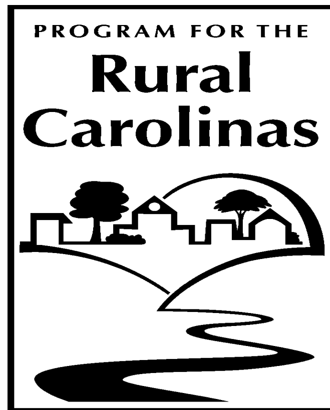

The Role of the Hospital in the Program for the Rural Carolinas

Chapin Hall Center for Children
at The University of Chicago

on behalf of The Duke Endowment

March 2006

Established in 1924 by North Carolina industrialist and philanthropist James Buchanan Duke, The Duke Endowment is a private foundation that serves the people of North Carolina and South Carolina by supporting selected programs of higher education, health care, children's welfare, and spiritual life.

This report is based on work supported by the Endowment and we try to ensure the accuracy of all information it provides. However, this report relies upon data obtained from many sources, and The Duke Endowment cannot guarantee the accuracy of the information or its analysis in all cases. Further, The Duke Endowment is not engaged in rendering clinical, legal, accounting, or other professional services. This report should not be construed as professional advice. Any opinions, findings, conclusions or recommendations contained herein are those of the author and not necessarily reflect the views of the Endowment. Neither The Duke Endowment nor its programs are responsible for any claims or losses that may arise from use of any information contained in this report.

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From The Duke Endowment

We entered new ground while traversing old trails. The Endowment has been working with rural churches and rural hospitals since its inception and for over 80 years. We take this work very seriously.

Working in concert with our traditional beneficiaries, in August 2001, the Board of Trustees of The Duke Endowment approved the creation of the Program for the Rural Carolinas, an effort to help rural communities in the Carolinas develop their economic assets. The rural program was a three-year initiative and operated on the principle of helping traditional Endowment beneficiaries develop partnerships with other agencies in their communities to work together on a common goal. We believe our beneficiaries and their work will prosper when their communities experience healthy growth and economic stability.

This program was divided into two parts: Option 1, for rural communities demonstrating the ability to undertake large-scale collaborative efforts to energize community development and strengthen economic vitality, and Option 2, for rural communities that choose to undertake innovative smaller-scale projects with fewer partners but still with the potential for economic and community impact. Both groups received direct grants and assistance from the Endowment, as well as coaching, skills training and other assistance from MDC Inc., the Chapel Hill-based economic research and workforce development agency that is the Endowment's partner in managing the program.

Chapin Hall at the University of Chicago was another partner. They worked with participants in the Program – the sites, The Duke Endowment, and MDC – to establish a way to learn systematically from the planning and implementation of Program activities and to assess the successes and challenges the Program encounters. This learning and assessment provided information and analysis useful to participants as they refined and implemented their work and, potentially, to inform people and organizations working in other communities.

The Endowment selected 22 sites that received funding in 2002. Two sites withdrew in 2003 and 2004. Twenty sites participated through 2005, 14 sites are in a second phase with a focus on sustainability. The program will end in 2007. We learned much from this program and want to share this information with those interested in helping rural communities develop their economic assets, how rural churches and hospitals can have a role in this work and lessons we learned about managing a program of this scale.

Sincerely,

Eugene W. Cochrane, Jr. President	Toni L. Freeman Director of Project Research and Evaluation

May 2006

Participating Programs

The Endowment received 93 completed applications for the program, 57 from North Carolina and 36 from South Carolina. Staff members from the Endowment and MDC reviewed applications and made site visits to the communities submitting the most promising proposals we compared findings in a series of meetings and conference calls. In June 2002, Trustees of the Endowment selected 22 sites that would receive funding under the program. Two sites withdrew by 2005 and 14 sites are in the final phase of the program that will end in 2007. A complete list of the participating beneficiaries and their programs is in Appendix A.

Beneficiary	Service Area County
Allendale County Hospital	Allendale County, SC
Calvary Memorial United Methodist Church	Greene County, NC
Columbus County Hospital	Columbus County, NC
Duncan Memorial United Methodist Church	Georgetown, SC
Greenville District United Methodist Church	Beaufort County, NC
Hildebran United Methodist Church	Burke County, NC
Hinton Rural Life Center	Cherokee, Clay, Graham & Swain Counties, NC
Hot Springs Health Center	Madison County, NC
Hyde County Cooperative Parish (United Methodist Church)	Hyde County, NC
Isaiah United Methodist Church	Colleton County, SC
Maria Parham Hospital	Vance County, NC
Marion County Medical Center	Marion County, SC
North Wilkesboro District United Methodist Church	Alleghany, Ashe & Wilkes Counties, NC
Onslow Memorial Hospital	Onslow County, NC
Pender Memorial Hospital	Pender County, NC
Pilmoor United Methodist Church	Camden & Currituck Counties, NC
Pinetop United Methodist Church	Edgecombe County, NC
Randolph Hospital	Randolph County, NC
Roanoke Chowan Hospital	Bertie, Gates, Hertford & Northampton Counties, NC
The Rockingham District United Methodist Church	Robeson County, NC
Shady Grove United Methodist Church	Lower Orangeburg & Upper Dorchester Counties, NC
Snow Hill United Methodist Church	Stokes County, NC

Introduction to the Chapin Hall Learning Project Working Memoranda

March 2006

One of the products of the Chapin Hall Learning Project is a series of Working Memoranda that serve as a vehicle for dialogue about what the Program for the Rural Carolinas (PRC) is accomplishing, what challenges it is facing, and what strategies might help to address these challenges in order to maximize impact. This Introduction describes the purpose of the Working Memoranda, how they were developed, and what they have focused on.

What is the purpose of the Working Memoranda?

The goal of the Working Memoranda is to provide useful information and analysis designed to stimulate mutual reflection and learning about key questions and issues arising as PRC evolved. As expected, significant variation existed across the original 23 (now 20) PRC sites in their histories and contexts, strengths and challenges, and in the local opportunities on which they had to build. Our analysis was at the cross-site level whereby we aimed to draw from the unique experiences of individual sites to identify larger patterns, themes, and lessons. Our focus on learning rather than on assessment positioned us to be learning partners rather than evaluators, although we hoped that the issues covered in the Memoranda helped to shape each site's own self-evaluation.

The Working Memoranda are conceptualized as a collaborative effort, so we periodically asked all of PRC's stakeholders what questions they wanted the Memoranda to address. When we completed a Memorandum, we issued it in draft form so that everyone had an opportunity to review and provide input before it was finalized. We encouraged the sites to review the draft to see where their experience was consistent or not with the narrative: what was the evidence for their assessment? What other confirming or competing points or lessons on the topic could they contribute? What examples could they provide to help deepen the learning from PRC?

Because our aim was to capture the learning along the way, each Memorandum should be understood in the context of the particular stage of PRC's development in which it was released. Sometimes information was updated in later Memoranda and sometimes the same issue was treated quite differently in Memoranda that came out at different times.

On what data are the Working Memoranda based?

The Working Memoranda are based on a number of sources of data collected over a three-year period starting in April 2003: at least two site visits annually to the Option 1 sites, during which Learning Project staff attended team meetings and community events and interviewed team members, staff, local officials, program participants, and other observers. We also read site materials, communicated with team members and staff by phone and email; attended learning cluster workshops and annual cross-site learning institutes; administered surveys; talked periodically with MDC staff and coaches; and interviewed relevant program staff at The Duke Endowment.

Who is the audience for the Working Memoranda?

PRC teams, staff and other local stakeholders are a primary audience for the Working Memoranda. Other key audiences include The Duke Endowment and MDC. Finally, the memoranda may also be of interest to other practitioners, funders and policymakers concerned with rural economic development, community building, and the role of philanthropy in community change. A list of the working memoranda topics is in Appendix B.

Chapin Hall Center for Children at the University of Chicago

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The Role of the Hospital In the Program for the Rural Carolinas

September 2005

Introduction

Rural Methodist churches and rural nonprofit hospitals have long been beneficiaries of grant programs of The Duke Endowment (TDE). The grant programs have worked largely to strengthen these key institutions, build new facilities and services, and support their leadership. The Program for the Rural Carolinas (PRC) presented rural churches and hospitals with a different kind of opportunity, inviting them to take on a lead role, including that of fiscal agent, for an ambitious community economic development initiative. The hope was that these institutions could be leaders but not be in charge and that they could produce results but share that responsibility and credit with a range of other community partners, all of whom would work to sustain the community change process after TDE support ended. This was definitely not business as usual for rural churches and hospitals.

This Working Memorandum examines the experience of the nine Endowment-eligible rural hospitals or health entities participating in PRC. As in our Memorandum on the role of the church, the focus here is on the role hospital executives and their institutions have played in PRC and the impact of PRC on these institutions. The Memorandum is based primarily on interviews with the leaders of Option 1 and Option 2 hospital-led teams.

The Memorandum begins with a look at the backgrounds and characteristics of the participating health institutions. Then we turn to the roles that the hospitals and their leadership have played so far in PRC. This is followed by a summary of the impact that hospital leaders suggest PRC has had on their institutions. Next is a discussion of the hospital's role in sustaining PRC and in promoting community economic development in the future. Finally, the Memorandum ends with some emerging implications for reaching other rural hospitals with a potential interest their community's economic vitality.

Who are the Hospitals Participating in PRC?

The Table on the next page lists the individual leaders we interviewed for this Memorandum and provides some background on the participating hospitals and the counties in which they are located. All the hospitals have had previous grants from The Endowment, most for many years, largely to finance building and capital projects, to support new program initiatives, or to offset the costs of indigent care. Several hospital leaders also mentioned TDE staff as important sources of information, ideas, and data for planning.

TDE Eligible Hospital Profile

June 2005

	Hospital				Population							
	CEO/ Lead Admin. Interviewee[2]	Size				Racial/Ethnic Composition					Unemp.	Educ.
PRC Sites		*# Beds (Capacity/ In-Use)*	*2004 Budget (in millions)*	*# Staff (FT/PT)*	***Total Pop.***	*White*	*Afr. Amer.*	*Amer. Indian*	*Asian*	*Hisp.*	*Rate*	*Adults w/o HS Diploma*
Allendale County *(Allendale Hospital)*	**Ken Hiatt**	**69/69**	**$9.8**	**136/53**	**11,211**	27.4%	71.0%	0.1%	0.1%	1.6%	6.9%	40.0%
Columbus County *(Columbus Regional Healthcare System)*	**Bill Clark**	**154/113**	**$60**	**513/92**	**54,749**	63.4%	30.9%	3.1%	0.2%	2.3%	6.5%	31.4%
Hertford County *(Roanoke-Chowan Hospital)*	**Sue Lassiter**	**124/105**	**$47**	**500/150**	**22,601**	37.4%	59.6%	1.2%	0.3%	1.6%	6.0%	34.4%
Madison County *(Hot Springs Health Program)*	**John Graeter**	**0**	**$9**	**90/50**	**19,635**	97.6%	0.8%	0.3%	0.2%	1.4%	5.3%	30.7%
Marion County *(Marion Regional Healthcare System)*	**Peter Mulford[1]**	**124/110**	**$60**	**640/152**	**35,466**	41.7%	56.3%	0.3%	0.3%	1.8%	18.2%	32.0%
Onslow County *(Onslow Memorial Hospital)*	**Bob Swindell**	**162/130**	**$140**	**682/237**	**150,355**	72.1%	18.5%	0.7%	1.7%	7.2%	5.6%	15.7%
Pender County *(Pender Memorial Hospital)*	**Matt Mendez**	**86/68**	**$15.5**	**157/118**	**41,082**	72.7%	23.6%	0.5%	0.2%	3.6%	4.7%	23.2%
Randolph County *(Randolph Hospital)*	**Bob Morrison**	**145/115**	**$100**	**780/170**	**130,454**	89.2%	5.6%	0.4%	0.6%	6.6%	5.1%	30.0%
Vance County *(Mariah Parham Hospital)*	**Patrick Jackson[2]**	**102/98**	**$110**	**661/82**	**42,954**	48.2%	48.3%	0.2%	0.4%	4.6%	9.8%	31.9%

The Pop./Educ. data are from the 2000 United States Census Survey. The 2004 Unemployment data are from the NC and SC Employment Security Commissions.

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[1] Peter Mulford's interview took place in April 2005. He left his position in June 2005.

[2] As of April 2004, Patrick Jackson was appointed the Interim-CEO of Maria Parham Hospital, which is formally searching for a replacement for former CEO Michael Shields.

[3] Supplemental information was also obtained from the following hospital personnel: Deborah Albritton, Columbus Regional Healthcare System and Lisa Newsome, Roanoke-Chowan Hospital.

The Table indicates the substantial scale at which these rural hospitals operate. With the exception of the Hot Springs Health Program, which plays the role of a hospital in Madison County where no such facility exists, the hospitals participating in PRC have sizeable budgets and employ significant numbers of people. In most cases, the hospital is one of the top employers in the county: it employs the largest number of workers (along with the school system and local government) and it frequently offers the highest average hourly wage.

In addition to being major employers, these hospitals have long histories of community involvement. Most have been in existence for over 50 years. Although a few are working to overcome less-than-positive community perceptions due to previous problems, for the most part they enjoy positive reputations and relations with a wide range of community organizations and sectors. The hospital leaders report active collaborations with other health providers, schools, social services, health education and training programs, and city and county government; one has worked with an ecumenical organization to start a soup kitchen and free clinic; several North Carolina hospitals cite their participation in the statewide Healthy Carolinians program as sharing some of PRC's agenda.

Unlike many of the churches involved in PRC, the hospitals tended to have close relationships with local business. The CEOs are active in their local Chambers and United Ways, serve on various public/private planning groups and Economic Development Commissions, and participate on Committees of 100. Many community "movers and shakers" serve as hospital board members, further enhancing the institution's role as a powerful force in the community. In one community, the Chamber picked the hospital as its Business of the Year in recognition of its investment in the local economy. Another hospital reported a commitment to involving local businesses and vendors in its construction project contracts in an effort to contribute locally. At the outset, the hospital teams drew heavily upon their historic relationship with local business and had more business and government representatives than did the church teams. Over time, however, the differences in the composition of the church and hospital teams decreased: some hospital teams increased their nonprofit membership, and some church teams forged new relationships with local business and government.

Another characteristic that differentiates the hospitals from the churches in PRC is the stability of hospital leadership. With the exception of two executives who resigned in the first half of 2005, the other CEOs have been leading their institutions for an average of 10.1 years (range of 4 to 30 years). This relatively long tenure allows them to become embedded in the community's social and organizational networks, commit themselves to long-term projects, and take on important leadership roles outside of the hospital.[1]

Despite their considerable institutional strengths, the hospitals participating in PRC, like other rural hospitals, face significant difficulties: increasing numbers of underinsured or uninsured patients; reduced government reimbursement rates and payers; problems investing sufficiently in

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[1] Although specific comparative data from other hospitals in North and South Carolina are not available, this average tenure appears consistent with aggregate data about CEO turnover from the American College of Healthcare Executives. North Carolina has one of the lowest CEO turnover rates in the country--10 percent (adjusted)--while South Carolina's rate is in the mid-range--15 percent (adjusted). Seven of the nine PRC hospitals are in North Carolina.

technology and facility development; concerns about quality; and recruiting and retaining skilled staff, including the challenge of attracting physicians to their rural communities.

Why are the Hospitals Participating in PRC?

Most of the hospital leaders cited "doing the right thing" as one of the key reasons for their involvement in PRC. For them, PRC presented an opportunity to assume some responsibility for helping their own community grow and prosper. In addition to this, the hospital CEOs give three very clear reasons for participating in PRC:

- First, if PRC could improve the local economy, and put more people to work, more community residents would be able to pay for their healthcare either through their own resources or through employer-supported health insurance.
- Second, a better economy contributes to improved health outcomes. People are more likely to avail themselves of preventive services and less likely to rely on emergency room care. As one CEO put it, "it's easier to provide healthcare to a population that has income and the education to use it."
- Third, PRC could assist the hospital with its workforce needs. *"We have living wage jobs that we cannot fill via the local workforce"* so PRC can both help individuals and families become more self-sufficient and it can strengthen the hospital's operations by making it easier to recruit and retain a skilled workforce. Board members, in particular, tended to be enthusiastic about opportunities to recruit healthcare professionals and to grow the hospital's future workforce.

In sum, the CEOs articulated a powerful set of reasons for the hospital to take on PRC. Several CEOs also acknowledged their great debt to The Duke Endowment and were prepared to respond positively to whatever opportunities and requests the Endowment put before them. *"Had we not applied, I think that there would've been a question biting at the back of my head saying… 'How would the Duke Endowment look at us for not even applying?'"* However, no CEO expressed regret about participating in PRC, and it is clear that all were able to identify a compelling rationale for participation that went far beyond their relationship with the Endowment.

What Roles are the Hospitals Playing in PRC?

With the exception of one site, all the hospital CEOs sit on the PRC team, typically on the steering or executive committee, although most often not as the chair. Several teams have involved additional hospital staff including one hospital that had an existing Healthy Carolinians program that contributed that staff member's time to PRC so that all of the PRC resources could be devoted to program, rather than staff, costs. In many cases, the hospital was key to developing the proposal and getting PRC up and running but has, over time, reduced its leadership role. *"We got the right people together and got them to realize that this was an opportunity. Our biggest role at the beginning was to provide credibility. . . then we pulled away from the day to day involvement. . .and have long since quit being the leading member."*

All of the hospital leaders understood the importance of not having PRC be perceived either internally or externally as a hospital project. *"We made a conscious decision not to overpower the group." "We've been very intentional about not foregrounding the hospital in this project—we haven't gotten a lot of PR from it, but that's not what we were out to do." "I didn't want any of the members or other people in the community to think that this project was simply about us trying to feed ourselves." "I intentionally tried to steer it away from being viewed as a hospital initiative. In fact, it wasn't until the last six months to a year that we actually did something that could benefit us via the workforce initiative."* The result is that all our respondents think that the hospital is perceived as *"a facilitator rather than the driving force"* behind PRC.

Serving as a fiscal agent for PRC did not pose any significant challenges for the participating hospitals. As major employers, they had the administrative infrastructure in place to oversee fund disbursals, provide office space and support services, and hire staff as needed. Most teams hold some, if not all, of their meetings at the hospital, although a few teams started meeting elsewhere or rotating meeting locations in an effort to reinforce the idea that PRC is not "owned" by the hospital. While grant management certainly takes time, one CEO pointed out that it does keep the hospital connected to the Endowment and helps to underscore the hospital's catalytic role in community development.

What impact has PRC had on Participating hospitals?

The CEOs report that PRC has had a range of positive impacts on their institutions:

Enhanced reputation and visibility in the community

- *"People appreciate what we're doing to get people into the labor force."*
- *"The hospital is now viewed as a team player, as a part of the community... not just a direct patient care provider. Image-wise, we've sent the message that we're a part of the community and that we all have a responsibility to rectify the ills of this community."*
- *"It has had a positive impact, particularly amongst some of the staff members who are anxious to see the hospital move aggressively in community-building... getting away from 'sick-care' mentality...understanding that there is a much broader responsibility...to improve the quality of life of residents."*
- *"We've improved our capacity to sell our mission to the community."*
- *"It's been good for us to get outside of our four walls and interact with the community. It's been very helpful...We've also had a lot of people come through our doors as a result of this project and they, in turn, learn about what kind of healthcare is available in the county.*"
- *"I would be involved again – I do think it's been useful. It's been good for the community and good for the hospital. It has opened lines of communication that weren't there before and planted seeds of change. It's made us better organizations."*

New business connections and networks

The CEOs report new relationships and partnerships with a host of people and organizations with whom they had not previously worked closely: community colleges, schools, adult education, cooperative extension programs, tourism councils, local utilities, nonprofits, etc.

- *"We have created… developed a lot of dialogue. The community college comes to mind. We're talking to other players… understanding some of the barriers to entry in the nursing programs and Medical Laboratory Technician program. The effectiveness of communication has been improved."*
- *"We're being seen more and are more readily accepting the role of being a resource for the community. For example, we had a new company come into town, a call center that employs pharmacists and pharmacy techs… Even though that company sort of negatively impacted the hospital given that our pharmacists and pharmacy techs were being lured away, what we did was link them to the community college to create a pharmacy tech program, and our pharmacists worked with them to set this up."*

New community connections and understanding

- *"We've learned things we didn't know before about our community; maybe more important, we've met people we didn't know before. We've gotten involved and engaged with different groups – minorities and low income – that we were engaged with as patients before, but not other ways."*
- *"It has created good communication opportunities with Latinos in particular, with whom we haven't had much contact. It's also helped us to improve our routine communications with people in the African American community. People will pick up the phone and talk with you when they know you. I think we have a better understanding of these different communities' interests and concerns."*
- *"The biggest thing is that we're better informed in our work than we were before. I am more sympathetic and more supportive when nurses talk about the need for resources for patient education and discharge planning and support for families before they go home."*

New investment in workforce development[2]

- *"It helped to push the hospital toward greater investment in workforce development."*
- *"Graduates of the new training programs created a new employment pool."*
- *"It created new leadership development opportunities--we've found a way to put people in leadership roles, and they are honing their skills and growing. People are looking to us for leaders."*

Although only voiced by a couple of the CEOs, the following comments illustrate some limitations on PRC's perceived impact:

> **Limited impact institutionally:** *"PRC has not had an organizational effect on the hospital. The board supported it, and I include it in my CEO report to the board, but it's not a big part of hospital operations. There has been very little involvement, all of the PRC effort has been handled through my office. Other*

[2] Although most rural hospitals are challenged to recruit and retain a skilled workforce and hospitals recognized PRC as one way to address this challenge, for a variety of reasons only about half of the hospital sites chose to address their own institution's workforce needs through PRC. In fact, church-led teams were as likely to invest in health care training strategies as were the hospital-led teams. This may be in part because at the outset of PRC some hospitals already had workforce development strategies in place, often through partnerships with institutions like the community or technical college, and some put them in place after PRC began.

hospital staff are involved in other workforce development issues with community colleges and technical colleges... but they haven't been involved in PRC."

Limited ability to affect the larger funding and policy landscape: *"I hope that local money can be found to replace TDE money, but our county government has not changed. This was one of the things I was hoping we'd influence. They still value low taxes over services. I just don't see where the money is going to come from to keep the services we've started in place. I just don't think we've accomplished catalyzing a fundamental change in how the county sees itself. We've maybe planted a seed, and we can try to cultivate that seed to see if it grows. That may take a decade, fifteen years for us to see attitudinal change. Those of us interested in and active in the community will keep trying."*

Finally, because of their long-term relationships with the Endowment, some CEOs felt some pressure to deliver, especially early on. *"My personal commitment was on the line. I felt pressure because I told TDE that I would be committed…I wasn't going to allow it to wither away and die so I had to keep pushing the group to find a way. In recent months I've been involved much less, because we have a strong board and an accountable facilitator."* Although taking on PRC did create stress for some of the hospital leaders, even those most worried about succeeding look back and assess the experience positively.

The Hospital's Future Role in EconomiC Development

All of the hospital CEOs expressed an interest in PRC continuing in some form, and they voiced an array of strategies toward this end. One hospital has already made a 3-5 year commitment to allocating funds and sitting on the board of one of its major projects, a new Economic Development Partnership. Others plan to continue to provide in-kind support, to look for replacement funding, to operate through collaborations and partnerships, to write grants for work in related areas, to provide bridge funding until other grants come through, and/or to institutionalize various program components in different community institutions like the community college or a local nonprofit. Hospitals engaged in teams that used PRC funds for workforce training in the health care field reported that they were committed to continuing these activities, either alone or in collaboration with others. However, the CEOs underscore the fiscal constraints facing their own institutions as well as the reality that county budgets are getting increasingly tight and unlikely to be able to incorporate the costs of new programs.

In many cases, the CEO anticipates that the PRC committee or board will continue to meet *"if not just for the exchange of ideas."* In a few sites, the team has either created or is considering creating a new nonprofit organization that would continue the work in some form but independently from the hospital.

As hospitals consider their future role in promoting PRC or a similar economic development/community building agenda, it might be useful to review recent explorations of this

territory among hospitals in largely urban areas. Some urban hospitals in low-income communities have begun to see their role as "economic anchors" within in these communities and to use their assets to improve the economic health of the surrounding area. Although assisting the hospitals to take on more active economic development activities was not an explicit goal of PRC, as we have reported above, most hospitals participating in PRC do articulate a link between the economic health of the community and their own institutional well-being. However, only some of the participating hospitals have translated that link into an operational economic development strategy, and a few simply do not connect PRC to their economic development agendas. This group tends to separate PRC's collaborative approach to reaching people left behind by the economy from the hospital's traditional interest in economic development.

The Appendix at the end of this memo includes a "Strategic Framework for Leveraging Health Institution Assets for Community Economic Revitalization." The framework describes nine possible roles for hospitals interested in operationalizing an economic development agenda. Most of these roles have been played by at least one of PRC's hospitals, some by most of them. Our goal for including them here is simply to encourage participating hospitals to reflect on the possible benefits—both to the hospital and to the community—of taking a more intentional approach to the use of their assets for economic revitalization of their communities.

The "Core Business" Challenge

One of the biggest questions for the hospitals participating in PRC has been how much to engage their boards and embrace PRC as part of their core business. One CEO's comments capture this challenge: "*We've had to be careful not to let this distract us. We have to focus on our core business. For me, it's a serious and important effort but I don't let it distract me from managing the practice."*

Although all of the hospital boards supported participation, the CEOs reported that board members often saw PRC as a "sidebar" to the institution's core business. Typically the CEOs provide periodic information to the board but for the most part the board is *"very much on the periphery." "I'm not sure that our board really understands the long-range vision part of it." "If you ask them to describe the philosophy or the reason for it, they probably couldn't give a very good definition."* In one hospital, some key board members participated at the beginning but as the program evolved and garnered more community ownership, the group's vision for PRC, though never counter to that of the board members, diverged. In the end, these board members determined that their direct participation was no longer warranted. While a few board members played major roles in PRC, these efforts tended to reflect individual rather than board commitment, leading some CEOs to wish that they had engaged their board members more in PRC. *"I would have gotten more people in our board and management group interested. I did try, just didn't push, people are busy with other things. I'd like to see board members on the steering committee, volunteering on the program side, etc."* Few CEOs, however, had concrete plans to engage their boards more actively going forward.

There was one hospital in which the board was directly involved in PRC and expects to continue to be so for the foreseeable future. Members of the board played a key role in both facilitating the hospital's decision to apply to PRC and in shaping, garnering political support for and implementing one of the team's key strategies. In this hospital, board members view PRC as very important to the institution's core business and long-term health. They note that the hospital writes off a significant proportion of its budget due to bad debt or charity care. *"We generate those charges but it's of no consequence if people are not gainfully employed. Their uplift is directly related to our viability. We are in the business of building wealth."*

Depending on the PRC teams' goals and strategies, however, a direct board role may not always be clear-cut. Hospital boards are often composed of business and community leaders who have the skills and experience to govern a large and complex enterprise. While they may be instrumental in organizations that serve or employ those who are marginally employable, they themselves are rarely those "left behind" by the economy. One PRC hospital team was initially composed primarily of former hospital board members and people with similar profiles. The team then shifted its membership to include people closer to "those left behind," such as nonprofit and social services employees. According to that hospital CEO, if the team had not made such a change, the group would have taken different directions and chosen different initiatives. *"I don't think that either approach is inherently right or wrong, superior or inferior. I **do** think that strong hospital board involvement in the PRC work would produce different goals, initiatives and outcomes."* While increased board involvement might yield significant results in some respects, it is important to recognize that such involvement would possibly have, as a side-effect, a reduction in the influence of "those left behind" in the work.

Whether as a direct player or in a sounding board or advisory capacity, our sense is that the more the hospital's board can articulate and operationalize a connection between PRC's agenda and the institution's core business, the greater the chances are that the hospital will find creative economic development roles that will yield long-term benefits internally as well as institutionally. The "Strategic Framework for Leveraging Health Institution Assets for Community Economic Revitalization" might serve as a place to start the conversation on how the hospital's agenda might overlap with that of the community's and how the hospital's assets might be used for long-term economic renewal.

Looking Forward

Like the United Methodist Churches participating in PRC, hospitals have been positively impacted by PRC despite the relative lack of engagement of their boards. And, as with the churches, the hospitals have been effective intermediaries that have collaborated successfully with a diverse group of local organizations and individual citizens. Despite increasing fiscal constraints within the health care industry, the hospitals have been able to draw upon their long history in the community, their stable leadership, and TDE's resources to bring diverse movers and shakers to the table and to help facilitate a broad community change agenda. As mentioned above, even without TDE resources, most CEO's are prepared to continue lending their credibility and leadership to the PRC process, although it is important to recognize that without the "bait" of TDE resources, *"it may be harder to attract as many fish."*

Given the CEO's generally positive experience in PRC, it is not surprising that most of them responded affirmatively to a question regarding the potential interest of other hospitals in taking on similar enterprises focused on increasing economic opportunity for people left behind. While they acknowledge that not all of their colleagues link the hospital's self-interest so closely with the economic vitality of the community, many do. Most also see the Hospital Association as one vehicle for highlighting the potential of the PRC approach for other hospitals. A few wondered if the Hospital Association would see this as their role, but others felt that the Association's commitment to the viability of rural hospitals would make it receptive to serving as a conduit for communication about the value of PRC. In addition to the Hospital Association, there might also be potential for involving state medical associations since improved community economies resulting from the PRC process may attract more doctors to rural communities. Overall, the more that PRC can provide evidence of a concrete payoff resulting from the hospital's investment in the initiative generally and in workforce development more specifically, the more receptive the hospital CEOs expect their colleagues in other hospitals to be.

Appendix A

The Duke Endowment
Program for the Rural Carolinas
Participants

The Duke Endowment Beneficiary	Program Name/Summary	Participating Years
Option 1 Programs		
Greenville District United Methodist Church	Beaufort County Program for the Rural Carolinas Beaufort County, NC Affordable housing. IDAs[1] and an EITC[2] programs; small business development; and raising income levels through education and training.	2002-2006
Hinton Rural Life Center	Far West Mountain Economic Partners Cherokee, Clay, Graham & Swain Counties, NC Heritage tourism, small-scale agriculture, and affordable housing.	2002-2006
Maria Parham Hospital	TEAM VANCE Vance County, NC Reducing disparity between available jobs and unemployed people with skills. Identify key growth sectors. Affordable home-ownership. Connecting unemployed with jobs that have a career path towards a sustainable wage.	2002-2006
Marion County Medical Center	Marion County Collaborative Action Network Marion County, SC Industry retention through improved productivity increasing employment, the expansion of existing and development of new sectors, and increasing income and wealth of the left-behind.	2002-2005
North Wilkesboro District United Methodist Church	Northwest Alliance Program for the Rural Carolinas Alleghany, Ashe & Wilkes Counties, NC Leadership, marketing, program development, and entrepreneurial development.	2002-2006
Randolph Hospital	Randolph Program for the Rural Carolinas Randolph County, NC Goals are directed at increasing employment and wealth.	2002-2006

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[1] IDA is an individual development account for savings to purchase a first home, pursue job training or capitalize a small business.

[2] EITC is an earned individual tax credit that people of low wealth may use to reduce and individual's taxes. The reduction may be returned in the form of a refund.

The Duke Endowment Beneficiary	Program Name/Summary	Participating Years
Shady Grove United Methodist Church	Shady Grove Program for the Rural Carolinas (LO/UD) Lower Orangeburg & Upper Dorchester Counties, SC Increasing the employment income, financial literacy, and wealth of people left-behind.	2002-2006
Option 2 Programs		
Allendale County Hospital	Helping Hands Allendale County, SC Develop viable health care training programs and trustworthy communication links for the left-behind.	2002-2006
Calvary Memorial United Methodist Church	Contentnea Development Partnership Greene County, NC Employment business development, wealth building through EITC and homeownership. Increasing public awareness of economic development issues.	2002-2005
Columbus County Hospital	Discover Columbus Columbus County, NC Eco-tourism / Agri-tourism, Agri-business, and Leadership Development.	2002-2006
Duncan Memorial Untied Methodist Church	"Project Reach^2" Georgetown, SC Goals are to improve housing conditions while simultaneously providing job skill training for youth.	2002-2004
Hildebran United Methodist Church	East Burke Learning Alliance Burke County, NC Involve existing business and industry in creating employment opportunities; increase the involvement of the left-behind and access to distant markets, people, and educational opportunities through public Internet sites.	2002-2006
Hot Springs Health Center	Madison PRC Madison County, NC Increase the incomes of local farmers and craftsmen/artists and build the leadership and infrastructure that will sustain the increased income.	2002-2006
Hyde County Cooperative Parish (United Methodist Church)	Hyde County Program for the Rural Carolinas Hyde County, NC Supporting development of the Hyde-Davis Business Enterprise Center; developing a plan for the Machapungo Park Project[3]; and providing a framework for economic development, leadership training, and team building for the team.	2002-2005

[3] The Machapungo Park Project showcases the history and cultural heritage of Native American, European settlers and Civil War-era residents.

The Duke Endowment Beneficiary	Program Name/Summary	Participating Years
Isaiah United Methodist Church	CAN Program/The Collaborative Colleton County, SC Increasing employment and wealth through IDA program.	2002-2006
Onslow Memorial Hospital	Onslow PRC Onslow County, NC Assessing the needs of the left-behind, improving their financial literacy, and building their wealth through the establishment of EITC and IDA programs.	2002-2006
Pender Memorial Hospital	Pender Rural Economic Development Task Pender County, NC Complete a comprehensive needs assessment showing key demographic and economic issues, and development of a plan for implementing the new ideas identified by these studies.	2002-2006
Pilmoor United Methodist Church	Steps-to-Success Camden & Currituck Counties, NC Develop jobs, provide life skills training and mentor the left-behind. Create sustainable non-seasonal employment opportunities for coastal area citizens.	2002-2005
Pinetop United Methodist Church	Pinetops PRC Edgecombe County, NC Creating a new economic environment that provides new opportunities for employment and asset building through business development and growth.	2002-2004
Roanoke Chowan Hospital	Roanoke-Chowan PRC Bertie, Gates, Hertford & Northampton Counties, NC Workforce development and increasing employment.	2003-2005
Snow Hill United Methodist Church	Stokes PRC Stokes County, NC Support local farmers and foster workforce development.	2002-2006
The Rockingham District United Methodist Church	The Robeson County Program for the Rural Carolinas Robeson County, NC Develop a countywide CDC to help team achieve wealth building through home ownership, small farm and agricultural development, small businesses, and create a plan for the long-term sustainability.	2002-2005

Appendix B

The Duke Endowment
Program for the Rural Carolinas
Working Memoranda Topics

Constituting Effective Teams for Rural Development in the PRC (November 2003)
This memorandum reviews the rationale for the central role of collaborative teams in PRC's design and then examines the composition and structure of the newly constituted teams. Although teams differ considerably in their composition, most are relatively diverse by race and background but less so by class and age. The memorandum reviews the committee and governance structure each team has put in place to help it make decisions, allocate resources, and carry out the work. Even this early in PRC's implementation, about half of the teams are considering incorporating as a new nonprofit organization as a possible way to institutionalize the change process at the end of PRC. Teams also face the challenge of how to deploy staff effectively so that team members neither burn out nor reduce their much-needed engagement.

Doing Development Differently: Innovation and Learning in the PRC (November 2003)
The focus of this memorandum is on two challenges teams face as they translate new ideas about economic renewal into operational realities. First, how do they innovate without starting a large number of new programs that may neither maximize the use of existing community resources nor generate long-term support for sustainability? The memorandum describes how the teams are catalyzing innovation by creating and brokering partnerships and by strengthening the capacity of existing organizations to implement new programs. Second, how do teams build learning and evaluation into implementation in a way that enables them to reflect upon and refine their strategies as part of ongoing practice? Given implementation challenges, teams often have trouble finding the time to engage in iterative cycles of intentional learning, planning, doing, and evaluation that could improve their work.

The Role of the Duke Endowment's Eligible Institutions in the PRC (November 2003)
The rural Methodist churches and rural nonprofit hospitals that serve as team members and fiscal agents for PRC in each site face a number of challenges in PRC. They are expected to be leaders but not to be in charge, to produce results but to share that responsibility and credit with a range of other community partners, and to institutionalize the change process but not necessarily within their own structures. This memorandum examines what assets these churches and hospitals bring to PRC and how they have addressed the challenges inherent in their new roles. The potential for other rural churches and hospitals to develop increasing interest in playing leadership roles in promoting their community's economic renewal is also addressed.

Managing and Implementing the PRC: The Role of Staff (May 2004)
This memorandum reviews the role of staff in supporting the work of the PRC teams. It describes the central role of the project coordinator in facilitating, coordinating, and communicating; keeping team members engaged; and sustaining the pace and momentum of the work. What the coordinator and project staff actually do depends in part on what tasks the team members are willing and able to take on and what additional vehicles the team can create or

access for carrying out the work—such as using consultants, partnering with other organizations, or involving community members on PRC committees or task forces. The memorandum challenges teams to use staff and other vehicles to implement their agendas in ways that both produce program results and build enduring community capacity and support for a continuing partnership.

Leadership Development in the PRC (December 2004)
This memorandum examines the different ways that teams have tried to identify and cultivate a cadre of people who are committed to working on behalf of PRC's goals. Potential leadership can come from PRC team members, as well as from diverse sectors of the community: ordinary citizens who express an interest in community improvement, traditional power brokers, people who work in organizations and agencies that serve the disadvantaged, and people left behind by the economy. All of these different kinds of citizens are necessary constituents of a long-term partnership to advance and sustain PRC's goals over time. But diverse strategies are needed to identify, engage, and develop these different leaders. The memorandum reviews both the formal and informal ways that the teams have fostered leadership and challenges teams to develop ways of monitoring the success of these efforts.

Public Sector Involvement in the PRC (December 2004)
The focus of this memorandum is on the different ways in which the teams have approached the complexities of engaging the public sector, both elected officials and those who work for various government departments or offices at the municipal and county level. Clearly, teams cannot ignore the public sector and still access the resources and achieve the changes that are required for local economic renewal. But the timing and nature of the relationship involve strategic challenges, which teams have addressed in quite different ways with different results. The memorandum reviews the progress teams have made in garnering public support for their agendas, as well as for changing public sector policies to be more supportive of the interests of people left behind by the economy.

The Role of the Church in the PRC (May 2005)
This memorandum examines the experience of the eleven Endowment-eligible rural United Methodist Churches or church-related entities that are participating in PRC. The focus is on the role church leaders and their UMC institutions have played in PRC and the impact of PRC on these institutions. Overall, the churches—like their rural hospital counterparts—have been successful intermediaries and effective fiscal agents. In turn, PRC has had a positive impact on their reputations in the community and their capacities as community partners. Few of the churches, however, have engaged their membership in PRC in a substantial way. The memorandum outlines why this has been the case and summarizes the emerging tools and strategies that UMC leadership is testing to get the laity involved in order to provide continuity and sustain the long-term commitment of the church to PRC's interests.

The Role of the Hospital in the PRC (September 2005)
This memorandum examines the experience of the nine Endowment-eligible rural hospitals or health entities participating in PRC. The focus is on the role hospital executives and their institutions have played in PRC and the impact of PRC on these institutions. Overall, the rural hospitals—like their United Methodist Church counterparts—have been successful

intermediaries and effective fiscal agents. Despite increasing fiscal constraints, the hospitals have been able to draw upon their long history in the community, their stable leadership, and their close relationships to local business to help facilitate a broad community change agenda. As major employers, they have understood PRC's potential to address local workforce needs. A key question for these hospitals has been how much to engage their boards and embrace PRC as part of their core business. The memorandum ends with a strategic framework for leveraging health institution assets for community economic revitalization.

Managing and Supporting PRC (February 2006)

This memorandum examines the management and provision of support to PRC with an eye toward drawing lessons for other foundations, intermediaries and nonprofits considering similar multi-year, multi-site initiatives. As PRC's intermediary, MDC provided a rich and diverse portfolio of supports, such as coaching, cross-site meetings, and access to a technical assistance pool, that were intended to convey information, inspire, challenge, facilitate and connect sites to additional resources. For the most part, these supports complemented the Endowment's unique relationship with its beneficiaries. Both MDC and the Endowment report that it would have been useful to develop additional clarity at PRC's inception regarding how success in PRC was to be defined, measured and reported. Further, both organizations would have benefited from more structured opportunities for mutual reflection and learning about how the ideas behind PRC were playing out in practice.