OBJECTIVES

- Understand how Evidence-based practices (EBPs) are implemented across diverse rural communities
- Describe the barriers and solutions to EBP implementation in rural areas
- Further knowledge about the implications of research and funding of EBPs/promising practices for funders, researchers, and communities

BACKGROUND

In its role as a technical assistance provider to grantees funded by the Federal Office of Rural Health Policy (FORHP), the Georgia Health Policy Center (GHPC) is an information hub that assists in the dissemination of timely and relevant research to inform how communities move forward with health systems change and innovation. GHPC’s current analysis is a companion study that updates key findings based on the most recent grantee cohorts funded from 2015-2018. To help address some of the disparities and encourage the implementation of proven interventions, the FORHP at the Health Resources and Services Administration provided funding to grantees and consortia in rural and frontier communities through the Rural Health Care Services Outreach (Outreach) Grant Program and a pilot program called the Rural Health Care Coordination Network Partnership Grant Program (Care Coordination) which develops projects that address their own unique community health care needs. Between 2015-2018, the two cohorts included 68 communities representing 35 different states.

FINDINGS

Health and care in the United States are currently characterized by a number of competing stressors—trends related to the increasing prevalence of chronic conditions, fragile systems of care, unsustainable costs, and quality concerns, to name a few. Rural residents, providers, and leaders face exacerbated challenges, including higher rates of uninsured people and higher rates of chronic diseases. EBP has become increasingly important to ensuring that the system is sustaining positive patient outcomes, quality care, and cost savings. Analysis was done via a framework for the range of models used and describes how rural communities are adapting and implementing EBPs (e.g. from communities that select elements of EBPs for implementation to those that maintain close fidelity to a given model). This poster presents a synthesis of community level experiences in identifying, adapting, and implementing promising and/or EBPs in their rural and frontier communities.

MINOR TAILORING

Smaller adjustments were made to chosen models to more accurately meet the needs of grantees, as well as to improve the effectiveness of particular strategies. Examples include changes in staffing model from full-time to part-time.

ADDITIONS

- Additional components were added to an existing model to further enhance services to clients.
- Examples of these additions included:
  - Health services, cultural competency training for providers, and full integration of care coordination teams at clinic sites.

BLENDED MODELS

- Some communities pulled from and weaved together different models to create an initiative relevant to their care organizations, partners, and/or local systems of care.
- This sometimes occurred in a very explicit way with well-defined models being pulled together into a new program, and in other cases the selection and utilization of multiple models was less clearly defined.

WIDE-SCALE ADAPTATION

- Others adapted models significantly, such as changing the implementation setting, expanding a model to fit a different population or health condition.

CONCLUSIONS & IMPLICATIONS

Grants, such as these, afford the opportunity to test approaches in rural areas which could lead to more evidence for what works well in these communities. EBPs are expensive and not well researched in rural communities. The result is that communities must heavily adapt EBPs to their rural context, and it may be more difficult to maintain fidelity to a model if that model has not been tested in a rural community. Where communities are less able to maintain fidelity to a model, they may also be challenged in demonstrating the same outcomes linked to that model. Since it is unknown whether the same outcomes achieved through model fidelity will be achievable if only some parts of the model are implemented, an approach could be to consider additional funding for a rigorous evaluation component that could offer insights into these questions. Additionally, investment is needed to support research in rural settings on care coordination EBPs, while continuing to provide grantees flexibility in the development and tailoring of rural relevant initiatives.

Successful approaches observed from communities in these cohorts:

- Some of the most successful were able to integrate evidence-based programs into existing structures and operations (workflows, policies, and procedures)
- Selection of broader models with a high degree of flexibility (e.g. CHW, care coordination, patient navigation)
- Adoption of models with less established evidence that align well with addressing rural barriers to care
- Dedicated time to piloting or formative evaluation early on to gain community support. This may also minimize the need for mid-grant adaptations to the model.