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Moving Upstream: An Intersectoral Collaboration to Build Sustainable Planning Capacity in Rural and Appalachian Communities

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Introduction

In the early 1990s, data-driven health planning emerged as a disease-prevention strategy for public health issues such as substance abuse (Springer et al., 2004). Substance-use prevention initiatives historically had focused on programs delivered to small groups of individuals, and were not necessarily achieving the desired population-level outcomes (Orwin, Edwards, Buchanan, Flewelling, & Landy, 2012). As a result, grantmakers, policymakers, researchers, and evaluators tried various approaches to strengthen the selection and implementation of evidence-based strategies to achieve those outcomes (Aarons, Hurlburt, & McCue Horwitz, 2011).

While some grantmakers advocate to preselect strategies for organizations (Easterling & Main, 2016), this approach runs the risk of being presumptive (Couto, 2003) rather than empowering (Fetterman, Kaftarian, & Wandersman, 2015). Instead, for the initiatives discussed in this article, the Substance Abuse and Mental Health Services Administration (SAMHSA) promotes an alternative approach: community-driven strategy selection based upon local data. This approach is useful because while many proven prevention strategies exist (SAMHSA, 2017), organizations that are able to chart their own course using a data-informed approach can more effectively address community public health concerns in a more culturally relevant and sustainable manner (Trent & Chavis, 2009).

Key Points

- As part of an effort to address health inequities in Appalachian and rural Ohio, the state's Department of Mental Health and Addiction Services developed an upstream intersectoral health innovation that specifically addressed the lack of infrastructure and other capacity issues that create barriers to obtaining federally funded prevention services among communities with the highest need for those services.
- The department partnered with two nonprofit organizations and a university to create a performance-based, stepping-stone investment strategy that provided monetary awards to community organizations and included intensive, customized training and technical assistance that promoted capacity-building for data-driven strategic planning.
- This article discusses successes and lessons learned from implementing this infrastructure development initiative, which strengthened capacity of local prevention workforces in six Appalachian and rural communities. The findings will be helpful to foundations as they structure and evaluate funding opportunities to sustainably address persistent inequities in health and mental health.

[C]ommunities that are socially and economically vulnerable and lack access to community-level data are at even greater risk of health inequities because they do not have the necessary resources to effectively address their health issues.

Likewise, philanthropic grantmakers have shifted their expectations when funding public health prevention efforts. They no longer simply award grants, but instead make investments in initiatives, organizations, and communities that carry a desired "return on grantmaking" (McCracken & Firesheets, 2010, p. 55). Philanthropy also has moved toward making longer-term, multiyear investments in recognition that evidence-based prevention strategies need sufficient time to impact public health concerns (Julnes, 2019; Schell et al., 2013; Bartczak, 2013). Multiyear investments often include expectations of grantees to produce positive community outcomes, which means they need community-level data to track and report those outcomes.

While these shifts help optimize the impact of both government and philanthropic dollars, the approach overlooks a potential upstream social determinant of health (U.S. Department of Health and Human Services, 2010). Communities that are socially and economically vulnerable often lack the data and infrastructure necessary to select and implement locally determined evidence-based strategies (Brownson & Bright, 2004). According to Bharmal, Derose, Felician, and Weden (2015), upstream health innovations include those that provide socially and economically vulnerable communities with resources to protect and improve health. Importantly, researchers have noted that one of the biggest barriers to implementing effective substance-use prevention strategies is a lack of community-level data related to key indicators that drive the intervention selection process: consumption of substances, consequences of substance use, and community and individual risk and protective factors (Brownson & Bright). As such, communities that are socially and economically vulnerable and lack access to community-level data are at even greater risk of health inequities because they do not have the necessary resources to effectively address their health issues (Braveman, Arkin, Orleans, Proctor, & Plough, 2017).

Around 2010, state leaders in Ohio, along with other partners, began noticing health inequities in the state's Appalachian and rural regions, which historically have been vulnerable to behavioral health and economic disparities. Sixty-one of Ohio's 88 counties are designated as Appalachian and/or rural and struggle to equitably compete for substance-use prevention funding. For example, under the Strategic Prevention Framework–State Inventive Grant (SPF SIG), a five-year (2009–2014) SAMHSA initiative, only nine of those 61 eligible communities submitted applications to become federal subrecipient grantees. Further, only five had strong enough applications to be selected. Under a subsequent (2014-2019) five-year SAMHSA initiative, state leaders and other partners intentionally restricted eligibility for funding to communities designated as Appalachian or rural. Organizations from 24 of those 56 communities applied to become federal subrecipient grantees, and nine were selected. Although the number of applications from Appalachian to rural communities was greater than for the previous initiative, the comparatively small number of applications amplified concerns about deeper health inequities within those communities.

Ndumbe-Eyoh and Moffatt (2013) argue that action must be taken on social determinants of health in order to address health inequities. Since most social determinants lie outside of the health care sector, the authors note the importance of having intersectoral collaborators. In particular, they advocate for partnerships among both governmental and nongovernmental agencies, especially those outside of the health care delivery system.

With this in mind, the Ohio Department of Mental Health and Addiction Services (OhioMHAS) developed an upstream intersectoral health innovation for six Appalachian and rural communities. Three organizations — an institute of higher education, a nonprofit research and evaluation organization, and a nonprofit substance-use prevention organization for youth — partnered with the state agency to empower six Appalachian and rural community organizations to collect community-level data and then articulate a data-driven strategy selection process for their communities. Since financial investments alone are often insufficient to ameliorate disparities in vulnerable communities, graduated micro investments were offered with intentional wraparound support that included coaching, training, technical assistance, and evaluation services — all at no cost to the communities.

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Background

In federal fiscal year 2015, the OhioMHAS received a five-year, $8.1 million award under a cooperative agreement with the SAMHSA that aimed to address health inequities in the state by increasing access to evidence-based prevention services among Appalachian and rural communities. The SAMHSA's Strategic Prevention Framework Partnerships for Success (SPF-PFS) initiative included three goals:

1. Increase prevention services by building workforce capacity and infrastructure.

2. Prevent or reduce consequences of underage drinking for persons aged 12 to 20.

3. Reduce prescription drug misuse and abuse among persons aged 12 to 25.

As a federally supported initiative, grantees are required to use the Strategic Prevention Framework (SPF), a multiphased, evidence-based planning framework that supports the selection and implementation of culturally relevant, sustainable, and effective substance-use strategies using local data (SAMHSA, 2017). The framework has the advantage of being a comprehensive planning process with broad applicability to many substance-use and mental health issues. However, it requires access to community-level data to drive decision-making (SAMHSA, 2017), which parallels other population health initiatives that focus on "broad health outcomes" (Kindig, 2007, p. 142–143). Further, the SAMHSA (2006) requires national outcome measures (NOMs) to ensure uniform reporting of outcomes. This, however, perpetuates a critical health disparity among communities designated as Appalachian and rural that are socially and economically vulnerable and often do not have access to or the capacity to collect community-level data (Brownson & Bright, 2004; Borlawsky, Lele, Jensen, Hood, & Wewers, 2011). Such communities now have an additional barrier to implementing effective public health prevention strategies because they lack community-level consumption, consequence, and risk and protective factor data, which are needed to apply for grant funding, select population-level strategies, and evaluate outcomes (Brownson & Bright).

In 2016, the OhioMHAS issued a competitive request for proposals (RFPs) to fund community organizations from counties designated as Appalachian and rural to engage in the SPF-PFS initiative as subrecipient grantees. The department received 24 responses and selected

nine to become full subrecipient grantees with three-year contracts, renewed annually (Ware et al., 2019). Despite an RFP exclusively focused on funding Appalachian and rural communities, reviewers noticed a paucity of competitive responses from select areas of the Appalachian Ohio region. Among the nonselected proposals, some lacked critical structural elements for competitive substance-use prevention, including experience using the SPF planning process to implement prevention strategies and access to local data for community-level decision-making and national reporting requirements. As a result, the OhioMHAS decided to test an innovative upstream intersectoral approach to address these health inequities.

Methods

Given that capacity building requires dynamic and variable processes (Patton, McKegg, & Wehipeihana, 2016), the OhioMHAS collaborated with two partners to design and implement a contextually responsive evaluation: research scientists with evaluation and substance-use prevention expertise from Ohio University's Voinovich School of Leadership and Public Affairs and from the nonprofit Pacific Institute for Research and Evaluation. Ultimately, the three partners decided to use a developmental evaluation approach (Patton, 2011) because they knew the outcomes sought by the SAMHSA, but not all of the underlying assumptions to achieve them (Fitzpatrick, Sanders, & Worthen, 2010). Methodologically, a developmental evaluation approach emphasizes real-time, rapid-cycle feedback with the goal of nurturing strategic learning throughout the process. The collaborative nature of this approach also made sense given the capacity-building goals of the initiative, which focused on addressing an upstream social determinant of health.

In addition to offering technical assistance and training, evaluators acted as facilitators and conveners, engaging all involved in evaluative thinking, reflecting, and learning. They used reflective practice as a method of inquiry to systematically capture the evolving needs and achievements of the community organizations, including the iterative process of acting and reflecting to allow for continuous learning and adaptation (Patton, 2011). The evaluators also drew from empowerment evaluation principles: nurturing community ownership, inclusion, community knowledge, and organizational learning throughout the process (Fetterman et al., 2015).

When compiling the findings for this article, the authors utilized document analysis as a key method of study (Bowen, 2009). We reviewed three time points — baseline, end of year one, and end of year three — and analyzed the initial RFP, the submitted proposals, completed products and deliverables, and other artifacts. (See Table 1.) To frame this article as a case study, we also applied several validation strategies to ensure methodological rigor (Creswell & Miller, 2000). First, we had prolonged engagement in the field from the developmental process, which gave us time to learn from and document ideas and experiences. Other validation strategies included triangulation of findings, peer debriefing, and thick, rich description from documents, observations, and notes.

Innovative Strategy

Mini-Awards

The OhioMHAS created a series of tiered mini-awards to build organizational readiness and data capacity over a three-year period among the six community organizations. (See Table 2.) Based on the identified needs of these organizations, the department established two cohorts of awardees. The first cohort, consisting of two Appalachian community organizations, became the "data community cohort"; these organizations had no experience using the SPF and lacked community-level data on any of the NOMs. The second cohort, consisting of four communities (three Appalachian and one rural), became the "community readiness assessment cohort"; most had community-level access to at least some of the NOMs, which they could use to identify a problem of practice and begin assessing the readiness of their communities to address the problem.

The U.S. Census Bureau (2016) population estimates for 2015 for these communities ranged

TABLE 1 Mini-Award Timing and Data Sources

Time Points	Time Periods	Data Sources
Baseline	Sept. 1, 2016	• Documents (RFP, proposals) • Artifacts (notes, professional correspondence)
End of Year 1	June 30, 2017	• Observations • Documents (deliverables) • Artifacts (notes, correspondence)
End of Year 3	Sept. 30, 2019	• Observations • Documents (deliverables) • Artifacts (notes, correspondence)

Note: OhioMHAS originally contracted with the organizations based on the state fiscal year. Year one ran from July 1, 2016, to June 30, 2017. In year three the dates shifted to the federal fiscal year, which made the final year a 15-month period, from July 1, 2018, to Sept. 30, 2019.

TABLE 2 Characteristics of Mini-Award Communities

County Type	Organization Type	2015 Census Population	2016 ARC Economic Status
Appalachian	Medical foundation	28,000	Distressed
Appalachian	Mental health services provider	28,000	Transitional
Appalachian	Addiction and mental health services board	43,000	At-Risk
Appalachian	Nonprofit prevention organization	61,000	Transitional
Rural	Mental health services provider	45,000	N/A
Appalachian	Health coalition	77,000	Distressed

from 28,000 to 77,000. In addition, they all had high five-year (2009–2013) poverty rates and high three-year (2011–2013) average unemployment rates relative to the state and nation (Appalachian Regional Commission [ARC], 2016). In terms of economic classifications, the ARC designated two as distressed (lowest ranking out of five), one as at-risk (second lowest) and two as transitional (middle ranking) in 2016.

Tiered Funding

The OhioMHAS offered each cohort tiered investments over a three-year period and based continuation each year on demonstrated performance (e.g., completion of deliverables and buy-in). (See Table 3.) The two organizations in the data community cohort had infrastructural data-collection needs, and each received $2,500 in year one for staff to support those efforts. In year two, they were eligible for additional investments of up to $5,000 to select a problem of practice and begin coalescing efforts around that issue. In year three, they were eligible for up to $52,500 to complete the other SPF phases.

The four organizations in the community readiness cohort appeared ready to select their problem of practice and coalesce efforts around

TABLE 3 Tiered Funding and Performance Requirements

Data Community Cohort Mini-Awards	Community Readiness Cohort Mini-Awards
Year 1 (Eligible for up to $2,500) • Participate in learning community • Negotiate memoranda of understanding with schools • Develop quantitative data collection plan for community-level national outcome measures (NOMs)	***Year 1 (Eligible for up to $5,000)*** • Participate in learning community • Establish prevention data committee • Develop quantitative data collection plan for community-level NOMs • Identify problem of practice • Complete community readiness assessment • Reflect on overall readiness and community-level data
Year 2 (Eligible for up to $5,000) • Participate in learning community • Establish prevention data committee • Update quantitative data collection plan • Identify problem of practice • Complete community readiness assessment • Reflect on overall readiness and community-level data	***Year 2 (Eligible for up to $60,000)*** • Participate in learning community • Continue prevention data committee • Update quantitative data collection plan • Complete needs assessment • Process results and develop strategic plan map • Articulate theory of change and theory of action for outcomes • Participate in prevention conferences for professional development
Year 3 (Eligible for up to $52,500) • Participate in learning community • Continue prevention data committee • Update quantitative data collection plan • Complete needs assessment • Process results and develop strategic plan map • Articulate theory of change and theory of action for outcomes • Begin implementation of strategies • Evaluate results • Plan for sustainability • Participate in prevention Conferences for professional development	***Year 3 (Eligible for up to $60,000)*** • Participate in learning community • Engage a community action theory • Update quantitative data collection plan • Implement strategies • Evaluate results • Plan for sustainability • Participate in prevention conferences for professional development

that issue. They received up to $5,000 in year one to shore up data-collection plans and conduct a community readiness assessment. In each of the two subsequent years, they were eligible for up to $60,000 to complete the other SPF phases.

Customized Networked Learning

When building capacity, the type of structural supports offered by grantmakers matters (Grantmakers for Effective Organizations [GEO], 2014a). The OhioMHAS used funding from the SPF-PFS initiative to contract with three nongovernmental partners to offer extensive wraparound support: the Voinovich School of Leadership and Public Affairs at Ohio University, the Pacific Institute for Research and Evaluation, and PreventionFirst!, a nonprofit youth substance-abuse prevention organization and former subrecipient of the prior SPF initiative in Ohio (SPF SIG). The partners collaborated with state leaders to engage the mini-award recipients in intensive, networked learning events; peer-to-peer sharing; and personalized technical assistance. In addition, each grantee was assigned a local evaluator and content-expert coach to provide intensive, direct technical assistance.

TABLE 4 Access to Community-Level National Outcome Measures

Organization Type	Baseline		End of Year 1		End of Year 3	
	Access to Data	Annual Basis	Access to Data	Annual Basis	Access to Data	Annual Basis
Medical foundation	No access	No	Access to all	Yes	Access to all	Yes
Mental health services provider	Access to some	No	Access to all	Yes	Access to all	Yes
Addiction and mental health services board	Access to all	No	Access to all	No	N/A	N/A
Nonprofit prevention organization	No access	No	Access to all	Yes	Access to all	Yes
Mental health services provider	Access to some	No	No	No	N/A	N/A
Health coalition	Access to all	No	Access to all	No	N/A	N/A

A key capacity-building strategy for both mini-award cohorts involved the use of learning communities, which has been shown to effectively build shared practice (GEO, 2014b). Importantly, the evaluators and coaches did not act as experts dispensing wisdom from a distance, but instead worked as facilitators, conveners, and advisors to guide learning. They created learning environments where organizations would take the concepts being taught and put them into action. Then, they would come back together as a group for peer reflection to deepen understanding, which allowed the organizations to acquire additional skills and revise practices (GEO, 2019).

More specifically, in year one, all six community organizations participated in monthly learning events that generally occurred in an alternating pattern of daylong, in-person sessions followed the next month by shorter, virtual events. Before and after these events, personalized technical assistance provided additional support. Two key advantages of this support were peer-to-peer sharing for networked learning, cohesion, and knowledge transfer (Reagans & McEvily, 2003), and empowerment of community leaders to make community-determined, data-driven plans (Fetterman et al, 2015).

Further, the wraparound support encouraged customization based on emerging needs. For example, in year one, the readiness-assessment cohort engaged in such topics as conducting and analyzing qualitative interviews with key informants. In contrast, the data cohort engaged in such topics as negotiating agreements with local partners to support data collection. Again, the technical assistance evolved based on the needs of each organization and cohort.

Results

The mini-award investments produced three key results: access to standardized health measures, experience utilizing a planning process, and capacity to implement data-driven planning.

Access to Standardized Health Measures

At baseline, two community organizations indicated in their proposals that they did not have access to any of the standardized NOMs, two had access to some, and two had access to all. (See Table 4.) However, none of the organizations had adequate plans to collect or access them annually. By the end of year one, five organizations had access to all of the measures and three had approved plans for annual collection. By the end of year three, three of the organizations had access to all of the NOMs and continued to have annual plans for collection.

TABLE 5 Experience With the SPF Planning Process

Organization Type	Baseline	End of Year 1	End of Year 3
	From the Proposal	Detailed SPF Phase	Detailed SPF Phases
Medical foundation	• Some non-SPF planning experience • No SPF experience	• Assessment: Community-level national outcome measures (NOMs) data collection	• Assessment: Community-level NOMs data collection and readiness • Other phases: Capacity, planning, implementation, evaluation • Cultural competency • Sustainability
Mental health services provider	• Detailed non-SPF planning experience • Some SPF experience	• Assessment: Community-level NOMs data collection and readiness	• Assessment: community-level NOMs data collection and readiness • Other phases: Capacity, planning, implementation, evaluation • Cultural competency • Sustainability
Addiction and mental health services board	• Some non-SPF planning experience • Minimal SPF experience	• Assessment: Community-level NOMs data collection	N/A
Nonprofit prevention organization	• Some non-SPF planning experience • No SPF experience	• Assessment: Community-level NOMs data collection	• Assessment: Community-level NOMs data collection and readiness • Other phases: Capacity, planning, implementation, evaluation • Cultural competency • Sustainability
Mental health services provider	• Some non-SPF planning experience • Some SPF experience	• Assessment: Community-level NOMS data collection and readiness	N/A
Health coalition	• Minimal non-SPF planning experience • No SPF experience	• Assessment: Community-level NOMS data collection and readiness	N/A

Experience Utilizing a Planning Process

All six organizations indicated in their proposal (baseline) that they had at least some planning experience. (See Table 5.) The proposal reviewers considered this non-SPF planning experience to be a capacity indicator for knowledge transfer, meaning leaders could draw from experience to learn new skills (Reagans & McEvily, 2003). Further, four organizations said they had either no or only minimal SPF-specific planning experience and the remaining two had some basic SPF-specific experience. By the end of year one, all six had gained firsthand, detailed experience with at least the assessment phase of the planning framework.

In addition, four organizations had gained firsthand experience with the detailed assessment

TABLE 6 Stepping-Stone Investments in Six Rural and/or Appalachian Communities

Organization Type	End of Year 1 (SFY17)				End of Year 3 (FFY19)	
	Initial SPF-PFS Seed Investment	Initial TTAE From ANEP	Buy-In	Data Plan and PDC	Subsequent TTAE From ANEP	Subsequent Funding
Medical foundation	$2,500	$3,279	High	Yes	$4,244 (SFY18) $12,313 (SFY19)	SPF-PFS data cohort: $5,000 (SFY18) $52,500 (SFY19)
Mental health services provider	$5,000	$3,279	High	Yes	N/A	SPF-PFS subrecipient: $60,000 (SFY18) $60,000 (SFY19)
Addiction and mental health services board	$5,000	$3,279	Low	Pursued another opportunity	N/A	SPF-Rx subrecipient: $175,000 (SFY18) $85,000 (SFY19)
Nonprofit prevention organization	$2,500	$3,279	High	Yes	$4,244 (SFY18) $12,313 (SFY19)	Yes
Mental health services provider	$5,000	$3,279	Low	No; lacked local support	N/A	N/A
Health coalition	$5,000	$3,279	Moderate	No; lacked local support	N/A	N/A
Total	**$25,000**	**$19,674**	–	–	**$33,114**	**$495,000**

ANEP: Appalachian New Economy Partnership
TTAE: Training, technical assistance, and evaluation
SFY: State fiscal year
FFY: Federal fiscal year
PDC: Prevention Data Committee
SPF-PFS: Strategic Prevention Framework–Partnerships for Success Initiative
SPF-Rx: Strategic Prevention Framework for Prescription Drugs in Ohio

phase of community readiness assessments. By the end of year three, three organizations had gained firsthand experience with additional phases of the planning framework, including planning, selecting, and implementing culturally relevant and sustainable evidence-based strategies.

Capacity to Implement Data-Driven Planning

The OhioMHAS offered a stepping-stone approach to fund the two cohorts. (See Table 6.) At the end of year one, through the SPF-PFS initiative, it had made an initial investment of $25,000 among the six organizations. Two (the data cohort) each received $2,500 and four (the community readiness cohort) each received $5,000. All six received customized training and technical assistance from the wraparound support team.

Local evaluators also leveraged state funding under the Appalachian New Economy Partnership (ANEP). Administered through the Ohio Department of Higher Education and

Ohio's SPF-PFS initiative shifted the focus of capacity building away from teaching community leaders about selecting individual evidence-based programs to instead learning how to select the right program for the community based on the local context.

appropriated to Ohio University, the ANEP seeks to build the capacity of public and nonprofit organizations in the region in order to further their impact in critical areas such as health outcomes. In year one, ANEP support for the project totaled $20,000, which included dedicated local evaluators for the mini-award recipients. The OhioMHAS funded the evaluation team and prevention coaches under the SPF-PFS to provide additional wraparound support to the mini-award recipients; however, this support could not be directly quantified.

At the end of year one, the OhioMHAS invited three of the community organizations to continue receiving SPF-PFS funding in years two and three. They had demonstrated a high degree of buy-in (e.g., receptivity towards the cooperative process, active participation, and willingness to receive developmental feedback), and had also fully completed the deliverable requirements in year one. These three organizations had also identified local partners to engage the initiative in a community-based process.

In years two and three, one of the organizations from the community readiness cohort showed enough promise to become a full SPF-PFS sub-recipient grantee and received a total additional investment of $120,000 over those two years. The other two organizations, which comprised the data cohort, received more intensive training and technical assistance from the evaluation team during those two years. This support totaled a little over $33,000 from ANEP, and by the end of year three the two communities received additional investments of $115,000 from the OhioMHAS.

The three organizations that did not receive continued funding had low to moderate buy-in for the initiative. One organization decided to move forward with another SPF initiative in Ohio.[1] Despite supportive efforts from the local evaluators and coaches, the remaining two communities could not obtain adequate local support.

Discussion

Given the wide variety of evidence-based programs available, the OhioMHAS wanted to reframe the state's substance-abuse prevention approach. Ohio's SPF-PFS initiative shifted the focus of capacity building away from teaching community leaders about selecting individual evidence-based programs to instead learning how to select the right program for the community based on the local context. Using an evidence-based planning framework, with cultural relevance, sustainability, and capacity built into it, allowed the latter to happen. Similarly, because the SPF relies on data-driven decision-making, the community organizations based their strategy selection on unique local conditions and root causes. Moreover, not funding implementation of a particular strategy, program, policy, or practice provided a space for the organizations to learn more sustainable practices. Instead of an emphasis on action planning, they focused on building infrastructure to support community-based strategic planning — a data-driven decision-making process with a high propensity to achieve the intended outcomes.

Health Equity

This mini-award strategy addressed an organization-level equity issue with six communities. Notably, when communities lack the capacity

[1] Under that initiative — the SAMHSA-funded SPF-Rx: Strategic Prevention Framework for Prescription Drugs in Ohio — the organization received a total investment of $260,000 in state fiscal years 2018 and 2019.

and infrastructure to access local health data, it prevents them from selecting culturally relevant, sustainable, and evidence-based programs. As this article has discussed, communities with the greatest need for prevention services were not able to meet stringent federal outcome-reporting requirements. Instead of allowing structural barriers to disqualify six organizations from receiving funding under the SPF-PFS, the mini-award process built the capacity of these organizations to address substance abuse within a strategic and data-driven framework.

Some might argue that the mini-award strategy had only mixed success, because not all the organizations received funding for all three years. However, this innovative strategy allowed the grantmaker and grantees to mutually determine fit, which maximized the public investment and demonstrated respect for local choices. Likewise, all six organizations increased their substance-use prevention planning capacity by participating in year one alone.

Customized and Empowered Wraparound Support

Importantly, the grantee organizations received facilitated support from highly skilled evaluators and coaches. As others have discussed (Schweinhart & Raffle, 2019), this participatory approach pairs experts and community leaders as co-planners who progressively engage a set of processes to build knowledge, skills, and attitudes for data-driven strategic planning. These empowerment-focused and participatory processes encouraged the community leaders to take active control over what they implement, which researchers acknowledge as valuable (Cargo & Mercer, 2008; Stoecker, 2004).

Further, as others recognize (Frantzen, Solomon, & Hollod, 2018), participatory models have the benefit of allowing the organization, funder, and other partners to mutually learn from the process, which occurred here. Through this cohort-based model, the grantees needed to complete key steps in the planning process by submitting deliverables, which were then reviewed with a standardized rubric by one or more of four statewide committees.

Building data and planning capacities among communities situated in designated Appalachian and rural communities addressed an upstream social determinant of health: social and economic vulnerability.

Lessons Learned

Building data and planning capacities among communities in designated Appalachian and rural areas addressed an upstream social determinant of health: social and economic vulnerability. A number of broader lessons learned also emerged from this health equity innovation.

- *Address health equity with upstream strategies.* Monitoring health outcomes is necessary for public health initiatives; however, community organizations need access to local data and a planning infrastructure before they can engage in community-level, data-driven planning and monitoring. When communities lack access to these resources, they are at a competitive disadvantage that perpetuates health inequities because they are not able to meet the base requirements to apply for awards, much less submit competitive proposals. This innovative strategy provided opportunities for six communities to begin more effectively addressing their substance use issues.

- *Utilize evidence-based planning frameworks for sustainable planning capacity.* For more sustainable planning capacity, this initiative utilized an evidence-based planning framework that supported organizations in selecting and implementing culturally relevant substance-use prevention strategies based on their own community context. While this approach had an immediate

[E]ach of the three project directors acknowledged that having local information on the issues being addressed offered critical context that led each of them to select interventions other than those they had initially planned to use.

impact on their issues related to substance use, it also has had a long-term impact because communities are able to use the same process to address new issues as they arise. As Trent and Chavis (2009) note, engaging organizations in the process allows communities to be more successful and demonstrates respect for their voice. Likewise, it moves the conversation around sustaining programs away from viewing it as only an outcome to also seeing it as a process (Schell et al., 2013).

- *Consider incremental funding options.* The flexibility from the tiered-funding structure allowed the state agency to better engage Appalachian or rural communities across Ohio, regardless of individual community capacity needs or readiness levels. The funding structure also allowed the state to tailor capacity building to the needs of communities. Similarly, grant requirements expanded as grantee capacity grew. This incremental approach ensured buy-in and gave both the community organization and funder the option to continue. Similar to others who have used mini-awards to maximize resource distribution in public health (Arriola et al., 2016; Wiebel, Welter, Aglipay, & Rothstein, 2014), this initiative demonstrated similar success.

- *Recognize the benefits of learning communities.* Offering customized networked learning and technical assistance allowed multiple grantees to implement efforts simultaneously. In this case, having the two learning community cohorts allowed innovative ideas and practices to be shared frequently among grantees based on their level of planning readiness. It also built a collective community of practice, which allowed more contextualized learning to occur. However, community-of-practice models are resource-intensive and often require wraparound support from backbone organizations and technical experts. The experience of the SPF-PFS initiative reinforces the transformative nature of the SPF for coalitions and communities.

- *Employ developmental and empowerment evaluation methods.* The evaluation team provided a common evaluation and planning approach for all of the grantees, which meant each organization did not have to hire an evaluator. Further, developmental and empowerment frameworks allowed the evaluators and others to partner with community organizations to co-creatively build their capacity. It moved the conversation away from funding the right and perfect program to instead be about learning how to utilize a data-driven planning process. Finally, the developmental nature of this initiative allowed evaluators and coaches to provide rapid-cycle feedback to the communities and state agency, which in turn made real-time adjustments to the project. Moreover, the developmental process allowed an inequity issue to surface and be addressed. Finally, having four independent statewide committees review the key planning deliverables with standardized rubrics provided much-needed reflection and legitimacy to the work products.

Concluding Thoughts

The three communities that completed the annual collection of community-level outcomes in year one went on to utilize that data for planning purposes in years two and three. In particular, they selected culturally relevant substance-use prevention strategies based on the

readiness assessments and listening sessions they conducted. At the initiative's closeout event at the end of year three, the three project directors discussed how pivotal it had been for them to have community-level data. Interestingly, each of the three project directors acknowledged that having local information on the issues being addressed offered critical context that led each of them to select interventions other than those they had initially planned to use.

In federal fiscal year 2020, the two communities in the data cohort will receive additional funding. First, they will become federal subrecipients under a new, five-year $1.5 million SAMHSA award and will continue developing their capacity to address underage drinking and up to two additional data-driven substance-abuse prevention priorities. They also leveraged their mini-award investments to each receive an additional $13,000 ($26,000 combined) from the OhioMHAS to implement a strategy under the SAMHSA-funded SPF-Rx: Strategic Prevention Framework for Prescription Drugs in Ohio.[2]

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References

Aarons, G. A., Hurlburt, M., & McCue Horwitz, S. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration & Policy in Mental Health and Mental Health Services Research, 38,* 4–23.

Appalachian Regional Commission. (2016). County economic status classification. Retrieved from https://www.arc.gov/research/DataReports.asp

Arriola, K. R. J., Hermstad, A., Flemming, S. S., Honeycutt, S., Carvalho, M. L., Cherry, S. T., et al. (2016). Promoting policy and environmental change in faith-based organizations: Outcome evaluation of a mini-grants program. *Health Promotion Practice, 17*(1), 146–155.

Bartczak, L. (2013, Fall/Winter). Supporting nonprofit capacity: Three principles for grantmakers. *The Nonprofit Quarterly,* 74–77.

Bharmal, N., Derose, K. P., Felician, M., & Weden, M. M. (2015, May). Understanding the upstream social determinants of health: A working paper. Santa Monica, CA: RAND Corp.

Borlawsky, T. B., Lele, O., Jensen, D., Hood, N., & Wewers, M. E. (2011). Enabling distributed electronic research data collection for a rural Appalachian tobacco cessation study. *Journal of the American Medical Informatics Association, 18*(1), i140–i143.

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal, 9*(2), 27–40. https://doi.org/10.3316/QRJ0902027

Braveman, P., Arkin, E., Orleans, T., Proctor, D., & Plough, A. (2017). *What is health equity? And what difference does a definition make?* Princeton, NJ: Robert Wood Johnson Foundation.

Brownson, R. C., & Bright, F. (2004). Chronic disease control in public health practice: Looking back and moving forward. *Public Health Reports, 119,* 230–238.

Cargo, M., & Mercer, S. L. (2008). The value and challenges of participatory research: Strengthening its practice. *Annual Review of Public Health, 29,* 325–350.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory Into Practice, 39*(3), 124–130.

Couto, R. A. (2003, Summer). Review essay: Community-based research: Celebration and concern. *Michigan Journal of Community Service Learning, 9*(3), 69–74.

[2] For more information about the six communities discussed in this article, please visit the project website at pfs.ohio.gov/PFS-Communities/Data-Mini-Grantees. It features the work products and key accomplishments of the communities and includes tools, templates, and other resources utilized throughout this capacity-building effort.

Easterling, D., & Main, D. (2016). Reconciling community-based versus evidence-based philanthropy: A case study of The Colorado Trust's early initiatives. *The Foundation Review, 8*(4), 81–107. https://doi.org/10.9707/1944-5660.1329

Fetterman, D. M., Kaftarian, S. J., & Wandersman, A. (2015). *Empowerment evaluation: Knowledge and tools for self-assessment, evaluation capacity building, and accountability* (2nd ed.). Thousand Oaks, CA: Sage.

Fitzpatrick, J. L., Sanders, J. R., & Worthen, B. R. (2010). *Program evaluation: Alternative approaches and practical guidelines* (4th ed.). Upper Saddle River, NJ: Pearson.

Frantzen, L., Solomon, J., & Hollod, L. (2018). Partner-centered evaluation capacity building: Findings from a corporate social impact initiative. *The Foundation Review, 10*(2), 7–25. https://doi.org/10.9707/1944-5660.1412

Grantmakers for Effective Organizations. (2019). *Learning in philanthropy: A guidebook*. Washington, DC: Author.

Grantmakers for Effective Organizations. (2014a). *How can we support capacity building efforts?* Washington, DC: Author.

Grantmakers for Effective Organizations. (2014b). *What makes a successful learning community?* Washington, DC: Author.

Julnes, G. (2019). Evaluating sustainability: Controversies, challenges, and opportunities. *New Directions for Evaluation, 162,* 13–28.

Kindig, D. A. (2007). Understanding population health terminology. *Milbank Quarterly, 85*(1), 139–161.

McCracken, A. L., & Firesheets, K. (2010). Sustainability is made, not born: Enhancing program sustainability through reflective grantmaking. *The Foundation Review, 2*(2), 55–65. https://doi.org/10.4087/FOUNDATIONREVIEW-D-10-00012

Ndumbe-Eyoh, S., & Moffatt, H. (2013). Intersectoral action for health equity: A rapid systematic review. *BMC Public Health, 13,* 1056.

Orwin, R. G., Edwards, J. M., Buchanan, R. M., Flewelling, R. L., & Landy, A. L. (2012). Data-driven decision making in the prevention of substance-related harm: Results from the Strategic Prevention State Incentive Grant Program. *Contemporary Drug Problems, 39,* 73–106.

Patton, M. Q., McKegg, K., & Wehipeihana, N. (2016). *Developmental evaluation exemplars: Principles in practice*. New York, NY: Guilford Press.

Patton, M. Q. (2011). *Developmental evaluation: Applying complexity concepts to enhance innovation and use*. New York, NY: Guilford Press.

Reagans, R., & McEvily, B. (2003). Network structure and knowledge transfer: The effects of cohesion and range. *Networks and Knowledge, 48*(2), 240–267.

Schell, S. F., Luke, D. A., Schoole, M. W., Elliott, M. B., Herbers, S. H., Mueller, N. B., et al. (2013). Public health program capacity for sustainability: A new framework. *Implementation Science, 8*(15). https://doi.org/10.1186/1748-5908-8-15

Schweinhart, A., & Raffle, H. (2019). *Accomplishing radical community-based research while upholding rigorous standards*. Manuscript in preparation.

Springer, J. F., Sale, E., Hermann, J., Sambrano, S., Kasim, R., & Nistler, M. (2004). Characteristics of effective substance abuse prevention programs for high-risk youth. *Journal of Primary Prevention, 25*(2), 171–194.

Stoecker, R. (2004, May). *Creative tensions in the new community based research*. Keynote address prepared for the Community-Based Research Network Symposium, Carleton University, Ottawa, Ontario, Canada. Retrieved from http://comm-org.wisc.edu/drafts/cbrtensions.htm

Substance Abuse and Mental Health Services Administration. (2017). *Focus on prevention* (Publication No. SMA10–4120). Washington, DC: U.S. Department of Health and Human Services.

Substance Abuse and Mental Health Services Administration. (2006). *National outcome measures (NOMs) for co-occurring disorders* (Technical Bulletin No. 201212). Washington, DC: U.S. Department of Health and Human Services.

Trent, T. R., & Chavis, D. M. (2009). Scope, scale, and sustainability: What it takes to create lasting community change. *The Foundation Review, 1*(1), 96–114. https://doi.org/10.4087/FOUNDATIONREVIEW-D-09-00007

U.S. Census Bureau. (2016). *Population estimates for 2015*. Washington, DC: Author. Retrieved from https://data.census.gov

U.S. Department of Health and Human Services. (2010). *Healthy People 2020: An opportunity to address the societal determinants of health in the United States*. Washington, DC: Author. Available at http://www.healthypeople.gov/2010/hp2020/advisory/SocietalDeterminantsHealth.htm

Wiebel, V., Welter, C., Aglipay, G. S., & Rothstein, J. (2014). Maximizing resources with mini-grants: Enhancing preparedness capabilities and capacity in public health organizations. *Journal of Public Health Management Practice, 20*(5), S83–S88.

Ware, L. J., Raffle, H., Collins, D., Holt, N. A., Milazzo, L., & Wandersman, A. (2019). *Promoting health equity in Ohio's rural and Appalachian counties by assessing community capacity and readiness to engage in the Strategic Prevention Framework (SPF)*. Manuscript in preparation.

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