wave of work, e.g., with new networks, new leaders, and new or accelerating pockets of promising work. But these kinds of outcomes felt unsatisfying to Trust leadership.

While evaluating progress against concrete (quantitative) outcomes is the ideal way to gauge success, this is challenging when the initiative intentionally supports community-defined solutions to community-defined problems. Moreover, evaluation of complex, emergent, long-term change across so many different locations can be costly, time-consuming, and methodologically challenging. The Trust contracted with an external evaluation team that accompanied the work for the first few years of the evaluation, but then ended that work. It did not engage in evaluation again until the close of the project. This freed up resources for the community work, but left the Trust with less evidence about what was/was not working and how the change process was unfolding.



Discussion: Lessons for Fellow Funders



The Healthy Places NC evaluation provides insights for fellow funders in various sectors who want to shift norms, systems, power dynamics, and other conditions that produce inequity, particularly in rural communities.

Philanthropy, including the Trust, has a long history of entering communities with preconceived ideas and prescriptive programs, yet entrenched disparities persist. Given the power and privilege held by foundations, it is imperative that philanthropy shifts its behavior to be trusted partners and to advance long-term change in the communities they serve.

Lesson 1

Be self-reflective and transparent about the foundation's appetite for being "community-driven" versus "foundation-driven" throughout the evolution of the work. Make implicit assumptions and values as explicit as possible, as often as possible.

Foundations have adopted a variety of approaches to place-based philanthropy, sometimes focusing their resources on foundation-defined issues, and

other times supporting local stakeholders to pursue their own ideas to address whatever issues are most critical from the community's perspective. Healthy Places NC was clearly an example of the community-driven approach. The Trust decided that it should support solutions emerging *from the community*—because these solutions reflect local knowledge and can attract the buy-in required to sustain the work in the long run. In addition, this community-driven approach can build more trusting relationships between communities and foundations, as well as deepening the foundation's understanding of a community's diverse needs, interests, and dynamics.

The Trust began with a wide-open perspective, looking for promising ideas related to the broad topic of community health. As the work unfolded, the Trust supported those lines of work that were generating the greatest progress. However, it was not always clear—either externally or within its own implementation team—the criteria it was using to make this determination. This caused confusion and even, in some cases, reduced trust among community and team members who interpreted “hidden” criteria as a sign that the foundation was disingenuous about its desire to be community-driven.

During Stage 2, the Trust became more explicit about its own interests and agenda, especially around equity and systems change. Although it set priority outcomes and goals, it did so after more

than four years of getting to know communities and observing which issues had momentum. It still invited local stakeholders to determine the specific issues that would be addressed and solutions that would be advanced. Transparency about what aspects of the work is community- vs. foundation-driven increases trust and improves the ability of stakeholders, the foundation, and implementation team members to pursue opportunities in alignment with each other.

Lesson 2

Develop a clear shared analysis of how community change happens and philanthropy's role in it. Intentionally test and refine assumptions based on what actually happens (and doesn't happen).

While Healthy Places NC has a decidedly community-driven orientation, the Trust has been an active player in each community's change process. The Trust provided support beyond what local groups requested, often seeing a bigger picture than was apparent to those who were directly working toward change. The program officers and RSOs had at least an implicit theory of change about what would be needed for local groups to achieve the outcomes they were striving for, as well as how the Trust and its partners could best support that change process.

It is important that these theories of change be grounded in reality rather than wishful thinking. In addition, foundation staff and partners should bring their theories of change to the surface and ensure that they are consistent. When team members hold competing and even unspoken theories about community change, it limits their ability to work in alignment toward a shared goal. If differences are not surfaced and dealt with transparently, they sometimes manifest as conflict, distrust, or frustration with both the implementation team and among community members. Committing time as a team to identify and explore assumptions about community change and the foundation's role in it will ensure that the foundation and its partners are working effectively toward change.



Lesson 3

To know where to invest, program officers should spend considerable time in communities, meeting with a variety of local stakeholders, listening, and learning.

Healthy Places NC broke through the traditional funding model of philanthropy by identifying new groups that merit investment, especially grassroots groups that represent the interests of historically disenfranchised segments of the community. This was possible only because the program officers and RSOs spent so much time in community settings, often without a preset agenda. At the outset of their engagement, the program officers operated in learning mode—regarding issues, people, organizations, and the history and culture of the community. Much of this learning occurred through informal interactions. It set the stage for inviting grant applications and assisting networks in developing collective strategies.

Many more applications, especially well-constructed applications, came into the Trust than would have occurred through a traditional request for proposals. The learning process also provided the Trust with the information it needed to determine where to build capacity, which relationships to broker, and where to direct the RSOs to carry out capacity-building and facilitation.



Although time-consuming, the Healthy Places NC approach to cultivation allowed the Trust to identify critical ways to add value, while also building trusting relationships that served as the basis of the Trust's approach to promoting community change.

Lesson 4

Communities are not homogeneous. When a foundation adopts a community-driven philosophy, it must make choices as to which stakeholders it will support and whose interests will be advanced.

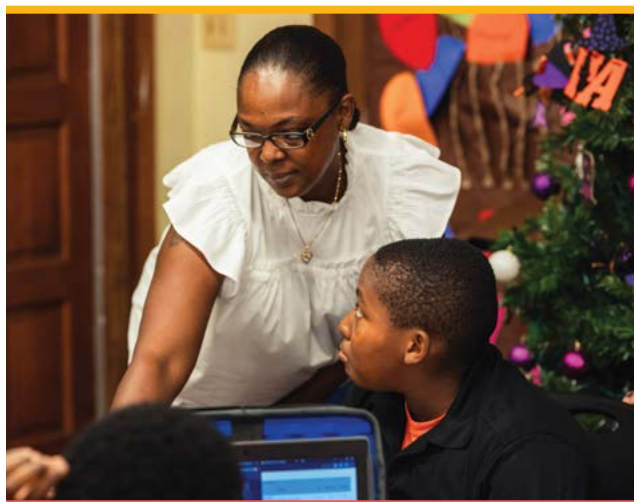
Communities hold more priorities than any one funder can support. A foundation must choose which efforts to fund. Regardless of whether a foundation is explicit about its own agenda, its funding decisions lend legitimacy and momentum to some stakeholders' priorities over others. It is important for the foundation to be explicit in naming whose priorities matter most. Otherwise, local stakeholders may find themselves guessing as to the foundation's interests and funding decisions.

In choosing whose interests to prioritize, the foundation is declaring a point of view. While the approach may still be community-driven in the sense that local stakeholders are determining what approaches will be supported, the foundation is driving the decision of *which* stakeholders have that discretion.

Lesson 5

When a foundation adopts a racial equity lens, it will want to see new work happen in communities, some of which involves a shift in power.

A foundation can support a shift in power by providing funding, visibility, and capacity-building to grassroots groups that directly represent the interests of communities of color. This support can also include connecting grassroots groups in ways that strengthen their collective power and deepen their community-change work.



At the same time, the foundation can challenge local institutions and established leaders to shift their orientation to be more inclusive and responsive to all segments of the community. This can involve attaching new expectations to grants and encouraging leaders to advance along their own equity journey.

Lesson 6

Differences in capacity across groups and organizations are the result of inequitable access to financial and capacity-building resources both historically and currently. Repairing these imbalances requires capacity-building to be targeted to traditionally excluded groups so that they are comparably resourced to engage in community change.

Many community change initiatives offer capacity-building support equally across all engaged community institutions and grant recipients. While this can feel more comfortable for foundations and protect them from accusations of being unfair, it also reinforces entrenched disparities between the power and resources available to well-resourced, well-established institutions and the community groups and organizations that have been chronically underfunded. If equitable community change requires more equitable and democratic community agenda-setting, problem definition, and

solution selection, then capacity-building resources should be targeted at communities that have traditionally been shortchanged on resources to engage in these activities.

Lesson 7

Although long-term community systems change can benefit from brokering relationships between established institutions and grassroots groups, foundations need to lay groundwork first to guard against tokenization and cooptation.

Foundations have increasingly come to recognize that creating more equitable and inclusive systems requires collaborative processes that actively engage not only the leaders of the institutions that anchor these systems, but also representatives of the communities that these systems are intended to serve. Historically, communities of color have been omitted from these processes, but more recent models of systems change (e.g., Collective Impact 2.0) have emphasized their inclusion. Foundations have acted on these new models and are encouraging white-led institutions to engage grassroots leaders, organizations, and other groups that represent low-income communities and communities of color.

However, when collaboratives dominated by existing power holders expand to include representatives of structurally marginalized communities, their voices can be swamped by prevailing norms, assumptions, and interests of more powerful institutional representatives. Traditional institutional collaborations can be unaware that their existing decision-making structures, norms, and shared assumptions close off different perspectives. At worst, powerful gatekeeping leaders can claim that a collaborative legitimately represents the wider community because it appears more diverse but makes no real changes to whose priorities and perspectives matter nor how decisions are made.

Lay groundwork to prevent this tokenization by first investing in grassroots power and capacity.

Cultivate champions for shifting power within traditional institutions to foment change from the inside. Then broker relationships so that collaborative negotiation can occur on more equal footing.

Lesson 8

Community change is deeply relational work. Progress can be disrupted by turnover among foundation staff and implementing partners. Expect turnover and develop a continuity strategy.

The “cultivation” model of community change cannot be reduced to a set of bureaucratic grantmaking processes. It depends on foundation staff having a deep understanding of a community and sensing hotspots of energy for change that could be boosted by an injection of resources. They need enough trust with a range of community members that they can broker relationships, candidly explore the pros and cons of ideas, and help folks work together to see where bigger systems change is possible. Likewise, implementation partners need to be experienced as trustworthy, high-value allies to community change makers. This means that forward momentum is highly susceptible to staff turnover, particularly in the early years.

Beyond building a clear and explicit shared analysis of how community change happens as recommended above, foundations and community partners also need other strategies for protecting continuity. Make sure that a community’s relationship with the foundation or a regional support organization isn’t held entirely by one individual. Try doubling up on program staff so that there is a backup person who holds some knowledge of and relationships within a particular community and who can step in when the lead contact departs. Use regular cross-team check-ins to share information and insights about a community. Document and pass on not only contact and grant information, but key observations and insights about a community’s power dynamics, areas of momentum, systemic barriers, and emerging ideas. Finally, engage community members in “onboarding” new staff by



helping those staff understand community dynamics, where work is now and is headed, and the sticking points and opportunities for keeping work on course.

Lesson 9

Standardized capacity-building approaches delivered by high-profile national organizations aren’t always a good fit for rural communities—or for complex community change efforts in general. When possible, invest instead in customized local support, as well as peer-to-peer and community-to-community learning to enhance capacity.

While bringing in expertise, frameworks, and pre-packaged technical assistance from high-profile national groups can spark new ideas, it requires a lot of time, effort, and contextual knowledge to translate to local needs and conditions. The mismatch appears particularly acute for grassroots groups and organizations led by and serving people of color, as many “high-profile” resources are not built with a deep understanding of the unique dynamics of systemic racism in rural Southern communities.

Complex community change work is contextually—and culturally—specific, and capacity needs evolve dramatically over time. Tailored accompaniment from someone who understands the local culture and context is often more relevant and useful.

Additionally, groups and organizations seem to benefit from peer-to-peer and community-to-community learning. It allows for more sophisticated and nuanced analysis of the systems by participants who compare and combine their own experience of local dynamics and then share strategies for tackling them.

Lesson 10

Although some critical systems change capacities can be embedded within rural communities, most don't have the market or population stability required to sustain them. A broader regional support infrastructure is critical to support ongoing community change efforts and health equity in rural communities.

Foundations have insufficient staff to maintain the depth of engagement in rural communities that is required for this kind of place-based cultivation work. Nor is it always appropriate for the foundation, as the holder of financial resources, to play all the support roles critical for supporting community-driven systemic change (e.g., neutral group facilitation and mediation, leadership coaching).

Like many other community change initiatives, Healthy Places NC aimed to embed these skills permanently within communities over time via capacity-building. However, rural communities rarely have a large enough market to support full time professionals to deliver these supports to their community. Some form of permanent infrastructure, such as a rural support organization, to facilitate equitable systemic change and support adaptive leadership is needed to serve the ongoing needs of local organizations and communities beyond the interest and lifespan of any one funders' initiative.

Lesson 11

Conventional foundation approaches to evaluation and expectations for success aren't a good fit. Prepare foundation staff and boards to think about success differently and to take a long view.

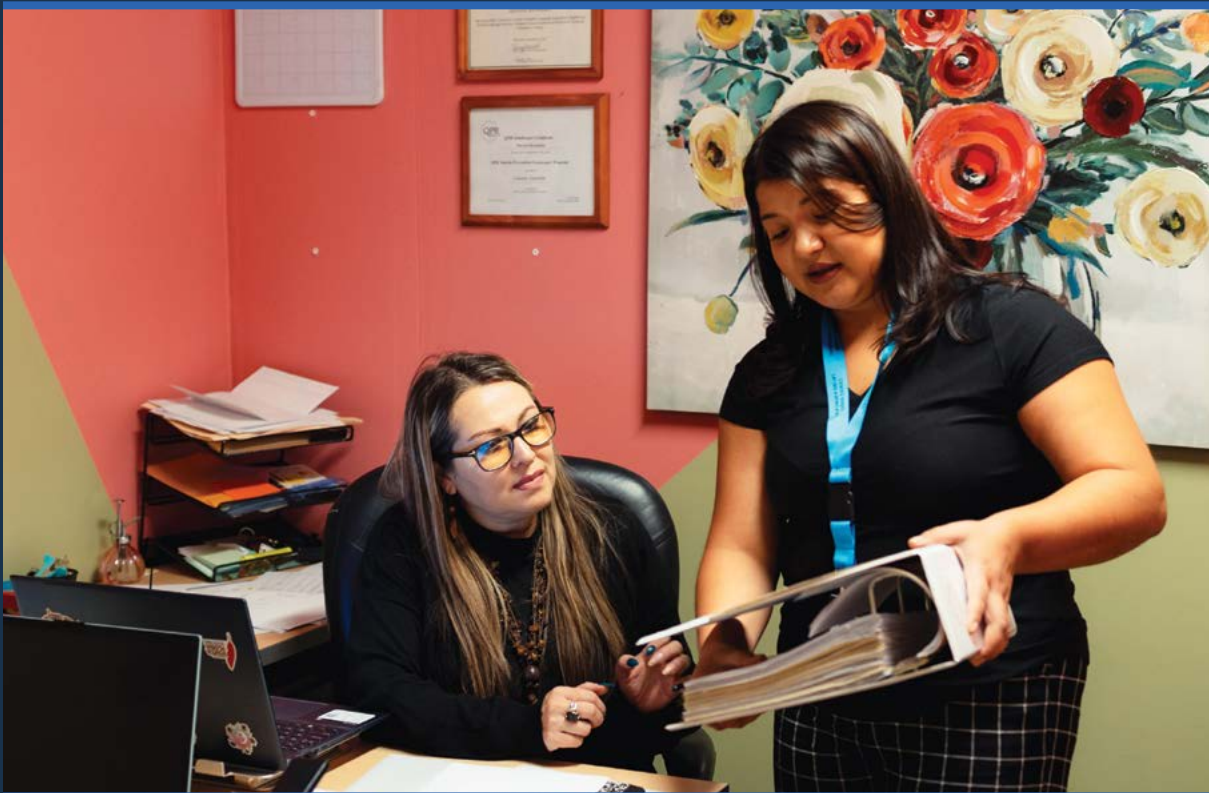
Foundation staff and trustees often look for success metrics and evaluation approaches that will show ever-improving trendlines for population health outcomes in a relatively short period of time. Conventional outcome expectations and metrics frameworks can easily lead foundation leaders to prematurely conclude that a community initiative is failing. Conversely, quick, measurable wins might lead foundations to incorrectly conclude things are going well, when the developing networks and collaborative strategies are reinforcing exclusion (which will exacerbate health disparities).

None of these conditions mean that outcomes aren't important or that evaluation is impossible. But they do challenge foundations and their trustees to think about success in new ways. Rather than expecting change in population health outcomes, focus on shorter-cycle learning and detection of changes in networks, relationships, power, and problem-solving norms within a community. Approach evaluation and measurement as a strategic intelligence tool to help understand in real time what's working (or not!) to build the necessary pre-conditions for systems change that support more equitable population health outcomes.

Lesson 12

The overarching purpose of place-based philanthropy is structural change that generates long-term benefits, especially to historically disenfranchised segments of the community. Because these changes take considerable time to occur, foundations should commit to supporting specific communities over the long haul.

Conclusion



After a decade of intentional investment, the Trust fulfilled its \$100 million promise to work with NC residents to develop community-driven strategies to improve health outcomes in 10 rural counties. Healthy Places NC was not only an opportunity to support the work of communities striving for equitable health outcomes, but it also ultimately changed the way the Trust worked. This retrospective evaluation identified key findings, lessons, and challenges that may be beneficial to the funding community, particularly those trying to address health inequities in rural areas. We

know that this is long-term work that requires an explicit focus on disrupting inequitable systems, centering racial equity, and amplifying power amongst historically marginalized groups to see a true impact in community. Moving forward, we plan to regionalize this rural work and invest in Healthy Places NC communities that are positioned to change policies at the local and state level. We invite you all to embark on this journey as we continue to work toward creating thriving communities and a more just and equitable state.



Acknowledgments

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References

1. Ramirez M. Why philanthropy continues to Underfund Rural America-and what grantmakers can do. Inside Philanthropy. August 15, 2022. Accessed March 6, 2024. <https://www.insidephilanthropy.com/home/2022/1/5/why-philanthropy-continues-to-underfund-rural-americaand-how-grantmakers-can-change-that>.
2. Kubisch AC, Connell JP, Fulbright-Anderson K. Evaluating Complex Comprehensive Community Initiatives: Theory, measurement and analysis. Rebuilding Community. Published online 2001:83-98. doi:10.1057/9781403919878_5
3. Gaining Perspective: Lessons Learned From One Foundation's Exploratory Decade. Gaining_Perspective_NWAF_execsumm.pdf. January 10, 2011. Accessed May 6, 2024. https://www.fsg.org/wp-content/uploads/2021/08/Gaining_Perspective_NWAF_execsumm.pdf.
4. Brown P, Fiester L. Hard Lessons about Philanthropy & Community Change from the Neighborhood Improvement Initiative. Microsoft Word - NII Report. 2007. Accessed March 6, 2024. <https://hewlett.org/wp-content/uploads/2016/08/HewlettNIIReport.pdf>.
5. Easterling D, Gesell S, McDuffee L, Davis W, Patel T. The cultivation approach to place-based philanthropy: Evaluation findings from the Clinton Foundation's Community Health Transformation Initiative. The Foundation Review. 2019;11(4). doi:10.9707/1944-5660.1497
6. Census Reporter. Accessed March 6, 2024. <https://censusreporter.org>.
7. Metz A, Easterling D. Using implementation science to translate foundation strategy. The Foundation Review. 2016;8(2). doi:10.9707/1944-5660.1302
8. "Healthy Places North Carolina Four-Year Evaluation Report." Submitted to the Kate B. Reynolds Charitable Trust by the Duke Division of Community Health, August 31, 2017
9. Dupre ME, Moody J, Nelson A, et al. Place-based initiatives to improve health in disadvantaged communities: Cross-sector characteristics and networks of local actors in North Carolina. American Journal of Public Health. 2016;106(9):1548-1555. doi:10.2105/ajph.2016.303265
10. Swepson PF, Snow MK. Community engagement toolkit. Community Engagement Toolkit. Accessed March 6, 2024. <https://www.shifthappenstoolkit.org/>.

Appendix

Appendix: Healthy Places NC Methods

This report used a mixed-methods approach to evaluate the contribution of the Healthy Places NC initiative, which informed lessons learned for funders. This evaluation was led by Dr. Kristen Burwell Naney, director of Learning and Impact, in partnership with an external evaluation team (Tanya Beer [Tanya Beer Consulting], Dr. Doug Easterling [Wake Forest University], and Dr. Mina Ruth Silberberg [Duke University]).

Early Initiative Evaluation

Evaluation during Stage 1 was conducted between 2013-2016 by a research team at Duke University's Division of Community Health. The primary methods used for the evaluation were: 1. Two waves of key participant interviews (KPIs), approximately two years apart, in each county; 2. Two waves of KPIs (approximately two years apart) with the implementation team, (i.e., personnel from the Trust involved with Healthy Places NC, program officer extenders, personnel from the regional support organizations (RSOs), and personnel from partner agencies); 3. Two waves of surveys (approximately two years apart) in the counties; 4. Analyses of health improvement and related work in Halifax, McDowell, and Rockingham counties; and 5. Case studies on the progression of efforts around specific health issues in the four original counties using the data from the other four methods.

Key Participant Interviews

Conducted in-person or by telephone, KPIs were designed to solicit respondent perceptions of county characteristics (assets, issues facing the counties); what Healthy Places NC hoped to do and was achieving; challenges facing the initiative and needed steps. From November 2013-February 2014, KPIs were conducted with the implementation team (Trust staff, program officers,

program officer extenders, RSOs, and other Healthy Places NC partners, n = 21) and individuals from the three initial Healthy Places NC counties, (Beaufort (n=13), Halifax (n=11), and McDowell (n=13),) doing important work in a variety of sectors, such as education, health, faith, and government.

County respondents included individuals actively involved with Healthy Places NC, individuals whom the program officers hoped would become more involved, and individuals who had expressed concerns about the initiative. As new counties were incorporated into the initiative, Wave 1 KPIs were completed for them as well: 13 in Rockingham from October 2014 to February 2015, 13 in Burke from June 2015 to October 2015, and 16 in Edgecombe/Nash from December 2015 to April 2016.

A second wave of KPIs was conducted with the implementation team (n=23) and respondents from the first four counties (Beaufort (n=13), (Halifax (n=13), McDowell(n=11), and Rockingham (n=9)) from May 2016 to March 2017. Wave 2 KPIs were conducted for Burke (n=16) from October 2017 to January 2018 and in Edgecombe Nash (n=22) from December 2017 to March 2018.

For initial analysis, first-tier interview codes were based on categories of information the instruments were designed to obtain (e.g., health issues facing the communities); second-tier codes were developed inductively. All interviews were double-coded and any discrepancies reconciled. Analytic summaries were developed by one member of the study team and reviewed and modified by a second. Data were reanalyzed for specific content (e.g., role of partners) following discussion of results with the Trust.

Surveys

Surveys were designed to collect respondent characteristics, network ties, and self-perceived leadership attributes. They were self-administered on the internet or conducted by telephone. Our sampling goal was to obtain feedback from

individuals either playing an important role in promoting health and well-being in the county or with the potential to do so.

Given our interest in understanding networks, only surveying those who were working with the Trust would create the problem of a self-fulfilling prophecy; we would see important actors making changes in their networks, because we had by default defined important actors as those working with the Trust. Moreover, we would be unable to assess whether Healthy Places NC was having the anticipated ripple effects on actors throughout the community. In theory, the survey sample could be expanded to encompass the residents and workforce of an entire county, since all of these might have something to contribute to a health improvement initiative. Clearly, this would be unmanageable. Nor would it be helpful to identify all the actors whose networks had not been affected by the Trust; catalyzing new relationships among all members of the community was not realistic, necessary, or even desirable, as networks grow to a point of diminishing efficiency.

The challenge then was to develop a sample that did not merely replicate program officer contacts but was meaningful. To do so, we took the following steps:

1. For each county, program officers provided a list of approximately 75 individuals whom they considered most important from among their county contacts (including those on their “wish list” and perceived critics).
2. The names generated through the KPIs were added to these lists.
3. Based on their environmental scan, the resulting lists were assessed by the evaluation team for gaps in racial/ethnic, geographic, and sectoral representation.
4. These gaps were filled by soliciting additional names from the program officers, through information provided by the environmental scan, and through additional research by the evaluation team.

5. The program officers and three core partners from the Trust provided feedback throughout this process to make sure that the resulting sampling frame had no clear omissions or illogical content from their point of view.

6. Finally in the survey itself, respondents were given the opportunity to provide names of individuals with whom they had relevant ties who were not already on the list. These individuals were then added to the survey sample.

First wave administration for the first four Healthy Places NC counties occurred May-October 2014. Sample sizes were:

- 92 for Beaufort
- 92 for Halifax
- 87 for McDowell
- 80 for Rockingham

Wave 2 survey administration for those counties took place from June 2016 to January 2017. Sample sizes were:

- 97 for Beaufort
- 76 for Halifax
- 79 for McDowell
- 120 for Rockingham

For Burke, the Wave 1 survey was administered March-August 2015 (n=107) and Wave 2 from November 2017 to June 2018 (n=100). For Edgecombe Nash the Wave 1 survey was administered March 2015-August 2015 (n=106) and Wave 2 from December 2017 to June 2018 (n=73).

Survey analysis used standard Social Network Indicators to describe the network and the centrality of individual players. Leadership attributes were measured on a five-point Likert scale. Tests of difference and change over time varied in accordance with the nature of the data.

Work Analysis

A work analysis was carried out in 2016. In each county, projects were identified through KPIs, Healthy Places NC grant funding, scanning of local news, and informal interviews. Projects were double-coded using a pre-established coding book.

10-Year Evaluation

Evaluation at the 10-year mark began in 2022 and was implemented in partnership with our external evaluation team.

Grantee Interviews

Forty grantee interviews were performed by Wake Forest University, led by Dr. Doug Easterling, to capture qualitative information on the following topics: 1) engagement between community and trust/support partners, 2) systems and policy change, 3) power, 4) organizational capacity-building, and 5) networks, coalitions, and collaboratives. Our sample mostly included organizations who received grants between 2017-2022 since we had less data on that time period; however, a few of the grantees had received Trust funding prior to 2017. Organizations were also excluded if they were funded for one year or less or were recipients of capital funds. The Trust was strategic in selecting organizations that were both grassroots and institutional representing each county, multiple funding types, and different goals since there were more than 40 groups that met the eligibility criteria. Themes were analyzed from grantee interviews to inform Stage 2 of the work and lessons learned 'For Our Community Partners' and 'For Our Fellow Funders.'

Grantee Surveys

A grantee survey was co-developed with external evaluators that covered the following topics:

1. Perception of Healthy Places NC
2. Capacity-building and collaboration
3. Power
4. Community engagement,
5. Systems and policy change
6. Support partners

Survey data was captured electronically by the Wake Forest University team using a REDCap platform, and consisted of multiple-choice, Likert-scale, matrix, and text questions. Descriptive statistics were performed to analyze the results reflected in the report. There were 45 unique grantee organizations who completed the survey out of 94 eligible organizations (~48% response

rate), representing grassroots and institutional groups funded since 2012 (Note: Organizations with undeliverable email addresses were not counted in the response rate. Of the 45 grantees completing the survey, 23 organizations had an opportunity to participate in the survey and interview, 22 organizations were exclusively given the survey, and 17 organizations only took part in the interview process. Therefore, our results reflect 66% of responses from eligible grantee organizations).

Staff and Affiliate Interviews

Sixteen staff and affiliate interviews were led by an external evaluator, Tanya Beer, to capture information about the initiative over the 10 years. Interviewees were associated with Healthy Places NC at various points during its history. Questions in these interviews covered topics related to the impact of how the initiative was operationalized, the impetus of community-level change, and how the articulation of clear outcomes influenced progress. Themes were analyzed and presented throughout the report.

Limitations

While there was a rigorous process used to get a representative sample of grantees and staff and affiliates to participate in data collection activities, every organization is not reflected in the results, nor the complete magnitude of the impact of the work. Furthermore, the intricate nature and scope of this work does not allow the Trust to fully distinguish their contribution to community change from other factors.





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